HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Ms L Linard MP (Chair)
Mr MF McArdle MP
Mr SE Cramp MP
Mr AD Harper MP
Mr DC Janetzki MP
Mr JP Kelly MP

Staff present:

Ms S Cawcutt (Research Director)
Ms T Struber (Inquiry Secretary)

PUBLIC HEARING—HEALTH (ABORTION LAW REFORM) AMENDMENT BILL 2016

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 28 OCTOBER 2016

Brisbane

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Committee met at 9.31 am

CHAIR: I now declare open this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's inquiry into the Health (Abortion Law Reform) Amendment Bill 2016. I would like to acknowledge the traditional owners of the land on which we are meeting today and pay my respect to elders past, present and emerging. My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. The other members of the committee are: Mr Mark McArdle, deputy chair and the member for Caloundra; Mr Joe Kelly, the member for Greenslopes; Mr Sid Cramp, the member for Gaven, will join us shortly; Mr Aaron Harper, the member for Thuringowa; and Mr David Janetzki, the member for Toowoomba South.

Today's hearing is part of the committee's inquiry into the Health (Abortion Law Reform) Amendment Bill 2016. In examining the bill, the committee will consider the policy which the bill proposes to implement and the application of the fundamental legislative principles. The bill, if passed, would: make it an offence for someone other than a qualified health practitioner to perform an abortion; regulate decisions about abortion if a woman is more than 24-weeks pregnant; provide for conscientious objection by a doctor or nurse, except where an abortion is necessary to save a woman's life or prevent serious injury; and prohibit certain behaviour in areas around facilities where abortions are performed and prohibit publication of images of people entering or leaving those facilities unless they have consented.

This committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee which takes a non-partisan approach to inquiries. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind you that intentionally misleading the committee is a serious offence. Witnesses have been provided with a copy of the instructions for witnesses, so we will take those as read. Hansard will record the proceedings and witnesses will be provided with a copy of the transcript. This hearing will also be broadcast.

I remind those attending today that these proceedings are similar to parliament in that the public cannot participate. Members of the public may be admitted to or excluded from the hearing at the discretion of the committee. Please also note that this is a public hearing and you may be filmed or photographed. I thank all witnesses who have made submissions to our inquiry, and those submissions are published on the committee's inquiry web page. Further submissions will be published as we formally accept them and authorise their publication. We will invite each witness to make a brief opening statement of up to five minutes and members will then ask questions. I ask witnesses to please identify yourself before speaking for the first time and to speak clearly into the microphone when addressing the committee. I now welcome our first witness.

PRICE, Ms Elizabeth, Counsellor, National Alliance of Abortion and Pregnancy Options Counsellors

CHAIR: Would you like to make an opening statement?

Ms Price: Yes, I would. I would like to thank the committee for the chance to represent the views of the National Alliance of Abortion and Pregnancy Options Counsellors, otherwise known as NAAPOC. I would also like to pay my respects to the Jagera and Turrbal peoples whose land we are on meeting on and to pay my respect to elders past, present and emerging. My name is Elizabeth. I am known as Liz professionally but I thought this was a formal enough occasion to warrant 'Elizabeth' making an appearance. I am one of the co-founding members of the National Alliance of Abortion and Pregnancy Options Counsellors. I am a social worker of 26 years experience, including just over 5½ years experience working in the area of unplanned pregnancy counselling and support. I am based here in Queensland and currently employed by Children by Choice.

As you may recall from our last appearance at your committee, the National Alliance of Abortion and Pregnancy Options Counsellors have expertise in pro-choice women-centred counselling. We believe that women have the right to freely determine their reproductive health choices and to access services, including abortion. I would invite you to refer to our previous statements and interviews in the first round of your deliberations on the first bill for other information about us.

I would like to move on to our key points for today. Our key messages today are that we support the Health (Abortion Law Reform) Amendment Bill 2016 in conjunction with the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016. We urge the committee to recommend that both bills are debated and voted on together as a package on the floor of parliament to reflect the true intent of the two pieces of legislation.

NAAPOC supports the conscientious objection clause but we urge you to strengthen it with a requirement for conscientious objectors to refer patients onwards to a practitioner who does not hold a conscientious objection to abortion. We believe this is a vital step in balancing out doctors' rights to hold their views with their ethical obligations to provide timely medical care for women, rather than leaving them without appropriate referral and potentially increasing the gestation at which they access a termination, placing them at further unnecessary risk.

NAAPOC supports the protection of patients and staff of abortion clinics through the provision of safe zones but urges the committee to consider extending these from 50 metres to 100 metres, based on the experiences of other jurisdictions. Whilst we do not believe it necessary to legislate for gestational limits, we urge the committee to consider the needs and issues faced by Queensland's most vulnerable women in considering other evidence tendered to you in relation to gestational limits. We understand gestational limits of abortion to be a fiercely debated issue. As stated in our submission, we do not view the legal imposition of gestational limits to be a necessity based on all of the evidence you would have heard in the first bill around the other things that provide regulation of that.

We would like to draw the committee's attention to the issues faced by more vulnerable women, with the example of those who experience domestic violence. Many women are disadvantaged by lower gestational limits, and women experiencing domestic violence are but one. In the recently published report by Australia's National Research Organisation for Women's Safety that looked at the exemplary evidence in this area, they identified that women experiencing domestic violence are two to three times more likely to experience an unplanned pregnancy and an abortion than other women, and face the additional hurdle of presenting with a more advanced pregnancy at the time of abortion. There is a raft of national and international evidence of this. I seek your permission to table an Australian article written by Taft and Watson as one example of research in this area.

CHAIR: Is leave granted? It is. Thank you.

Ms Price: Longitudinal research shows that women who are able to access an abortion experience less ongoing violence than those who are denied an abortion. This next piece is a study that comes out of the United States—a very large cohort of women and a very rigorous piece of research. I seek your permission to table this piece of research as well.

CHAIR: Is leave granted? Leave is granted.

Ms Price: This is just one example of women who would be disadvantaged by lower gestational limits than those proposed. Others would be women living in rural and remote areas. I am happy to field questions about some of those later.

I would also like to talk about the issue of consent of minors, an issue not included in the health amendment bill but worthy of a revisit. We refer the committee back to their own report in relation to this issue. I believe that the McMeekin ruling in the recent 'Q' case has given us a legacy of uncertainty in relation to consent of abortion of minors—both those of Gillick and non-Gillick competent. We urge the committee to consider ways in which this legislative opportunity could enshrine clarity over this issue, guided by the principle of the least intrusive option necessary to ensure timely, private access to reproductive choice for this most vulnerable group of Queensland women. I understand the Australian Centre for Health Law Research are appearing later today. I strongly encourage you to draw on their expertise in relation to this issue.

Another issue outside of the bill as it stands is the issue of gender selection. I understand there was a lot of discussion about this issue yesterday. On behalf of the alliance, I would like to let you know that this very rare but often misunderstood issue, as portrayed in the public realm dialogue, does not fit with the experience of the women that we work with. As a counsellor of five years in this area, I can confirm that in the very rare conversations about gender in decision-making, the desires

for sex selection are not limited to a culturally based son preference. There is no culture that does not have gender discourses that may influence gender preferences and decision-making in pregnancy. Some preference and the myth of some preference is a symptom of a deeply rooted social bias and stereotype about gender. These issues cannot be resolved by banning abortion and sex selective abortion. The real solution is to change the societal values that underpin a preference for sons.

If the committee would also allow, I would like to tender this document that has come out of the States that helps us to make sense of raw data in relation to the different number of boys and girls born. It is a complex issue to make sense of raw data, and this is a fabulous article to help you work through how that can be done empirically.

CHAIR: Is leave granted? Leave is granted.

Ms Price: Thank you. That is the end of my opening address.

CHAIR: Thank you for your opening statements and the articles which we will have a look at at a future time. I have two questions. The first is in relation to conscientious objection. Obviously, views differ significantly about whether there is a need for something like this in legislation but also how to balance the interests of the woman or patient and the medical professional. Do you think there are other possible ways to balance those interests so that a medical professional who, through their own conscientious objection, not only feels they do not have to obviously carry out or prescribe a drug for a termination but also does not then have to send a woman on to somebody who they know probably will provide that opportunity? You have suggested here a requirement for publicly available disclosure of their objector status. Is there a way to have some public disclosure of those who do not have such an objection instead?

Ms Price: I think that is another way forward which allows women to access information to select an appropriate medical provider. The issue becomes that you waltz into your doctor's office—a doctor you may have seen for a number of years and believe you have a trusted relationship with—without checking that and consequently fall into the trap of not being referred on by a conscientiously objecting doctor. I think it is up to the doctor themselves to be transparent about that. Women presenting to doctors for assistance around an unplanned pregnancy do so at an incredible time of stress. To be turned away without further information is really compounding of that distress and again delaying of their access to abortion ultimately.

CHAIR: With regard to the women that you see, does that happen often? We have all had many conversations through the inquiries, formally and informally, and many doctors who have spoken to me who do have a particular conscientious objection would always still refer. How often are you hearing that it is occurring? How big is the issue?

Ms Price: We regularly hear stories from women who are bundled out of the office and told that there is nothing they can or will do for them. There are other stories which are more heavy-handed in that in response to the woman's request for support. This is something that happens quite regularly in Queensland to the women who seek our support.

CHAIR: My second question relates to patient protection or safe zones. You have mentioned in here the words 'harassment' and 'intimidation'. Can you define for me what you consider to be 'harassment' and 'intimidation'?

Ms Price: I would have liked that to be a question on notice but I will have a crack at it. In regard to the actions of protestors outside clinics, their mere presence is a form of harassment. The presence of placards with images on it and messages that are counterpoint to the values held by the woman who are exposed to them—these are all in my view intimidating of the woman who has to seek passage past them. Whilst intimidation can take many forms, I believe in that moment where anxious women are attending a medical centre for a medical procedure, any such presence of a negative matter is potentially intimidating for that woman.

CHAIR: It would be your view that people who do not agree with termination at all actually should not be able to stand anywhere near the facility?

Ms Price: That is my point of view. The alliance would stand with me on that point of view. There are plenty of other places they can stand. It is a big state.

CHAIR: I am sure my colleagues will return to this. Some of the testimony we heard yesterday was around whether or not that would be constitutionally upheld around people's right to protest. Thank you very much. I just wanted your view on that so I appreciate that.

Mr McARDLE: Thank you for coming back in to appear at the inquiry. You refer to the Criminal Code and having the sections repealed—224, 225 and 226. I want to look at that a bit further. Section 224 refers to an attempt to procure an abortion; that is, a person who with intent does something to procure an abortion is guilty of a criminal offence, and 226 deals with supplying drugs for that purpose. We tend to think of those two sections as dealing with the woman in question knowing what is going on, being a party to the desired outcome. What happens if a partner or a father, without the knowledge of the woman, supplies a drug unbeknownst to her that causes a termination? Given that the woman has no knowledge of what is taking place—the termination has been caused by a party—should that person not be convicted of an offence under either section 224 or if they supply the drug, under section 226? The reason I pose that is that there are sometimes consequences that are unintended that flow from removing or changing the law.

Ms Price: It goes back to a statement I made in the opening address which is that the two bills need to be considered as a package of legislation because the amendments to the healthcare act take account of that. The section that refers to only a qualified health practitioner may perform an abortion would then mean that the actions of a father or a partner would not comply with that recommendation. Hence, we are saying that we need to look at these two pieces of legislation together. If we are going to remove those sections of the Criminal Code, there are some other things that need to go in place to regulate the kinds of things you are talking about here.

Mr McARDLE: Secondly, with the objection based upon conscience, the AMA protocol does not directly require a practitioner to refer to another practitioner who does not hold the objection. It states, in essence, that the practitioner cannot impede or in any way hinder the delivery of the service. That is a much wider definition I think than actually referring to another practitioner who does not hold the objection. The AMA are saying that would cover the scenario in their mind. Do you agree with that?

Ms Price: I think it leaves things a little bit loose. To not impede is very different to providing some kind of formal referral on to a provider. If you do that in a way that indicates to the woman that the service is not available or that it is outside of the law, which many doctors will say to women who seek their assistance, then she is left with a complete lack of clarity about whether she actually has any other options to explore. In relation to this particular medical procedure, I think it is warranted that that referral is enshrined in the legislation because of the nature and the sensitivity of it.

Mr McARDLE: You used the phrase 'the nature' and you said that it is sensitive. I agree with that; it is sensitive. There is no question about that. However, if I am a doctor and I hold a personal belief for whatever reason that termination is a matter I cannot endorse, why should I then be forced to refer to a doctor who is going to terminate given that that referral itself runs contrary to my belief pattern as opposed to going through the AMA process? While they do not impede—

Ms Price: That is because you, the doctor, are not the person who is pregnant and seeking an abortion.

Mr McARDLE: I accept that. You said that it is sensitive; I agree with that. As a doctor or a nurse, for that matter, or a nurse practitioner should I not have the right to say, 'Wait on, the fact of referral on in the sense you are using it runs contrary to my conscience and my conscience beliefs. Should I not go to the AMA and use their guidelines?'

Ms Price: Not if your actions are going to impede the woman's access to her rights.

Mr McARDLE: I think that is right. As long as we do not impede the action of a woman to take the step, I agree with that. However, you go further in that; you say, 'No. You're not just impeding; you must actually deliberately take an action to ensure that a referral is to a practitioner.'

Ms Price: There is a significant power imbalance between a medical provider and the woman who sits before him or her. I believe that that clause is necessary to address that in regards to this issue where practitioners' ethics may be used as a reason for acting in a more subtle way to impede and delay her access.

Mr McARDLE: Finally, the AMA read the bill, and clause 20 of the bill refers to who can provide a termination. They raised that clause 20(1) and (2) deal with a practitioner and also a nurse qualified. They then say that subclause (3) says 'a woman does not then commit an offence'. They seem to believe that is inconsistent; that is, clause (3) is inconsistent with subclauses (1) or (2). I understand the reason as to why that is there. Do you have an opinion upon subclause (3)?

Ms Price: I do not at this present point, but I understand the AMA are appearing before your committee this morning or later on today. I suggest that you open up that discussion with them.

Mr McARDLE: You would hold the view that the law as proposed here should protect a woman?

Ms Price: Yes, I do believe that the law should protect a woman from being viewed to have committed a crime of agreeing to abortion or being involved in one, yes.

Mr McARDLE: Otherwise the problem that we now have continues to perpetuate itself.

Ms Price: Yes.

Mr KELLY: If it makes you feel more comfortable, feel free to call me Joseph. My questions are mainly restricted to the counselling aspects of your organisation. I do have one question, because you have raised it in your submission, in relation to clause 20. The clause refers to who may provide an abortion and talks about a qualified health practitioner and defines that as a doctor and a registered nurse. Before I read your submission I had wondered whether or not that should include midwives as a separate category. I note that in your submission you have referred to midwives as well.

Ms Price: Yes, there is a general trend in health provision of the specialist role of both midwives and nurse practitioners who have an advanced level of skill and experience in the area who could play a more active role in the provision. We certainly look at that as a potential model for provision in remote communities where we have a system of remote area nurses regularly visiting those communities, but women in those communities do not have the same access to a medical practitioner per se.

Mr KELLY: Yesterday there was much discussion, as there was at the previous inquiry, around the concept of mandatory counselling, and South Australia was held up as a model that we should consider. There were some statistics given to the committee yesterday—and I am sorry I do not have them in front of me—that in I assume a 12-month period a number of women in the high 500s sought terminations through the public hospital system, which requires a mandatory appointment with a social worker. Something like in the high 400s turned up. That means 100 people roughly did not turn up for that appointment. My question to you as a counsellor is: what happens to those hundred people who do not turn up for a termination? What are the potential outcomes for people in that situation?

Ms Price: It is hard for me to know in relation to those particular hundred women—and that is South Australian data that you are quoting there. I do not work in that jurisdiction. There may be a number of reasons to explain that. Some women, as part of their decision-making process—and we often see this in the counselling that we do with women—may decide to book an appointment and then see if on the day when they wake up they are still committed to following through with that. A decision-making process can look really different from one woman to another. For some women, it is imagining herself taking the next step that helps them get clear about whether that is something they want or not. We are also aware of women in Queensland who do not front up for procedures because sometimes the money was spent by somebody else or there had been actions on the part of other members of her family or community to prevent her from following through with her decision. Again, counsellors from Children by Choice, who are appearing later, can give you some examples of this. We often hear from people who have been harassed by text by a partner saying, 'Don't murder our baby,' or this, that and the other. We know that for some women there may be intimidation and coercion applied to them that has them not accessing the procedure. There would be a raft of reasons for that.

Mr KELLY: Would you be concerned that if there were mandatory requirements for counselling it actually may inhibit some women from actually seeking advice around reproductive issues and termination if that is what they chose?

Ms Price: I think mandatory counselling is just one more hurdle for women to face. The vast majority of women do not need, require or want assistance in making that decision and requiring mandatory counselling delays access for those women. It also means that women who may have very little support from family or community to do what they are doing have to find another appointment to get to and get home from without that becoming obvious. Those women who are in a more vulnerable position anyway have more things to try to navigate. Does that make sense as an answer?

Mr KELLY: Yes. My personal experience of dealing with people who identify as Indigenous in the health system is that they do not engage necessarily as well as people who are not Indigenous. Would this be an additional barrier particularly for that group?

Ms Price: I certainly think so. To explain to some white person why you have decided to end your pregnancy is a tough call.

Mr KELLY: I want to turn to the safe zones in the context of 'footpath counselling'. We heard evidence yesterday from a constitutional lawyer that this clause may have some challenges in terms of constitutionality because of the issues around freedom of political speech—that is the way I put it—or I think political protest was the terminology used yesterday. As a counsellor, what is the quality of information that is being provided by 'footpath counsellors' and what evidence base is used by those people who provide that information?

Ms Price: On the day that I ran the gauntlet with the process I did not actually take their pamphlets and have a look at them, but I wish that I had. They are there with a very clear agenda, so their information is not going to include all options. It is going to be very much skewed towards one option rather than the other and heavily value laden in its nature. It is going to be impositional of values that they believe are important for the woman to be taking into consideration.

Mr KELLY: Every healthcare practitioner these days battles Dr Google and the Facebook physio. The question I have is: as counsellors, what is the potential damage to people of being provided with information that is not based on sound clinical evidence?

Ms Price: Certainly the research that is done on the impact of passing protesters and receiving information from them is that women are distressed by that, and that is certainly most impactful of women who are more distressed on the day. It throws women's decision-making into chaos because they then have to sift through what information is correct, what is incorrect and how does this sit up against what I believe and value? When misinformation is landed in that territory it complicates an already complicated decision and requires the woman to be involved in not only sifting through their own personal values and conversations with partners; it requires them to also then be able to apply a lens of discernment at a time of great stress as to what is true and what is not true, what is accurate and what is inaccurate.

Mr KELLY: Finally, there has been some discussion both in the first hearing and people approaching me outside of hearings in relation to decisions to terminate in the case of non-fatal foetal abnormalities. People particularly were approaching me in relation to foetuses diagnosed with Down syndrome. The figure has been bandied around that 95 per cent of pregnancies where Down syndrome is detected are terminated. I conducted a research brief on that using the Parliamentary Library and I do not believe that figure to be correct. The answer is quite complex as many of these things are. Down syndrome is not the only non-fatal foetal abnormality detected late in pregnancy. From a counselling perspective, what steps are occurring when a non-fatal foetal abnormality is detected in terms of assisting families and women to make a decision, and what is actually happening now in practice in real terms?

Ms Price: There are certainly folks who sit within the public health system as some genetics counsellors who provide support to women who are given genetics diagnoses as part of the work-up of their pregnancy later on. Some of that support in decision-making may be offered by a genetics counsellor within the public system and there have been times when those women have also been referred to us for further counselling.

In that process women are trying to weigh up, 'Is this a definite diagnosis versus something that is a risk?' They are trying to weigh up whether this is a risk they are prepared to take. Through the conversations that counsellors would have with them, they are also looking at the consequences of proceeding with this pregnancy on the care and needs of the children they already have. They are supported to look at that decision from a really complex and nuanced point of view. It is not just purely done from the point of view of whether 'this is a foetus I want or not'; it is done from a point of view of, 'What's the impact on my life and the lives of those who depend upon me in relation to this decision?' and whether this is a risk that this family and this woman are prepared to take.

Mr JANETZKI: Thank you, Ms Price, for being here this morning. Apologies if you have given this evidence in the first round of hearings. I was not present at those. I just want to understand NAAPOC's role. Is it a counselling organisation of its own or do you represent, say, an alliance of different counselling services?

Ms Price: That is correct. We are a national alliance of abortion and pregnancy options counsellors, bringing together social workers and psychologists who work within the specialist field of supporting women around unplanned pregnancy, abortion and pregnancy decision-making. Our alliance has members from South Australia, Victoria and Queensland at this point.

Mr JANETZKI: And numbers of members?

Ms Price: We are tiny. I think at the moment we have probably about 12 to 15 members of the alliance. That actually represents pretty much the bulk of all of the people in Australia who specialise in this area of work. It is not that we do not represent the body of work that is being done; it is that it is incredibly niche.

Mr JANETZKI: That leads to my next question. I expect that you will say that, given the current legal standing, it is very difficult to get accurate information as to numbers of women seeking or undergoing abortions. Is it possible for you to reveal how many women you or your alliance members would see in any given year?

Ms Price: I can tell you how many women Children by Choice may support over any one year. At the moment that is sitting just around the 2,000 mark. If we are thinking that there are about 10,000 to 14,000 abortions done a year and that represents about half of the unplanned pregnancies, we are seeing 2,000 of the potentially 30,000 women who are sitting with an unplanned pregnancy.

Mr JANETZKI: That is about 10,000 to 14,000 in Queensland? That is your best estimate?

Ms Price: That is a rough estimate as best we can do it. The alliance members from somewhere like South Australia, where they are positioned within the public system, where 99 per cent of the terminations are provided, would be seeing the very vast majority of women who are accessing an abortion, along with women who seek their support around decision-making.

Mr JANETZKI: This may be more difficult to reveal or to ascertain. Out of those women your members would counsel, how many would you expect to go on and undergo an abortion and how many would choose to continue their pregnancy?

Ms Price: Again, that varies markedly from one organisation to another because the contexts of our work are quite different. Obviously in South Australia, where they are located within a provision setting, they are predominantly seeing women who are proceeding to have an abortion. The Dr Marie counselling service—a private provider that offers counselling—sees women who are really uncertain. We see a raft of women. We see some women purely for decision-making counselling and we see some women purely for abortion access and then we see a bunch of women who sit between those two things, who may be seeking advice and information about access but are still in the process of making a decision for themselves in relation to their pregnancy. I do not have the exact numbers.

Mr JANETZKI: That is fine. I am just getting a bit of an indication. Do you offer postabortion counselling services?

Ms Price: Yes.

Mr JANETZKI: So it is right through?

Ms Price: That is correct. Largely, the women we see for postabortion support are not women we have seen before the abortion, because the best postabortion support a woman can get is what happens before she has the abortion. Largely, women and couples who have sought out our counselling have found some peace with their decision prior to, but we do see some women who are really struggling with that who have not had contact with our service prior to.

Mr JANETZKI: Yesterday we heard evidence in respect of cooling-off periods, mandatory counselling, right-to-know information and things like that. What is your professional opinion on initiatives like that, perhaps reflecting on other jurisdictions that may have those initiatives or measures in place? What is your view on that?

Ms Price: My view is what the research supports me to understand about that, which is that the majority of women do not need and do not want decision-making counselling and are quite capable of making that decision for themselves. As we tendered in our last submission, we see a very big difference between what a medical practitioner would call informed consent counselling versus therapeutic decision-making counselling, which is what we are in the business of. Every woman having an abortion would go through an informed consent counselling process with their provider, but not all women require therapeutic decision-making counselling as part of that process. There is a big difference between those two and it is something that is not necessarily clearly understood by people who would recommend compulsory counselling. It just adds another delay.

CHAIR: Ms Price, that brings our available time with you to a close. Thank you very much for coming before us.

Ms Price: Thank you all.

MARSH, Ms Kate, Communications Coordinator, Children by Choice

TOOKER, Ms Sian, Counsellor, Children by Choice

CHAIR: Welcome. Thank you for coming back before the committee. I invite you to make an opening statement of up to five minutes.

Ms Marsh: Thank you. We would like to acknowledge the Jagera and Turrbul peoples, on whose land we meet today, and pay our respects to elders past, present and emerging. My name is Kate Marsh and I am here with my colleague Sian Tooker, a member of our counselling team at Children by Choice.

Thanks to the committee for the opportunity to appear today. Given your familiarity with our service and our position on abortion law reform, we will reiterate only briefly what you already know, which is that we support the removal of abortion offences from our Criminal Code. We emphasise that, while we support the measures contained within the Health (Abortion Law Reform) Amendment Bill, we do so only in conjunction with Rob Pyne's first bill, the Abortion Law Reform (Woman's Right to Choose) Amendment Bill. To pass this second bill without the first would give us legislated regulation but no decriminalisation. To achieve the intent of the two bills they must be debated and voted on together, and we urge you to recommend as such.

Turning to the specifics of this bill, we support all of the clauses it contains if they occur in conjunction with decriminalisation. In regard to the requirement for a second doctor's approval for terminations after 24 weeks gestation, we raise objection to the continual references to these procedures taking place in abortion clinics. As Queensland Health testified in the first inquiry, terminations at this gestation all take place in hospitals, without exception, and number 'one or two a year if that'.

Regarding exclusion zones, we are very supportive of the inclusion of this clause in the legislation. We reject utterly the assertions made yesterday that the adoption of these clauses is driven by clinics wishing to protect their so-called profit motive and point out that, if adopted as per the clause in this bill, they would result in an area equivalent to 0.000004 per cent of the state where protest about abortion would be illegal—hardly the substantial burden on freedom of speech that was argued yesterday.

Ms Tooker: We are concerned that this inquiry process has heard few women's voices about their abortions and note that you yourselves have commented on this during both inquiries. We would like to let you know that you did have women who have had abortions appear in front of you; you just did not know it. There are women in this room today who have had abortions. With up to one in three Australian women choosing abortion at some point in their lives, it is an issue that affects women across all ages, backgrounds, belief systems and socio-economic brackets. We believe that their voices should take centre stage instead of other people talking about and over the top of their experiences.

While we are here as experts in the field, we are also here to represent the best interests of the clients we support every single day, like the woman whose second pregnancy was diagnosed with fatal foetal anomalies and had to not only organise her own procedure from the floor of her living room but also travel 130 kilometres to get to it because the extent of the help her local hospital was prepared to offer was a list of specialists' phone numbers; or the woman who was told by the domestic violence service that picked her up from the hospital after her husband had broken her jaw that they could not help her get an abortion because it was illegal; or the suicidal inpatient of a hospital psychiatric unit who was told that she was not eligible for a hospital abortion because her mental health issues were not severe enough; or the 13-year-old who was violently raped in her own bed by a friend of a family member, then told by a GP to chalk it down to experience and maybe try and use contraception next time, then told by her local hospital that she would need a court order to terminate her resulting pregnancy because of our abortion law; or the woman whose fourth and fifth pregnancies nearly killed her but whose hospital refused her a sterilisation and then a termination for her sixth; or the wheelchair bound mother of three whose physical health problems are severe enough for Child Safety to be concerned about her ability to care for her children but not severe enough for a public hospital abortion; or the woman who was raped inside her own home by an intruder and had to walk past protestors calling her a baby killer to get inside the clinic, where she had to pay for her own abortion because her local GP could not find out from her hospital if she could get one publicly provided.

Ms Marsh: Each one of you is the local MP for at least one of those women. They are by no means the only ones in your electorate with experiences that difficult, and we could tell similarly horrific stories to each of the other 83 members of the Queensland parliament.

We have heard repeatedly that abortion is accessible in Queensland but not about the extreme personal hardship that access often entails or how reliant it is upon the generosity of strangers and the support of compassionate professionals. These services are delivered in spite of the law, not because of it, by people who risk their careers to do so. The stories you have heard today belong to women who will remain anonymous, but they could be any one of us. We seek permission to table stories belonging to more women who have had abortions in Queensland as evidence for the committee.

CHAIR: Is leave granted? Leave is granted.

Mr HARPER: Thank you both for your submissions and the work you do in this field. I think it is important to recognise, looking at this submission, 40 years experience with Children by Choice and some 200,000 women that you have counselled. I think you can speak with a degree of authority and you have highlighted some of those cases today. Do you think in our modern society the increased abortion rates that we see are largely unplanned and accidental, in your experience as counsellors? Do you correlate that?

Ms Marsh: We do not actually know if the abortion rate is increasing or decreasing because there is no data collection. We know from South Australia that their rate has been decreasing slightly since the 1970s. It is continually dropping. There are spikes every so often, but the rate overall is decreasing slowly. Most women who seek abortion in Australia—it is estimated, but around two-thirds or more—are seeking abortion because the contraceptive they were using at the time did not work.

Ms Tooker: What we do know from overseas research is that countries that have improved access to contraception services see lower rates of unplanned pregnancy and subsequently lower rates of abortion. Ultimately, if you want lower rates of abortion, improve contraceptive access.

Mr HARPER: In terms of your experience in rural and remote settings, can you talk to me about some of the challenges faced there, with women having to travel?

Ms Marsh: Absolutely. I am really glad you asked. At the moment there are 10 clinics across Queensland that provide abortion services. Seven of those are in the south-east corner; the others are in Rockhampton, Townsville and Cairns. The Rockhampton and Townsville clinics are closing in February next year, which will mean there are no surgical abortion services north of Nambour until you reach Cairns and none west. We are going to have probably around two-thirds of our HHSs with no abortion availability after nine weeks gestation. Those women are already facing incredible travel distances and increased costs—accommodation, time off work, organising child care et cetera. They are now going to have to face travel to Brisbane or up to Cairns in order to access services. Some of those women have to travel to get an ultrasound. These are the sorts of remote communities we are talking about.

Ms Tooker: If you add on the stigma that surrounds this procedure, these women are often having to try to do this in silence. That is very difficult when you are living in a remote or rural community.

Mr HARPER: I am glad you touched on the silence. I just wanted to see if you could draw a parallel to the high domestic violence rates that we see in our state. Do you correlate that with some of these higher abortion rates in your counselling service?

Ms Marsh: Around 30 per cent of the work of our counselling team is with women experiencing domestic sexual violence and reproductive coercion, so it is quite high. We know that, as Liz mentioned earlier, the correlation between domestic violence and abortion is quite high.

Ms Tooker: The other issue that comes along with that is that these women are leading lives of such chaos that it makes it very difficult for them to access professional support in a timely manner. Accessing a telehealth medication abortion or something like that is out of their reach because the gestation has advanced beyond that, so they have no choice but to travel for a surgical abortion. When they may even be physically restrained from doing so by a partner or silenced by their community and so on—

Ms Marsh: Or experiencing financial control—

Ms Tooker:—it becomes nigh on impossible.

Mr HARPER: My final question is around the exclusion zones. Can you just provide some examples or evidence where your clients have described what goes on and articulate if you can what your recommendations might be with regard to the 50-metre clause?

Ms Tooker: I believe 50 metres is inadequate. I would support it being increased to 150 metres, which is consistent with legislation further south. In terms of the impact of these people outside of the clinics, I think protesting is a very generous term because they are not standing there stating something to parliament or to the public. They are attacking individuals. They are attacking individual women and their support people and clinic staff, and they do that verbally. They do that physically by impeding their access. They do that by showing graphically manipulated imaginary, so it is false imaginary that is provided. They do that providing inaccurate information which, as Liz has previously mentioned, becomes incredibly stressful for the woman to try and process on top of everything else that is going on for her. To call that protesting is incredibly generous. These people are out there to harass, abuse and intimidate women.

Mr HARPER: Thank you, ladies.

Mr JANETZKI: Thanks for being here. I was one of those people who commented yesterday that we did not have enough testimony from women who had undergone abortions, so I am happy that there are people in the room today. I apologise in that I am going to ask much the same questions as I asked of Ms Price, but I would love your perspectives on it. With respect to Children by Choice counselling services, how many women would you see in any given year?

Ms Marsh: Last year it was 1,700.

Mr JANETZKI: Out of those women—and, again, you have heard me ask the question—what kind of proportion would proceed to go on with an abortion and those that would not?

Ms Marsh: We do not actually know for most of them. We do know that the majority of our work is with women who are seeking to access an abortion and are having difficulty.

Ms Tooker: The reason for that is we are a unique service, so that gets funnelled to us because so few other people will provide that service to women.

Mr JANETZKI: That is probably a good lead into my next question. How would your clients come to you?

Ms Marsh: How do people find us?

Mr JANETZKI: Yes. How do people find you?

Ms Marsh: Clinics actually refer a lot of women to us for counselling and support, so women who might present to a clinic for a termination or call to inquire about one and the clinic thinks that they are not sure of their decision get referred to us for counselling.

Mr JANETZKI: Would they be private clinics?

Ms Marsh: Absolutely.

Mr JANETZKI: Hospitals?

Ms Marsh: Yes, we get some from hospitals.

Ms Tooker: GPs and community services that—

Ms Marsh: Dr Google.

Mr JANETZKI: Out of the women—let us say 1,700—you are not sure which way they go as to whether they go on to have an abortion or not?

Ms Tooker: The reason for that is we are a non-directive service, so we are not telling women which way to go in their decision making. In the counselling session they may have with us we hope they develop the tools they need to make that decision and often that is enough for them to take away and go through that decision-making process for themselves with their partner, for example, or some other supportive person, so they often get the tools they need to make that decision from us but not generally speaking the outcome. In terms of the type of counselling we do, absolutely I have spoken to women who have decided to continue the pregnancy or who have decided to go down the adoption process as well, so it is quite varied.

Mr JANETZKI: I did not want to show my ignorance to Ms Price, but she said—I wrote it down and I was going to research it later—therapeutic counselling versus decision-making counselling.

Ms Marsh: No, versus informed consent counselling.

Mr JANETZKI: Sorry, informed consent counselling. Can you just describe the difference?

Ms Marsh: Informed consent counselling is what every person has before any medical procedure anywhere in Queensland which is where the practitioner will sit down with the patient and explain what the procedure involves, what the risks are, what the anaesthetic is going to be like and any after-care. That is partially what was being discussed yesterday with the 'right to know'.

Ms Tooker: You could always ask the clinics for their material that they use around informed consent counselling because it is quite thorough.

Ms Marsh: Yes. They have consent forms that every patient routinely has to sign, so that is informed consent. The therapeutic counselling is more what Sian was just discussing which is decision making and the post abortion work is also therapeutic.

Mr JANETZKI: Would you see many women for counselling services post abortion?

Ms Marsh: It is only a small percentage of our work. It is generally around five per cent or less each year. All of the clinics that do the vast majority of abortions in Queensland have brochures of ours to give to patients as part of their after-care, which includes information about what we can offer them if they are struggling after a termination and it is natural to feel some sort of up and down of emotions afterwards but if they feel like they need some additional support that they can contact us.

Ms Tooker: What we find with those women is that the decision-making process has been quite a complex one and they just need time to work through that.

Ms Marsh: Yes. They are generally women who may have felt that they did not have another option apart from to seek a termination or women who may have felt previously that they would never have an abortion or that an abortion was wrong so they are having trouble squaring their actions with their values or they are women who had wanted pregnancies and had something catastrophic happen halfway through.

Mr JANETZKI: My final question is what is your experience with women and how they view the criminality under the Criminal Code. What is your experience of women dealing with that particular problem and why this bill may diminish that concern?

Ms Tooker: Either they do not know about it and they are shocked to discover it or they are scared—they are scared of what might happen to them, they are scared it means they have no choices, they are scared it means they have to travel interstate or internationally. That all feeds into the stigmatisation of the procedure and we know—you can see our references in various submissions—that stigmatising the procedure produces poorer mental health outcomes for women.

Mr JANETZKI: There is also that nuance. Obviously the lawyers here and you would know McGuire's comments in that case in the 1980s that allows for abortions in Queensland in certain circumstances.

Ms Marsh: In theory, yes.

Mr JANETZKI: In theory, and that obviously in your experience is not sufficient enough to address women's concerns about prime facie Criminal Code illegality.

Ms Tooker: It is absolutely not sufficient enough.

Ms Marsh: No.

Mr KELLY: Thank you for coming along today, Kate and Sian. I want to turn to conscientious objection, and I note your submission in relation to that. Most conscientious objection commentary has focused on the relationship between a medical or a nursing practitioner and a patient. In the first inquiry we heard evidence of what I would call institutional conscientious objection. Most people will immediately think of Catholic health institutions, but in my experience they are actually quite open about where they stand on these matters. We heard evidence of other healthcare institutions where one or a very small number of individuals at a very high level who will never have a face-to-face relationship with a patient make decisions that impact on that patient. My question is: should this bill be attempting to also deal with institutional conscientious objection and ensure that if an institution is making a collective decision to be objecting conscientiously that should be notified to the public in some way, shape or form?

Ms Marsh: Yes would be my short answer. We absolutely have contact with institutions that either explicitly or implicitly are conscientious objector facilities. We have been told by a public hospital in the south-east of Queensland that we are not to advise women to present there requesting a termination no matter what the circumstances because it will not be offered to them. That is not a Catholic hospital; that is a Queensland Health facility. I think it is around 40 per cent of our financial assistance from last year went to one HHS which is Metro South because there is no virtually no public abortion access in that district. I do not know how you would necessarily legislate around

conscientious objector facilities, but I do absolutely think that if there are people or organisations that conscientiously object that that cannot be an impediment to women's access to those services and that other pathways need to be put in place to make sure that those facilities are not getting in the way of women being able to access services that they need.

Ms Tooker: I would also add that those facilities are certainly capable of engaging in coercion where women have presented and been told to just go to the antenatal clinic and they will be fine. In terms of these facilities, I have certainly seen in my work with women that it damages their relationship with the women and makes it much harder for them to feel comfortable returning to that hospital for other medical care because they feel that their trust has been breached so badly and they have been treated so badly.

Ms Marsh: Yes.

Mr KELLY: My second question relates to the issue contained in the bill relating to the gestational limits. Certainly before the beginning of these inquires I had no understanding that for a woman to present and request an abortion on the basis solely of a foetal abnormally was technically illegal in terms of my reading of it. The first bill corrected that issue from a legal perspective. The second bill now introduces a test and a process after 24 weeks that looks to me on the face of it to be almost exactly the current situation in that beyond 24 weeks a woman has to present again and the issues have to relate to the mother and not the foetus. Effectively, does this second bill put people beyond 24 weeks of pregnancy straight back in the same situation that we are trying to avoid?

Ms Marsh: I think by clarifying it actually makes things simpler for practitioners and for women who might be seeking a termination at that point. We know from practice that at the moment women are presenting to multiple practitioners at that gestation. If they even are presenting at that gestation, they will often be talking to a social worker, a paediatrician or a psychologist perhaps—there is a range of practitioners—and then it goes to an ethics committee. I think by seeking to clarify what is required after that gestation is a step forwards, but I do think that those procedures would probably remain in place in hospitals in terms of approving terminations at that gestation.

Ms Tooker: I think the key thing to remember is that terminations at that gestation only happen in hospitals, so they happen under fairly rigorous guidelines and frameworks with multiple health professionals involved.

Mr KELLY: Yes. I think the statistics and the information available through this inquiry process has been shown to be relatively poor and inaccurate, but on the available data it seems to me that about 0.8 per cent of terminations are occurring somewhere between the 20 and beyond gestational limit yet that absorbs a very significant proportion of the debate, and understandably so. Something else I guess I was not fully cognisant of at the start of this inquiry process is the concept of perinatal palliative care, and we had evidence given yesterday from a specialist in that particular field. Granted that there is a very small percentage of people who will be affected by this issue, in your opinion should counselling services be ensuring that perinatal palliative care is also presented as an option for people who are in that difficult situation?

Ms Marsh: I think that is an issue for hospitals and practitioners given the extremely small number of procedures that take place at that gestation and the fact that we are often are not involved at that point.

Mr KELLY: Thank you very much.

Mr McARDLE: Thank you, ladies, for coming before the committee. Ms Price when I put to her about the Criminal Code believed quite strongly that the provisions of clause 20 protected a woman and also captured all circumstances that could occur under 224 and 226. Do you envisage no circumstances under which the implementation of clause 20 would actually allow a person who might be guilty under 224 or 226 being acquitted or not being charged; or do you see that clause as removing any question about the necessity for those clauses existing in the Criminal Code?

Ms Marsh: I do not think there is a necessity for those clauses to exist in the Criminal Code. I think it would be possible to perhaps amend the wording of clause 20 in the first bill. It already says it is unlawful, doesn't it, for anyone to—

Mr McARDLE: It does. I am more concerned about the circumstances. For example, if I supply a person a drug I do not perform the abortion, but section 226 says that if you supply a drug you could still be guilty of an offence. All I am concerned about is that clause 20 deals with the issue of performing the abortion, but if I supply, for example, the lady over here a drug to pass on to her sister, supplying that drug is caught in section 226, but clause 20 does not capture that.

Ms Marsh: Does it not?

Mr McARDLE: No, it does not. It says, 'perform an abortion', or, theoretically, it could well be interpreted that it does not capture that scenario. All I am simply saying is that we need to be cautious when we move down a line to ensure that we capture those elements that need to remain illegal. If we do not and remove a clause, potentially, we could allow a potential convicted criminal to get away with it. That is what I am saying.

Ms Marsh: My potential answer to that would be to amend clause 20 to make sure that it covers medication abortion.

Mr McARDLE: That is the point that we are both agreeing on.

Ms Marsh: Use some of the wording from the current Criminal Code.

Mr McARDLE: Exactly.

Ms Marsh: It includes medical treatment, for example, which would cover a medication abortion.

Mr McARDLE: To sew it up.

Ms Marsh: To sew it up. The second point is that it is very rare for someone to just be administered with mifepristone, which is RU486, and have that result in a complete abortion. They need the second dose of medication, which needs to be held between the cheek and the gum for at least half an hour to dissolve. If you can figure out a way to get someone to do that without them knowing—

Mr McARDLE: Can I indicate to you that medical science advances—

Ms Marsh: Yes.

Mr McARDLE: In five or 10 years time what is impossible now could become quite possible. I think we are in vicious agreement that there needs to be a look at what we are trying to protect.

Ms Marsh: Absolutely. As long as a woman is consenting to a procedure, that should be the threshold.

Mr McARDLE: That is different. That clause does not necessarily deal with section 226. The other point is that we spoke about the issue of protest. Clause 24 bans protests. Yesterday, the professor raised the point that the law in this nation says that you cannot ban a protest. I am not talking about harassing, hindering or intimidating; I am talking about people standing around an area holding placards. He said, 'Wait on, if you're going to ban it here, we'll have to ban the green activists as well who picket Rio Tinto or picket BHP Billiton, because they're standing outside a building holding a placard in a silent protest.' His idea is that, if you ban it here, you ban it across all sectors. You cannot have a, 'I like it here but don't like it there.' I am not talking about hindering, intimidating or harassing; I am talking about a quiet protest with placards.

Ms Tooker: That is the thing, though; they are not protesting. That is not what they are doing.

Mr McARDLE: His argument is that, if they are standing outside with a placard, that is a protest. They are not intimidating. They are not harassing.

Ms Tooker: What is the content of the placard?

Mr McARDLE: It does not matter.

Ms Tooker: It does very much.

Mr McARDLE: From his point of view the law is quite clear. Clause 24(c) is not allowed in this nation. Do you see that as a problem? If we allow the green activists to do so—if we allow the LNP to do so, or the ALP to do so for that matter—is that not the same thing?

Ms Marsh: Not being a constitutional lawyer, I am probably not the best person to answer that question.

Mr McARDLE: That is a great answer.

Ms Marsh: I would also reiterate what we said in our opening statement, which is that 0.000004 per cent of the state does not seem to present a substantial burden to that limitation of political process.

Ms Tooker: Again, not being a constitutional lawyer—

Mr McARDLE: But does not a limitation impose a limit?

Ms Marsh: Of 0.000004 per cent?

Mr McARDLE: Does that make it right?

Ms Marsh: Does it make it unreasonable?

Mr McARDLE: Therefore, there are shades of right?

Ms Marsh: Again, not being a lawyer—

Mr McARDLE: Thank you very much.

Ms Tooker: I will add to that, too. Also, not being a constitutional lawyer—

Mr McARDLE: Neither are we.

Ms Tooker: I think to a degree—

Mr McARDLE: I am only repeating what he told us.

Ms Tooker: I think to a degree it is apples and oranges, because these people are seeking to impede a woman's access to a medical facility for medical treatment.

Mr McARDLE: That is intimidation or harassment, not a protest.

Ms Tooker: I think it is very difficult to tease out protest versus intimidation and harassment.

Mr McARDLE: I agree with that.

Ms Tooker: They are attacking individuals; they are not attacking—

Ms Marsh: Rio Tinto.

Ms Tooker: No. They are going after the women as individuals. That is not protesting.

Mr McARDLE: Therefore, you would ban the green activities as well from protesting in that vein?

Ms Marsh: We are not talking about green activists in this particular—

Mr McARDLE: We are talking about protests, though, are we not?

Ms Marsh: You are talking about protests.

Mr McARDLE: That is the wording of the bill that you agree with.

Ms Marsh: Yes.

Mr McARDLE: Thank you very much.

CHAIR: Thank you. Our time for questions has expired. Thank you for coming before the committee today. We appreciate your assistance.

Ms Marsh: Thank you.

KERR, Ms Katherine, Social Worker, Women's Legal Service

LLOYD, Ms Bronwyn, Solicitor, Women's Legal Service

CHAIR: Welcome, Ms Lloyd and Ms Kerr. Thank you for coming before the committee. I think you came the last time.

Ms Kerr: I did.

CHAIR: And we are meeting you for the first time?

Ms Lloyd: Yes.

CHAIR: Welcome. Would you like to make an opening statement of up to five minutes?

Ms Kerr: I would. Thank you. Thank you for the opportunity to contribute again today. We would like to start by acknowledging the traditional owners of the land on which we meet today, the Jagera and Turrbal people, and elders past, present and emerging. The Women's Legal Service provides specialist legal and social work support to Queensland women regarding family law, child safety and domestic violence. Over the past three months, 85 per cent of our clients have identified experiencing domestic violence, with 55 per cent of all clients stating that their safety is at immediate risk. Thirty-nine per cent of our clients have an income of less than $26,000 and 68 per cent have an income of less than $52,000. Seventy-seven per cent of our clients have children.

The Women's Legal Service supports the decriminalisation of abortion and the repeal of sections 224, 225 and 226 of the Criminal Code. To that end, we support the Health (Abortion Law Reform) Amendment Bill but only in conjunction with the Abortion Law Reform (Woman's Right to Choose) Amendment Bill. We recognise the many varied and valid reasons women have for choosing abortion, but our particular expertise and focus is on women seeking a termination while in a domestic violence relationship. We have worked with clients who have expressed concern about continuing a pregnancy due to their partner's violence and that future child's exposure to his abuse as well as the consequent additional obstacles they may face in separating and remaining safe from him once they are bound together as co-parents.

We recognise that there are many barriers under the current system for women to access an abortion where they have chosen to do so. These are compounded for women in domestic violence relationships due to their ongoing experiences of trauma and stress, which may mask typical pregnancy symptoms leading to later awareness. They may have no money or autonomy to purchase a home pregnancy test, prenatal care or an abortion. They may have difficulties accessing reliable information about their options due to the perpetrator's surveillance and they may struggle to access any or repeated medical appointments. While there is still much to be done to address and end violence against women in our community—and we acknowledge the great headway made by the current and previous governments—it is important to address and overcome any unnecessary onus on women making decisions for their own and their for children's safety that may involve exercising reproductive rights, including abortion.

The Women's Legal Service submits that the majority of the proposed amendments under this bill will go a long way to ensuring a safe and effective response from a system for pregnant women at risk who choose abortion. We support the specific amendments proposed under this bill, which will offer and contribute to greater transparency for medical practitioners and for the community as to the availability and provision of abortion in Queensland. We hope that with greater clarity will come improved accessibility, an essential barrier to overcome for women experiencing domestic violence.

However, we have reservations regarding proposed clause 22 concerning conscientious objection. We have concerns that, without a requirement to refer to an alternative provider who will offer abortion, or an appropriate support service for accurate information, women in violent relationships may face further risk to their safety or be unable to access their decision to terminate. Women in violent relationships have limited opportunities to access appointments and information and rely upon accurate information referrals being made. It is not enough to assume that women will be able to access information independently or contact or visit multiple service providers to find a willing and qualified provider. This is time and effort that many women in abusive relationships do not have.

Where a woman in a violent relationship has decided that it is not a safe time for her to continue with a pregnancy and have a child, the system needs to be able to respond quickly and efficiently in order to promote her safety, both immediately and into the future. The Women's Legal Service recognises and respects her ability and capacity to make such a choice and that it must be supported and facilitated. Thank you.

CHAIR: Thank you very much. Thank you for your submission to the second inquiry. We appreciate that. I know that you made a submission and obviously came and assisted us with our first inquiry as well. With regard to the bill as it relates to 24 weeks of gestation and what occurs after that, the point is made in your submission—and, of course, you have just mentioned it—that you believe that the medical opinion not being a specialist in any particular field is important. Given that pregnancies of this gestation—from 24 weeks on—are obviously at an advanced stage of six months or more, they would occur in a public health facility or a tertiary health facility anyway. I assume—correctly or incorrectly—that there would already be access to a specialist in that situation. In fact, some would argue that, given how advanced the pregnancy is, it would be in the woman's best interests to have a specialist. Can you comment on that?

Ms Kerr: Yes, and I think that is a safe assumption. Our concern in terms of legislating particular requirements around a level of expertise or specialisation for that second opinion is we would be worried that that could potentially create an undue barrier for women, particularly women who are in regional and remote areas where that may not be available and may create an unnecessary delay. While that may happen in practice—and we would hope that as far as best practice goes that is what would be happening—we would have concerns about that being a legislative requirement in the act.

CHAIR: Your issue is with the second doctor?

Ms Kerr: Yes.

CHAIR: Do you feel that it would be appropriate that the second doctor should see the woman and speak directly to that woman?

Ms Kerr: That is probably a question that would be better answered by someone who works in the medical field. We can only speak to our concerns around creating obstacles for women experiencing DV in remote areas where they may not be able to travel further, if they would need to travel to see the second doctor for a further opinion, and whether that would create any problems for her in access.

CHAIR: If the second doctor were at the same facility as the first doctor and there was no additional travel, you would have no issues with that proposition? Your main issue is does it include more time and distance?

Ms Kerr: Yes.

CHAIR: Thank you. The second question I had was in regard to having to need to refer. The bill does not require a doctor to refer. I note your comments—

... we hold grave concerns for women not being provided with accurate information at a first point of contact....

You also mention that the window may be small. In requiring to refer, how would the bill get around that proposition? You could still potentially see a doctor who did not wish to perform a termination and you still have to seek a second appointment.

Ms Kerr: We would hope that a requirement to refer would avoid any further need for a third, fourth, fifth appointment or contact with a medical practitioner. If a woman is given reliable information that the next person that she contacts will be able to either provide the termination themselves or provide her with accurate information about how she can access that termination, that closes that window and it means that she can reliably get the information that she needs at that second point of call rather than needing to continue to try to find someone at multiple different—

CHAIR: It does not overcome the barrier; it just limits the number of them?

Ms Kerr: Yes.

CHAIR: Thank you. The third question that I wanted to ask is that many of the witnesses who appeared yesterday commented, 'It's not about making terminations more accessible; they are already highly accessible by the numbers' and that we should be addressing the issues. We had testimony from those before you about some, obviously, incredibly difficult and awful situations that women were in. You would hear them all the time, too. What is your comment in regard to, 'The real problem here is the broader issue of violence in the community' and those sorts of issue and that we should be addressing that rather than looking at the issue so extensively?

Ms Kerr: We submit that to address, to fix or end domestic violence in our community will take time. It will take not only a lot of initiatives but also a lot of social and community change to really end that.

While we have great hope at Women's Legal that that will eventually happen and that we will be able to live in a violence-free society, that does not mean that we should not be paying attention to addressing the issues that the violence is currently creating or contributing to these issues. We should still be addressing the situation that we currently have to deal with, which is that women who are experiencing violence and are pregnant and are choosing to access an abortion need to be able to access that procedure as safely and as easily as possible.

Ms Lloyd: If I can add that while it is a very good aspirational goal to try to resolve domestic violence in the community long-term, just from a family lawyer's point of view, family law matters that involve children conceived in the context of extreme violence and non-consensual sex are very common. From my point of view, I am a family lawyer specialising in domestic violence law, the take-home point from my practice is that in terms of other options it is completely unrealistic to think or to say that a woman can separate from a violent relationship and then use the legal process to simply keep the father away from her and the child. That is not how our family law system works.

CHAIR: The other criticism that has been levelled at the bill and the committee is that by simply allowing easier access we are allowing situations such as incest to potentially compound and continue by masking violence or abuse that could be occurring. What would be your comment or response to that? A situation was given of a child accessing repeated terminations in a situation of incest and that we are just compounding the issue by allowing that.

Ms Lloyd: In terms of involvement when there are children, medical professionals I think are obligated to report child abuse to child protection agencies. I don't think you have to choose one or the other. We don't want to divert resources away from preventing child abuse but we want to make sure that as little harm to the people involved and to the community is caused when it does eventuate, but this isn't instead of diverting resources away from the child protection system. I would still say that they would come to the authority's attention and they need to be addressed and as many resources as necessary should be put towards prevention of that as well.

CHAIR: I would clarify that the criticism was levelled at the clinics, is my recollection, not the doctors in those facilities. Sorry, did I interrupt you?

Ms Kerr: I was going to add, to build on Bronwyn's point, that I think that if a young person or a child is accessing a termination then hopefully the best practice guidelines for those doctors and for those clinics or hospitals would bring that to attention. The advantage of having smooth and clear access points, and to touch on what Liz said from NAAPOC earlier around clarification processes for young people too, would hopefully mean that then that process of needing to go through a termination as a result of incest would be as less traumatic as possible in those circumstances rather than needing to go through what is now a criminal act or decision.

CHAIR: I will just clarify that my question was not focusing on minors, it was women as well in violent situations and that that is compounding the issue, just making it accessible and the violence continues, and as a government we have a responsibility to address those broader issues as well and that this is a masking of that.

Ms Kerr: It is a good question to consider as far as that goes, but as far as our client group goes, these women, regardless of how many times they have decided to access a termination, that is still their decision, they are still assessing that that is the safest option in their circumstances, for them to go through with the termination in the violent relationship, whether that be for their own safety or wanting to avoid bringing a child into a violent relationship. Hopefully there would be point of contact where she may be able to then access support around the violent relationship and whether she wants to develop a plan to leave then and that can be the first point of contact especially if there has been those repeated contacts as well and hopefully there would be a few more questions asked around her safety at that practice level for the clinics in terms of screening for violence or screening as to any other issues that need to be drawn to attention as far as why she is accessing repeatedly.

Mr CRAMP: Thank you, ladies. Just picking up on some commentary and with reference to your submission, your submission talks about supporting women through obviously some very difficult circumstances, when you are not just talking about abortion you are talking about domestic violence and violent partners. When you speak to women about their options, if they want to give birth to the child, keep the child or even adoption, do support mechanisms ever come into it? I am wondering how far the support goes.

Ms Kerr: We are not a pregnancy advisory service at all. If a client presents I can give a social worker's response in terms of how we work. Our social work team only work with women who are experiencing domestic violence. One of the first and ongoing things that we do is a risk assessment

and we will check for pregnancy as part of that risk assessment because we are aware that pregnancy does increase a woman's risk of physical assault. Often when physical violence starts in a relationship it starts for the first time during pregnancy.

Mr CRAMP: I thought you dealt with women who were in late-term pregnancy.

Ms Lloyd: I give advice to women who seek legal advice from our service about potential family law matters. The family law matters don't actually come into existence until after the child is born so that is why that is from my perspective, but I have spoken to women who are investigating adoption options and from my experience and discussions with Child Safety, because they are the body that help facilitate adoptions, it is only done with both parents consent. We are talking about women from the perspective who are within or they are considering separating from violent relationship. Unless the father is not known or the mother purports that she doesn't know who the father is and the father is not named on the birth certificate or unless both parents consent adoption isn't really an option through Child Safety. In the context of a controlling and violent relationship where the woman is lacking reproductive autonomy, you are not likely to get the consent and cooperation of the father to facilitate an adoption in those kinds of circumstances. In those kinds of circumstances, when the woman is trying to picture what the future is going to entail for her and her child, the advice about future family law proceedings really does need to include how difficult it is to protect herself and the child from a violent relationship and from a violent father.

Mr CRAMP: It certainly was not just about adoption, but if they wanted to keep the child if that option was available to them.

Ms Kerr: That is something that we would explore. Depending on her gestation, part of that risk assessment would be including how she is feeling about the pregnancy and what her thoughts are and making any referrals dictated by her. Regardless of what her decision is, whether it is to continue with the pregnancy or not, there is going to need to be some intensive safety planning and strategising around how she is going to keep safe with either decision. That is something that we would be exploring with her based on her decision.

Mr CRAMP: The reason I ask in relation to this bill is, Ms Lloyd, you brought up a very interesting point in your statement then and also in your opening statement that whilst we are talking about the removal of the Criminal Code for alleged easier access for abortion, I am wondering what is your opinion on would it be more effective to strengthen laws to stop convicted violent males in this case from having access to their children. I can see your point. That is a form of control and I recognise that. Is it a more effective strategy for the legislature to look at laws around that for this particular issue you are talking about and, on your last point, also to look at the fact that if we have convicted violent offenders perhaps negating their right for access, not only access to the children but permission on what happens to those children in terms of adoption or care?

Ms Lloyd: I certainly don't think it needs to be one or the other. There are countless reviews of the family law system and they often conclude that the family law system as it stands now fails to protect women and children from violence and, in fact, facilitates the father having regular time with the child and also regular ongoing involvement in the mother's life through joint decision-making. That is often under review. That definitely needs to be strengthened and improved, absolutely, but not instead of these amendments.

Mr CRAMP: I was not suggesting that, but I was wondering whether that would be more effective to address those particular issues you noted.

Ms Lloyd: They are all options that need to be pursued and the woman needs to have as many options available as possible when deciding what is in her best interests. Part of what you said was a man who is convicted of criminal offences. The level of conduct that is needed to secure a criminal conviction is very, very high. Even if you did have that kind of thing, we are talking about the civil courts, the family law system, and even in the current system, due to the private nature of domestic violence, it is extremely difficult to get enough evidence to show that there is domestic violence and even if that can be proven it is very, very rare that it results in the exclusion of the father from the family relationship. I have been in practice for about 10 years and I can only recall two occasions where I have seen an order for no time between a child and a parent and that is where the father has actively made threats to the mother in open court or in an interview with a report writer. So the most extreme cases. I think both needs to be reviewed and they are constantly being reviewed. There are reviews and reviews and reviews into the family law system. It needs to be followed up with adequate funding and action.

Mr CRAMP: I concur with you. I had the great pleasure of opening the third edition of the STEP program for the Gold Coast Centre Against Sexual Violence this week. It was very interesting to see the stats on how few convictions there are. I do concur for these matters and certainly your point is well taken. Thank you.

Mr KELLY: I again thank your organisation for participation in the community leaders forum against domestic violence this week. This bill does not contain any provisions in relation to counselling, mandatory or otherwise, although that issue has been raised in the previous inquiry and again in this inquiry. There is always the potential of amendments being put. There were some statistics given yesterday in relation to South Australia where counselling is mandatory and it seemed like about 20 per cent of women who inquired about a termination did not then show up for a mandatory counselling service. If there was a mandatory counselling requirement, how would that impact on women who are affected by domestic violence, in your opinion?

Ms Kerr: We would have concerns about any mandatory requirements prior to being approved for the procedure itself. We are very mindful that women experiencing domestic violence often have limited availability or even possibility to get to multiple appointments which would include the counselling and then any other medical appointments that would be required as far as that. We would have concerns that additional appointments, including counselling, potentially could create an insurmountable barrier to the woman accessing the procedure and potentially place her safety at risk in continuing with that pregnancy with the perpetrator. We would have concerns around that. There are benefits to counselling being available, but it should always be optional for women to be able to elect into that if they choose to.

Mr KELLY: Yesterday we heard evidence from a constitutional lawyer that the provisions around protected zones may have some challenges. My question is to Ms Lloyd. It would seem to me that the intention of footpath counsellors is not to change the decision of a legislation body or a business or a community group, it is about changing the decision of an individual about whether or not they proceed with a termination or not. I put that question to the lawyer who appeared yesterday and the response was—my words not his—if the person is engaging in protest and footpath counselling then effectively it becomes an act of protest. In a scenario that you folks deal with where a woman is coming to a court, like a Magistrates Court that I am familiar with and I am sure you are familiar with too, and it is not uncommon that a spouse will attend and attempt to change the decision of that woman in terms of proceeding with the matter, I would imagine, under the advice given yesterday, it would be quite possible for a person to show up or a group of people to show up with some placards with their intention being to change the decision of that person about whether to proceed or not with the matter, but that would be deemed as political protest. Are there any restrictions placed on people being able to conduct such protests outside of the Magistrates Court where matters of domestic violence are being heard or any other matters?

Ms Lloyd: The domestic violence court is a closed court for reasons of respecting women's privacy and enabling them access to safety procedures as much as possible. In terms of women accessing clinics, from our clients' point of view they are highly likely to be traumatised as victims of domestic violence already. We want to ensure that they have the most amount of options available at an early stage.

Mr KELLY: To be clear, I could not show up with a placard at the Holland Park Courthouse and say, 'I am opposed to the domestic violence court and, while I am here, I am going to have a conversation with a person I have a relationship with to try to prevent her from proceeding with the action'?

Ms Lloyd: I am not sure. I have never seen that happening, although I have seen some men's rights groups at the table out the front of the federal courts, but they are quite a distance away. I am not sure whether security would let them in if they are not involved in their own matters, although the federal family courts are public open courts; they are not closed courts like the domestic violence court.

Mr KELLY: What distance away are they, roughly?

Ms Lloyd: It is from the front door. I cannot say. They are probably at least 30 to 40 metres away. I do not know if they are involved in any particular matters that are there. I think they are just general fathers' groups, fathers' have rights and those kinds of things.

Mr KELLY: Is there anything specifying that they have to be that distance away?

Ms Lloyd: I am not sure. I am usually there representing one client in my one matter. I am not a constitutional lawyer, but I am aware that there is a process of getting a police permit to have a protest and that the police can put conditions on general protests. They would weigh up the public interest with the private interest when they put certain conditions on protests.

Mr KELLY: Is that a Queensland law?

Ms Lloyd: Yes, that is part of the protest process here. The regulations say you need to get a police permit and they can also restrict protests when they are near military fly zones and things like that. They weigh up the options. They weigh up everyone's rights and interests. It is not just a blanket right to protest.

Ms Kerr: Can I add, in your example of pressure to withdraw potentially a domestic violence application, anecdotally I am aware that clients I have worked with have experienced that, but that pressure happens behind closed doors. It happens away from the court. It is that individual pressure rather than any protest at a Magistrates Court that may potentially be a systemic opposition to the availability of domestic violence orders, to continue that analogy on. It is similar with abortions. We do know women in violent relationships where their partner may be aware of the pregnancy and opposed to her decision to access a termination. Similarly, she may experience that increased pressure behind closed doors, away from any public attention. With domestic violence orders in particular, potential respondents to an application would probably be reluctant to have any public demonstrations of controlling behaviour, because that would then work against any findings of the fact that a domestic violence order would be warranted against them.

Ms Lloyd: As part of a domestic violence order, there is often an order that he is not allowed to get someone else to contact the aggrieved on his behalf. Often the woman will receive a call from their mother-in-law saying, 'Why are you doing this? It's not helping.' That can sometimes be shown to be a breach of the order if they are excerpting pressure on her or delivering messages or trying to get her to withdraw it. In that respect, communication aimed to stop her taking action to protect herself is already prohibited as part of a protection order.

Mr JANETZKI: You mentioned in your report that during the 2014-15 year between 90 per cent of your legal case work clients and 98 per cent of your social work clients experienced domestic violence. How many clients would you see in a year?

Ms Kerr: That is a very good question. Over this year alone, we have had around 10,000 women who contacted Women's Legal Service. However, those client contacts are then seen or responded to in a number of different ways.

Ms Lloyd: That is women who have made contact with our help line and then they are referred or triaged and they can receive legal advice over the phone or in person or ongoing legal work or be referred to a different crisis organisation if they need to. We have also received a 40 per cent increase in calls for our help in the last 12 months.

Mr JANETZKI: A 40 per cent increase in the past 12 months?

Ms Lloyd: Yes.

Ms Kerr: Part of that triaging process is screening for domestic violence. That is where that data is coming from, at the initial contact point.

Mr JANETZKI: The WLS is based in Brisbane, but serves all of Queensland?

Ms Kerr: That is correct.

Mr JANETZKI: I asked the previous witnesses as well and I would like your insight, given you cross the social work/legal divide: are the women who come seeking your service aware of the current legal position on abortion in Queensland and also the McGuire findings in the 1980s case?

Ms Kerr: I can comment anecdotally. Clients that I have had who are contemplating a termination in instances of domestic violence are not swayed at all by the criminalisation of abortion. They have come to a conclusion that that is the best and safest option for them in their circumstances and will go through whatever process they need to attempt to access that procedure. Most are not aware that it is a criminal law matter at all.

Mr JANETZKI: What do you put the 40 per cent increase you have seen in the last 12 months down to?

Ms Lloyd: I put it to down to better public awareness of levels of acceptable and unacceptable behaviour in the community. We have seen a high jump in older women seeking advice about separating from relationships that they have been in for 40 years. I think there has been a real impetus towards awareness of domestic violence and also promotion of the different services that are available to separate safely. However, that is stretching our resources.

Mr JANETZKI: I can imagine. How many staff did you say you had?

Ms Lloyd: We have quite a big staff, but we are never going to meet the demand. It is endless. The phone does not stop ringing.

Mr JANETZKI: Finally, of the 90 per cent of your legal case work clients and the 98 per cent of your social work clients, what proportion of those would you see in these horrific circumstances where they are seeking abortions because of domestic violence relationships or because of actions conducted in those relationships?

Ms Kerr: We do not collect specific data on the types of violence that our clients are experiencing, so our knowledge around this area is purely anecdotal. Through consultation with our solicitors and our other social workers, we know that this is a matter that comes up. It is not unusual for it to come up as far as us needing to respond to that client in terms of her request for information, but also as far as the safety planning by the social work team to respond to her. We do not have accurate data on how often it comes up, but anecdotally I would not say it is frequent, but it does come up.

Ms Lloyd: What is common is to see a woman get legal advice from us after she has several children and she has remained in that violent relationship because she knows how hard it is to get a Family Court order to stop the father seeing the children. She has decided that, despite the very serious risks to her and the children, she will stay in the relationship to either monitor his behaviour or divert the violence towards herself. That is probably something that I see that is quite common.

CHAIR: Thank you. The time for questions has expired. Thank you both very much for coming before the committee today. We appreciate it. I now welcome Ms Amanda Bradley from Pro Choice Queensland and, via teleconference, we will be joined by Dr Caroline de Costa.

BRADLEY, Ms Amanda, Pro Choice Queensland

De COSTA, Dr Caroline, Pro Choice Queensland, via teleconference

CHAIR: Welcome. Thank you for joining us. Would you like to make an opening statement?

Ms Bradley: Good morning and thank you for the opportunity to speak to the committee. I begin by acknowledging the Jagera and Turrbal peoples of the land on which we meet today and pay my respects to their elders past, present and emerging. In our submission, we listed the organisations and individuals who support the Pro Choice Queensland campaign. You will have hopefully noted that many of those organisations provide critical services to vulnerable women: women who have had violence perpetrated against them including rape, young women, homeless women, women with disabilities and incarcerated women. Their lives may not be like yours or mine. They are often already facing discrimination, stigma and marginalisation, overlaid by poverty. Their access to health information and health services is already inequitable. Those women are facing social issues.

When you talk about social abortions, you are talking about a woman whose husband attempted to strangle her in front of their two-year-old child. You are talking about the woman with seven children whose husband controls all of their finances. You are talking about the woman confined to a wheelchair whose caregiver sexually assaulted her. You are talking about the 16-year-old still in high school whose contraception failed. Those women all sought abortions for social reasons, not medical reasons. They are not imagined women who should have kept their legs crossed, used contraception or waited to have sex until they were in stable relationships. They are real Queensland women using Queensland social services who are victimised and affected by the criminalisation of abortion.

In February next year, Marie Stopes, a not-for-profit organisation, will close its surgical clinics in Rockhampton and Townsville. That will mean no abortions past eight weeks and six days for women living north of the Sunshine Coast and outside of Cairns, that is, 83 out of 89 of Queensland electorates and two-thirds of Queensland's hospital and health service districts. That is just one of the impacts of the criminalisation of abortion. Regulation makes sense in the context of decriminalisation.

Dr de Costa: Good morning. Thank you for the opportunity to speak. I support the five main provisions of the bill. However, they will have little effect without decriminalisation. I speak as one of the few doctors in Queensland who have either provided or are providing abortions in this state. We work in a grey legal area that hampers the proper provision of care to women seeking it, and it discourages many other doctors from being involved directly in abortion care, even though we know most general practitioners in practice in Queensland want to be able to refer women requesting abortion to safe, legal, accessible services.

It also makes health service administrators fearful about providing abortion in public hospitals. There are two current examples of the difficulties doctors face in this state. Amanda has already mentioned the fact that the clinics which provide surgical abortions in Townsville and Rockhampton are about to close. These are fly-in fly-out at the moment because no local doctors can be found to provide these services. It is not cost effective. We face a similar situation in Cairns. In fact, Dr Mike Carrette has retired, and although there is some succession planning it is incomplete. There will then be virtually no surgical services from Nambour to Cairns and possibly little in Cairns. This is a vast region. It is equal to a large part of western Europe where rural and remote women, in particular, will be unable to access needed services.

The other example is that of my colleague Dr David MacFarlane, who has been the subject of a vexatious complaint to AHPRA around his very professional handling of the Q case. He is currently unable to undertake badly needed specialist locums in South-East Queensland which he had been doing. In fact, he has gone overseas as a result. What message does this send to other doctors who might be approached to care for pregnant minors of whom there are an estimated 200 at least aged 14 and under in Queensland each year?

You are hearing or have heard from RANZCOG, my college, AMA Queensland, a group of maternal foetal medicine experts led by Dr Glenn Gardener and individual abortion providers—all of us doctors maintaining that we need a 21st century approach to the legal provision of abortion care. We need decriminalisation.

CHAIR: Thank you, Dr de Costa. I will hand over to the deputy chair to open questions.

Mr McARDLE: I note that in regard to clause 21—that is, termination post 24 weeks gestation period—you refer to the Victorian model as being a way forward. That is slightly different from the model proposed in this bill. The Victorian model requires consideration of all medical circumstances.

It does not appear directly in the terms of clause 21 and it also does not take into account the social circumstances. It refers to the physical and mental health but not social circumstances. Do you think that clause should be amended to reflect the Victorian model more accurately?

Ms Bradley: I do not have a problem with a 24-week limit. Abortions post 22 weeks in Queensland are very rare. I think Queensland Health, which was interviewed in the last inquiry, said that there had been one or two in the past 12 months. Caroline might have something to add to that.

Dr de Costa: There are very few abortions, as we have testified previously, after 24 weeks and they are for serious medical reasons. The social reasons for abortion should be evident before 24 weeks. I have no problem with the way that the bill is written at the moment by Mr Pyne.

Mr McARDLE: Doctor, you mentioned that you have no concerns about the issue of objection based upon conscience and the like in requiring a doctor to on-refer to a practitioner who will perform the termination, and you referred to the AHPRA guidelines in that regard. The AMA have given us their guidelines. What are the AHPRA guidelines?

Dr de Costa: I do not have them before me, but they are similar. The main responsibility of a doctor—even one who is a conscientious objector—is to the patient and the doctor must take that on board when a woman is requesting an abortion and it is available to this woman. There is a very strong ethical obligation for that doctor to make an appropriate referral or an effective referral. It does not necessarily have to be to a doctor that he or she knows will perform an abortion. It can be to a service such as Family Planning Queensland, for example.

Mr McARDLE: In doing that, the doctor will be able to say, 'My conscience is satisfied. I have not referred that particular lady on to a doctor who will perform the termination.'

Dr de Costa: That would be my view, yes.

Mr McARDLE: You support a register of practitioners. Would that be maintained by the AMAQ, or which body would maintain that register? Do you see that, given there is still a stigma around terminations, the publication of that register may be a concern to a number of doctors who do not publicly or in an overt manner publish the fact that they do terminations?

Dr de Costa: I do not think I have said I support a register. Where was that?

Ms Bradley: In the Pro Choice Queensland submission we say that we support a publicly available register of conscientious objectors. The other option I think you are speaking to, Mr McArdle, is an option where doctors who will perform abortions could potentially be on a list somewhere. At the moment Children by Choice, which I am the manager of, has a list of abortion providers in Queensland and nationally. Not all doctors choose to be publicly published on that list. If a woman rings us and says, 'I live in XYZ town in Queensland,' we can refer her specifically to a doctor who is happy to have referrals made to them, for example, for medical termination of pregnancy.

Mr McARDLE: You would not advocate a publicly—

Ms Bradley: It does not have to be public.

Dr de Costa: I understand now and I am in agreement with Amanda.

Mr McARDLE: Thank you very much.

Mr HARPER: Thank you, Ms Bradley and Dr de Costa, for your submissions. Your news today of the Townsville and Rockhampton Marie Stopes clinics is concerning as a regional member. The impact that will have on our local rural and remote area I imagine will be significant.

Ms Bradley: Yes.

Mr HARPER: I do not know how many clients they see, but a quick review online shows they also do medical terminations. You did say surgical?

Ms Bradley: Yes. The surgical services are closing. The medical termination services will remain available, but that goes up to eight weeks and six days, as you are very aware. We know, for example, that women who have experienced violence as part of their pregnancy are up to twice as more likely to present for health care in the second trimester of pregnancy. They are usually 12 weeks and beyond, or much more likely to be 12 weeks and beyond, which eliminates medical termination of pregnancy as an option.

Mr HARPER: Dr de Costa, do you have any comments?

Dr de Costa: Yes. There will only be medical abortion available, and not every woman is suitable for medical abortion, as Amanda has said. There are also medical reasons for a woman not to undergo a medical termination but to have a surgical procedure for certain medical conditions. There does need to be the availability of both forms of termination of pregnancy to provide an equitable service, which is what the women of the south-east will continue to have.

Mr HARPER: Dr de Costa, you might be well versed to comment on the exclusion zones of 50 metres as part of the bill that is before us. Do you have any commentary that you might be able to provide based on your experience with your clinic in Cairns?

Dr de Costa: I have certainly been subjected to a certain amount of harassment but nothing compared to what I know has happened around the fertility service in Melbourne and in Albury, in New South Wales, where it has been atrocious. It is important that women attending for abortion services or for discussion about them and their partners, or whoever their support people are, can do so privately. These are very personal, intimate matters, and it is often very difficult for a woman to make this decision and to go through the process. She should not be confronted by the kind of thing that does happen outside clinics. At the same time, I appreciate that people have a right to freedom of speech, but there are plenty of other places where they can make their views known and they should not be interfering with access to clinics. This legislation has now been put in place in Victoria, in the ACT and Tasmania, and I think it is appropriate that Queensland have the same type of legislation.

Mr CRAMP: Thank you both for appearing today. Ms Bradley, you noted that a lot of women are in particularly difficult situations. Obviously this bill relates to the whole of Queensland not just to people in those circumstances, but let us focus for the moment on those women. My colleague the member for Caloundra asked questions about women in these situations, and the answer that came forth was that most women are not aware that abortion is illegal in Queensland and source a termination procedure regardless. Your commentary was that they cannot get access?

Ms Bradley: Part of the reason that—

Mr CRAMP: I am trying to find out if there is a discrepancy.

Ms Bradley: Absolutely. I hear what you are saying. Part of the reason that abortion access is so difficult is that 95 per cent of abortions are being provided in private clinics. The law creates confusion for medical practitioners, and hospitals are acutely risk averse. Public hospitals are particularly acutely risk averse. A small number of passionate doctors are happy to provide private services. We believe somewhere between 95 and 98 per cent of abortions are happening in private clinics. If I am a woman who has been sexually assaulted, I am very likely to end up paying for my own termination of pregnancy. That is the kind of inequality that I am talking about.

Mr CRAMP: There were over 10,000 abortions last year.

Ms Bradley: Yes.

Mr CRAMP: You are saying that 95 to 98 per cent of those are performed by a couple of private clinics?

Ms Bradley: Ten private clinics plus we do not know how many are being provided in GP services under medical termination.

Mr CRAMP: We rely heavily on the witnesses who come forth and I am trying to make sense of this. You are saying that it is very difficult and women cannot do it because of the current laws, but the previous speaker stated they can and the number of abortions is around 14,000.

Ms Bradley: Yes.

Mr CRAMP: So there is a lot still happening?

Ms Bradley: Yes

Mr CRAMP: Do you think abortions will increase as a result of this or stay the same?

Ms Bradley: Absolutely not. The indication internationally is that countries and jurisdictions that make abortion legal also have better sex education and access to contraception, and that results in lower abortion rates.

Mr CRAMP: So a positive approach in the sense of teaching sex education and—

Ms Bradley: Absolutely.

Mr CRAMP: Basically, the change in the law will not change any circumstances in regard to the abortion rate.

Ms Bradley: I do not believe so. We do not have the data to be able to measure that, though. That is the interesting thing.

Mr CRAMP: Correct, which is why I stated we rely heavily on our witnesses who come forth. I was very interested in your comment about a public or private register, however you seek to put it. I want to confirm that you said a public register for doctors who will be conscientious objectors.

Ms Bradley: No, I was saying it could be either way around. You could have a register of providers, for example. At the moment, currently on the Children by Choice website we list abortion providers who are willing to be publicly listed.

Mr CRAMP: That was more a clarification because I would have thought most directories list who can perform a service, be it for anything—I am just saying generally.

Ms Bradley: Absolutely. I think the difficulty would arise in smaller rural and remote communities where there might only be one or two GP practitioners and there might not be access close by.

Mr CRAMP: I could be wrong, but I would assume that doctors who are willing to perform abortions would be quite passionate about that and quite happy to put their name on a register as opposed to—

Ms Bradley: Not always, because of the stigma and the criminality that they are facing.

Mr CRAMP: Could that work both ways? Would doctors who are conscientious objectors prefer to have that privacy if a patient comes to them or if they put it in their surgery? They would prefer it not to be bandied about.

Ms Bradley: You could put a sign up in your clinic if you wanted so that your clients know that you do not provide those services. That would be acceptable.

Mr CRAMP: So not so much of a directory?

Ms Bradley: Yes, absolutely.

Mr CRAMP: I am concerned for both sides. I would hate to see any persecution of or stigma attached to doctors who want to perform terminations as opposed to doctors who do not. I think we need to be very careful that these people work hard, study hard, are professionals in what they do, and I want to make sure that they are protected in this process as well. That would be fair enough?

Ms Bradley: I agree.

Mr JANETZKI: Thanks for being here. On page 2 of your submission, you spoke about the principles of international law. Yesterday we had plenty of testimony from lawyers and a philosopher in relation to principles of international law that attribute rights to the unborn child under various international law, documents, covenants or the Universal Declaration of Human Rights. Do you agree? Let me start with that question first.

Ms Bradley: I do not agree because I do not believe that the unborn is protected under the law.

Mr JANETZKI: I expected that to be your answer. Can you distinguish—and it may be unfair; I am not sure if you are a lawyer or not—

Ms Bradley: No.

Mr JANETZKI: I apologise. I am trying to work out the distinguishing features between the two arguments. What would your evidence be on that point?

Ms Bradley: I am a mother of four children so I have been pregnant and given birth. Under the legislation that we have in Australia, a child becomes a registered human—I am talking very legally; I am not talking emotionally or from the perspective of a mother who has been pregnant—when they get a birth certificate when they are born. If you look at any of those pieces of legislation, they say a child is somebody under the age of 18. I agree there is no starting point in many of those pieces of international law. I am not a lawyer; this is not my area of expertise. I think every woman consciously makes a decision when she is pregnant at the time at which she feels, 'This is a baby.'

Mr JANETZKI: It was probably a little unfair, and we have some professors later this afternoon from the School of Law so I will be asking them. My apologies. The other testimony we had yesterday was from one doctor in Victoria in relation to gender selection. Would you consider gender selection as a social reason for undergoing an abortion?

Ms Bradley: It is incredibly rare in Australia. There is no evidence to support it—

Mr JANETZKI: There was only one instance. I asked for further cases yesterday and he was not aware of any.

Ms Bradley: I believe Liz Price tabled a paper produced in the US that outlines how we measure birthrates of boys and girls. I absolutely think we have gender bias. Australia has sadly slipped in its place of equality at international level for women. That is absolutely worth considering, but I do not believe there are any significant cases of gender selection happening in Australia. I think it gets a bit blurry as well. Dr Caroline de Costa might want to talk to this. There are medical reasons why some boys or girls carry certain genetic issues. If you make a rule for one group of people, you might be cutting off your nose to spite your face, so to speak.

CHAIR: Thank you. Our time for questions has expired.

PERMEZEL, Professor Michael, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists

CHAIR: Thank you for coming back before the committee. I invite you to make an opening statement of up to five minutes.

Prof. Permezel: I will make a brief statement. It is good to see you all again. Basically, as a college, we clearly support choice for women. More specifically, we support decriminalisation and, more specifically, we also support all five provisions of the bill. Clearly there are experts in Queensland issues and also in the social area of early termination expertise that I personally do not have, but I do want to emphasise, as I did before, the important issue of late TOP availability. As you have just heard, these are very rare cases but they are very deserving cases in that women are sometimes placed medically in the most extraordinary circumstance of having to make a decision regarding a baby with serious problems for which they may not know how bad the issue is going to be at an early stage—say, before 24 weeks if that is where the cut-off is.

I would like to quote three quick scenarios. The first is the cytomegalovirus infection, which I am sure you have now heard of, which affects about 500 pregnant women in Australia—so proportionately that number in Queensland. At 20 weeks, you may know that the foetus has that infection but you will not yet know how seriously it is affected. By 30 weeks, you are getting a very good idea through ultrasound assessment of foetal brain development and whether or not that foetus is seriously affected by that condition. We think it is totally unreasonable for any legal framework to impose the necessity of the woman to be making that decision before she knows what is going to happen.

Similarly, this is a completely different scenario but another one where the late TOP option is the only fair thing to do for women. It is when there is gross discordance in twins—that is, one twin is perfectly healthy and the other has extremely serious abnormalities. If she has to make a decision before 24 weeks with respect to termination, then she is exposing the very healthy twin to the extreme risks of premature birth—between, say, 24 and 30 weeks. Whereas, if she could defer the decision on the twin with serious abnormalities until later in pregnancy, then that healthy twin is not put at risk by the decision to terminate the one with serious abnormalities.

The third issue around late TOP is the women with most socioeconomic disadvantage. These are the ones who cannot get their scan done for whatever reason in their public hospital. They eventually get around to accessing medical services at a relatively late stage, and they are the ones who most often present after 24 weeks, if there is a 24-week limit. It is totally unfair to the woman with poor socioeconomic circumstances who just cannot get things done earlier in the pregnancy.

The other issue I will briefly address in this introduction is that, as our document has said, we are very happy with the two doctors and the suggestions of those five provisions in the bill. We certainly do not support a panel, and we do not support a panel for a couple of reasons. One is that these are intensely private matters. I think everybody agrees with that and I have heard it said a couple of times today. Also, as soon as you get into a broad panel, you start to draw into people with issues of conscience and it becomes very difficult progressing any termination issue once the panel gets large. We support the two doctors as suggested.

CHAIR: Thank you very much.

Mr KELLY: It is good to see you again. I have put this question to other people. I accept that the issue of termination later in pregnancy is rare but it still occurs. It was not evident to me until I went through this inquiry process that here in Queensland seeking a termination for the reason of foetal abnormality is technically illegal. The first bill that this committee inquired into removed three sections of the Criminal Code, which in my understanding would have remedied that situation. This second bill now introduces at 24 weeks a test that is very similar to the one we currently have—which is that to proceed with a termination, the tests relate to the state of the mother rather than the state of the foetus. What is the view of the college in relation to that issue?

Prof. Permezel: It is a very interesting point. As I heard just before, the Victorian law concentrates on the issues of the mother—the physical and mental health of the mother. That was an interesting comment I heard about social circumstances possibly being considered as well.

We actually do not strongly support that a foetal condition should be grounds for termination. I think the reason for that is that it is offensive. I work at a hospital where there are not any terminations—where many, many women continue with severe abnormalities through the pregnancy. This is particularly with babies with Down syndrome who exist in the community and are much loved

by their parents. I think it is offensive to those children and their parents if the abnormality itself becomes grounds for termination. It is much preferred if it is the impact of that abnormality on the woman and her family that is the grounds, not actually the abnormality itself.

I will quote an anecdote. In my own practice, a woman had had six children and she came in for her seventh. She had a very low risk of Down syndrome so everything was fine. The baby was born with Down syndrome. She had a religious objection to termination of pregnancy so it was not an issue. She did not turn up for her six-week check but she came back six months after she had had the baby and she said, 'Why didn't you tell me what this would be like?' I said, 'What do you mean?' It was all about the impact of the seriously handicapped child on her family. It was not the handicap that was the problem; she is a loving mother and loves this child dearly and can look after it but it is the broader impact of looking after the child in that particular circumstance. Certainly, my personal view and I believe that of the college is not to cite the abnormality, but the grounds are very much the impact of that abnormality on the woman and her family.

Mr KELLY: That is the way under this bill that you would have to frame any termination occurring after 24 weeks; it would be the impact on the mother. Do you think a clinician may find themselves in a position where they would have to say to a woman, 'We cannot proceed'?

Prof. Permezel: I do not believe that is the case. If there is not that negative impact on the woman and/or her family, then I do not think the termination should take place. Society as a whole should be very supportive of those women who want to continue with the pregnancy. I say again that it is not the abnormality that is the reason; it is the impact of that abnormality. I do not think it necessarily is depression but just the total global impact of the abnormality on the woman and her family.

Mr KELLY: You mentioned diagnosis of Down syndrome. I have done some research in that area because a number of people in the community have approached me regarding that. I do not believe the widely quoted figure of 95 per cent of foetuses diagnosed with Down syndrome being terminated is accurate, at least based on the research I have seen. There is one comment that sits with me from the research brief and it is from Down Syndrome Australia. It says, 'If diagnostic testing reveals Down syndrome, parents are usually offered a choice about continuing or terminating the pregnancy.' It would seem to me, based on the statements that you have just made, that the discussion should not be about whether to continue or terminate the pregnancy; the discussion should be a holistic discussion around the implications for everybody involved in that situation where there is a foetus with a disability. Is that common? Or do you believe that in the community there are views held by people, including health practitioners, that somehow people with disabilities will create a burden and termination should be the first option?

Prof. Permezel: I certainly believe and we train our fellows and our trainees to counsel in that global, comprehensive way that you have said. I referred last time to the issue of foetal abnormality and the counselling around that. I have visited a termination clinic and asked, 'Do you counsel everybody?' The answer was, 'No, we don't need to because they leave and they're the happiest people in the world. You just see the relief on their faces.' Wait on. The ones with abnormalities need lots of counselling because it is a desperately wanted baby.

I am very confident that our training procedures and the fellows in practice absolutely approach it in the way that you have suggested. It is not, 'It's Down syndrome. You're having a termination,' but a global look at the impact of that. That is, 'Could you look after it? How would your family cope? Do you need more information about what Down syndrome is and the range of the spectrum of abnormalities?' My approach and the approach of all of my colleagues has certainly been that it really is about that personal element. It is not just Down syndrome; it is everything. It is cystic fibrosis, it is severe preeclampsia, it is having an eighth baby when she has got seven. That is what obstetrics is. I often say that obstetrics needs more counselling skills than anything else. It is the most sensitive area and you really need to be able to explore globally into the ability of that woman and her family to cope with a myriad situations.

Mr KELLY: A number of people have approached me in the community and have said that when they have had a diagnosis of a foetus with Down syndrome that up to four different health practitioners have said, 'You should have a termination in this case.' That would suggest to me that there is a bias there. Those people have described to me that they felt pressure to make a certain decision.

Prof. Permezel: Can I say that—

Mr KELLY: I know this is anecdotal, but from what you are saying you believe that the training being provided by yours should mean that that situation—

Prof. Permezel: I think that is extremely disappointing. If we found that to be prevalent, we would put new modules in and double the training in that area. Counselling is a huge part of women's health care. You can imagine what the issues are from teenage contraception all the way through. If we are not getting that message across to our fellows—and diplomats as well. Obviously, some of these people performing abortion services are GPs. In terms of the Down syndrome issues most of them will come to specialists—not all, but many will. There are some women who are just so determined that it is clear the amount of counselling required is much less. It goes both ways. If a woman is adamant that she wants to continue, a lot of counselling is not really going to help. In fact, sometimes it makes things harder for her. If a woman is going to continue with a pregnancy, spending an hour telling her how bad it is going to be is not really good medicine. If a woman is definitely going to terminate unequivocally, then spending an hour trying to persuade her to continue again is not good medicine. All it is going to do is make things more difficult for her. That is what being a doctor is all about.

Mr McARDLE: Thank you for coming back to the committee. Your submission refers to the issue of objection based upon conscience or religious grounds.

Prof. Permezel: Of the doctor.

Mr McARDLE: You then refer to the AMA guidelines in that regard. They do not actually require a doctor to directly refer to a practitioner who will undertake the termination. How does that actually work because the wording that you have here is a bit convoluted? What happens if I am a doctor and I have an objection to performing a termination, but I know you would perform a termination? How do I comply with the AMA guideline?

Prof. Permezel: It is my view that you would never refer for a termination if you have a conscientious objection, and I work with a number of doctors who do. I do not think you need to; you refer for further counselling so that when the patient goes to another provider, abortion is one of the options including continuing with the pregnancy. Certainly I refer to doctors with whom there is a range of options, including termination. They are not going to do a procedure; they are going to have further counselling, but this time the counselling can include termination of pregnancy. I think a doctor with conscience can refer providing the option of continuing with the pregnancy remains on the table. You are not referring for a service; you are referring for broader counselling than you as a conscientious objector are able to provide.

Mr McARDLE: There are organisations and individuals who would argue with you that delays the termination and could place the woman in a position of going outside the gestation period. How do you—

Prof. Permezel: Yet again that is another reason why beyond 24 weeks is mentioned, because the person most likely to be close to that margin of 24 weeks is the one of socioeconomic disadvantage. Again, our document I think is clear that the provision of referring to somebody without conscientious objection for counselling should not lead to unreasonable delays. Certainly I know of anecdotal cases where someone with a conscientious objection refers to somebody else with a conscientious objection who refers to somebody else with a conscientious objection, and the woman goes round and round in circles until the gestation gets so late. That is just appalling behaviour. I think that happens very rarely and I could not quote a case off the top of my head. That is the sort of thing that we want to avoid and I think the wording does avoid that; you have to refer to someone without conscientious objection.

Mr McARDLE: You cannot impede the woman's right.

Prof. Permezel: I think the word 'timely' is in our document, a timely access. I do not think you have to refer to the provider itself; you have to refer to someone—

Mr McARDLE:—to an organisation—

Prof. Permezel:—who is happy to broadly counsel, and part of that counselling includes termination.

Mr McARDLE: You would see that as a better way forward than making an obligation of a practitioner to refer to a further doctor who will provide—

Prof. Permezel: I think that is right. I am not speaking personally, but as someone who was an abortion provider it is completely wrong to regard yourself as a technical person who does the procedure. Any doctor performing a procedure has an obligation themselves to fully counsel and consent the procedure, which includes other options. The most basic form of consent is that you will not only tell them what is going to happen, you tell them what the other options are if they are not going to do it, which in this case is continuing with the pregnancy and all the ramifications thereof. We are certainly not technicians as doctors. Even surgeons are not just technicians.

Mr McARDLE: When you consider the jurisdictions across the nation and looking at termination on demand and then gestation periods, they differ widely. You have Victoria, 24 weeks and beyond that there is a requirement; South Australia, up to 28 weeks gestation before you need to get consent; WA, 20 weeks; Tasmania, 16 weeks; Northern Territory, 14 weeks. There is no consistency in relation to a gestation period that I could pick up looking at the various pieces of legislation across the nation. Do you have an opinion as to whether there should be a definitive gestation period?

Prof. Permezel: Again, my expertise is in the area of foetal abnormality and complex pregnancies as opposed to social. I think that gestation limit probably does have some social implications and I would not be the one who would advise on that—16, 20, 24. I think in the case of foetal abnormality, if it is two doctors and you have an honest belief that that is producing a serious impact on the physical or mental health of the woman, then the limit becomes almost irrelevant because you have an ability, if it is a serious situation, to continue with that pregnancy even if the limits are exceeded. Whether it is 16, 20 or 24, the change in the Queensland law, as I understand it, would be that two doctors would be required as well as some provision of an impact on physical or mental health. I think we can live with that in the foetal abnormality area. I think socially, there is a difference in the way you would approach 16, 20 and 24, but I am happy for you experts in where your population sits in relation to social termination.

Mr McARDLE: With consultation referred to in the bill post 24 weeks looking at both physical and the emotional and mental health, who would you say needed to be involved in that diagnosis by way of the first doctor and the second doctor? Would the second doctor have to be an expert in an area such as psychiatry or obstetrics?

Prof. Permezel: No, as I said before, we train our obstetricians—and I think you have seen some maternal foetal medicine subspecialists whose area of practice is dealing with foetal abnormalities. No-one is more expert in the counselling, support, providing information and all the necessary backup to manage these situations. It really is the obstetrician, the specialist obstetrician. If the abnormality is complex—every specialist obstetrician is capable of counselling for most of the common foetal abnormalities. Sometimes they are extremely difficult and a maternal foetal medicine subspecialist may get involved. Sometimes they are very rare and you might need a geneticist involved, but that really should be at the discretion of the specialist obstetrician and what they feel their ability is to counsel the particular situation. I think it is very wrong to obligate specific disciplines just like—it is probably a bad analogy, but we are going through some Commonwealth issues at the moment with the Medicare review. It is really difficult to define who is able to do what. The issues of credentialing should be around the hospital and being a specialist obstetrician. Trying to partition who does what then gets very complex.

Mr McARDLE: Would you expect the second doctor to be similarly qualified as the first doctor though?

Prof. Permezel: I would expect the second doctor to be similarly qualified. I think after 24 weeks and as the college—I know that there will be some issues of many general practitioners performing early terminations. However, I would prefer that there be at least one specialist obstetrician involved after 24 weeks.

CHAIR: My questions follow on from the deputy chair. The second doctor should be of a similar specialty, yes?

Prof. Permezel: Yes, I think one of the two needs to be a specialist obstetrician in my view.

CHAIR: Should the second doctor have to at least see the woman or just review her case file?

Prof. Permezel: I would not want to obligate counselling. One issue I have not addressed is—I did briefly when I said these are much wanted babies and the psychological trauma is extremely difficult for the woman when she is faced with terminating something that she desperately wants but she knows the outcome is going to be terrible if she continues. If you then force her to panels, which I addressed, and are now forcing her to a second doctor it is like, 'I'm a terrible person and I've now come to you to beg for a termination of pregnancy,' it really puts a woman in an appalling situation. What happens in reality is that if the first doctor is very confident with the decision, then speak to a colleague who signs off. I work in Victoria where we have had the two-doctor rule for a while. If the first doctor has some lack of confidence because of a rare abnormality or some complexities around that abnormality then the second doctor is going to be a geneticist or someone who has confidence about the particular issue that is involved.

CHAIR: Would it be fair to say that your opinion is that the legislation should not really require the first doctor to go to a second doctor; it should be more a decision that the first doctor makes should they require additional information, or do you feel that that is—

Prof. Permezel: I think the community feels more comfortable with the second doctor as is currently worded in the provision. If it is a case note review in a straightforward case—I have been the second doctor in some cases with serious foetal abnormalities, the ultrasound is there and you know exactly what is happening—there is no need to drag the woman in. It is not quite humiliation, but it is in that vein that she is doing something so bad that another doctor has to be involved. Some of them are just so obvious—you have the genetic report or whatever—that a second doctor can confidently sign off and in other cases it will be necessary to see the woman. I think that should be discretionary but I think the community perhaps wants a second doctor. It seems to work well in both Victoria and Tasmania.

CHAIR: With regard to the second doctor, if say it is not about humiliating the woman but about ensuring that thorough process is followed—

Prof. Permezel: Giving her more detailed information perhaps.

CHAIR: Yes and in matters which could be quite complex. Can you outline for me the practical process you go through in the case review? You get all the files and you essentially go through them. You get detailed information even if you have not met the woman yourself.

Prof. Permezel: Essentially there are two or three possibilities. If there were major structural foetal abnormalities in which case you would at a minimum have the ultrasound report, but sometimes you would have the ultrasound films and that might be all you need. If it is anencephalic—are you familiar with anencephaly? It is where there is no brain development. There is a very straightforward report and a competent ultrasonologist. Given this report there is no discussion, no point, in that woman being drawn back for further consultation. It is very straightforward. On the other hand, a partial deletion of chromosome 22 on the short arm of 2,000 base pairs in this region is complex and a geneticist is very likely to actually want to see the woman and give the explanation. If I as an obstetrician is faced with that report when I look for a second doctor, I would want it to be somebody who could give at least as good, if not better, counselling than I can give and I would get her to see the geneticist. That happens in practice and will happen every time. Theoretical fears just do not eventuate.

CHAIR: If we put foetal abnormality aside because the legislation does not require that, then what role would the second doctor play if there are no scans to look at?

Prof. Permezel: You are talking about social termination now after 24 weeks?

CHAIR: Yes.

Prof. Permezel: I do not have experience with that personally. I do obviously engage with colleagues. I go to a lot of meetings and engage with colleagues who are in that area. The circumstances where late terminations are being performed socially are extremely rare. I know of very, very few in Victoria, but the social circumstances are generally appalling and the doctor involved—because of the appalling social circumstances it is almost always in a public clinic and there are all the supports of other doctors in the hospital. Often it is the medical director of the hospital who will be the second doctor who has the reports of the social workers, the psychiatrists and everybody else. Again, I do not think they should be obligated. There are such myriad circumstances. It does well to look at what has happened in Tasmania and Victoria and what has happened is not much. It is now available for the very, very few woman who need these late terminations. In terms of the adverse consequences, the numbers remain very low and the adverse impact on the hospital system has been extremely low.

CHAIR: I certainly appreciate that they are very rare. It is just more that it is contained in the bill, so of course we inquire into the wording and how it practically will work. The other statement that you made—and I do not want to push you on this because you have already said that foetal abnormality is your specialty and social is not. You made the comment about social implications around whether it is 16, 20 or 24 weeks. This obviously is a significant area of debate, even amongst your own colleagues, around that point of viability and whether 24 weeks is too great and whether this requirement should be brought back to 20 weeks as in South Australia—obviously it is different everywhere. What did you mean in regard to whether it should be 16, 20 or 24 weeks? What are you envisaging there?

Prof. Permezel: Certainly my preference is for 24 weeks. We deal a lot with babies born around 22, 23, 24 and 25 weeks. I work at a big tertiary hospital, which has a big NICU and so forth and 24 weeks is the time at which there becomes a realistic prospect of survival without severe disability. Of course, there are a few at 23 weeks and hardly any at less than 23 weeks. It is really 24 weeks where survival with some prospect of little disability really becomes an issue.

I just think 24 weeks is better. I think the community can see that survival issue as a reason for having a threshold at that point. There is no difference between 19, 20 and 21; why would you draw a line at 20? There is no difference between 15, 16 and 17; why would you draw a line at 16? Twenty-four weeks is when things change, and I think 24 is when it should be. It really does become a more complex issue because, as I understand the legislation—certainly in Victoria—it then becomes the impact on the woman, mental health, the second doctor and all these sorts of issues. It is quite a different circumstance, whereas I think up to 24 it should be a more straightforward process, and I think that is what the Queensland legislation will allow.

CHAIR: In terms of your comment with regard to the social implications of 16, 20 and 24 weeks, were you meaning what is socially acceptable to the broader community?

Prof. Permezel: Yes. I believe that 24 weeks is the appropriate line to draw because I think there is a meaning to 24 weeks for the community—that is, the difference between viability and non-viability.

Mr JANETZKI: The member for Caloundra raised the vast discrepancies in gestational periods for abortion on demand, even in Australia. Then you look at Europe and you see that countries like Germany and France have 12 weeks for abortion on demand. In your view, why is there such a discrepancy in gestation periods? Is it cultural? Is it differing medical views of things?

Prof. Permezel: I cannot really answer that. I just come back to my answer to the last question. There is no reason for drawing a line at 12, 16 or 20 but at 24 there is. Twenty-four is the difference between viability and non-viability. Again, there is no reason for it being 28. There is no difference between 27, 28 and 29—it is part of a continuum—but at 24 there is a big change. You could draw a graph in terms of community expectations from that pregnancy. Having looked at umpteen thousand pregnant women—their expectations rise through pregnancy, sure—at 24 weeks, when suddenly they are viable, there is a complete change in the woman's approach and the family's approach. Suddenly they have a viable foetus whereas a week earlier it was non-viable. I think community expectations rightly escalate at that 24-week mark.

Mr JANETZKI: I seem to recall some evidence given at some stage in relation to late-term abortion numbers in Victoria rising since 2008, when the law changed. Your testimony today is that that is not the case; is that right?

Prof. Permezel: Certainly that is not my experience. There are complex issues. There was some rise when all the other states started clamping down. There was a lot of interstate migration into Victoria to have terminations. The other thing you will appreciate from what I said earlier is that, before the legislation, the woman who had the discordant twins had to have a termination at 20 weeks. A whole lot more 20-weekers were done. The woman with CMV was having a termination at 20 weeks, even though the kid was probably going to be okay at 30. She was forced to make an early decision. She could not have the late one. The woman with a complex heart and who could not work out what was going on just had a termination anyway, whereas now she could wait and perhaps continue with the pregnancy if it turned out to be not too bad.

CHAIR: There being no further questions, I thank you, Professor Permezel, for coming back. We appreciate your expertise.

Prof. Permezel: Thank you again for having me.

FOX, Ms Melissa, General Manager, Health Consumers Queensland

CHAIR: Thank you for coming before the committee again today. Would you like to make an opening statement of up to five minutes.

Ms Fox: I will keep it brief because I am always fascinated by your questions. Thank you for having me here today. I would like to acknowledge the traditional owners of the land on which we are gathered. The reason for our organisation's submission on an issue which we acknowledge is controversial in our community is that we believe this is one around access, equity and informed choice and informed decision-making by Queensland women and families. We believe that it is not good enough in our state that especially our most vulnerable women including, as we have heard, women in rural and remote Queensland, young women and women who are experiencing domestic violence are unable to access services because of either geography or lack of services. Dr Permezel talked about the fact that some of those women cannot get things done in a timely manner. We would say that is due to profound structural and societal barriers that prevent those women from accessing services currently.

We also believe more broadly for all Queensland consumers—Queensland women—that it is unacceptable for them to be currently in the situation of being in a postcode lottery around access to services due to either fear that we have heard of doctors and hospital administrators facilitating access to termination services as a result of the illegality of the procedure in Queensland or, as we are aware through our networks, an unwillingness to refer to other health professionals who will provide a range of options if health professionals have their own conscientious objection.

We welcome the committee and the Queensland parliament looking at this issue. We believe that it is long overdue and, for the sake of Queensland women, we say that it is time for decriminalisation and regulation.

Mr HARPER: Thank you, Ms Fox, for your submission and your presence here today again. It seems like only last week that we were speaking to you on a different matter. I took note of your 'postcode lottery' comment. I thought that was quite interesting. I imagine that Health Consumers Queensland would also have some concerns about the closing down of the Rockhampton and Townsville facilities and the impact that will have on health consumers broadly. Do you want to make any further commentary around that? Also, what are your views on exclusion zones around clinics?

Ms Fox: It is a concern to us—it is noted in our submission—that there is inconsistency of application of the statewide clinical guideline around termination of pregnancy. We are aware of some hospitals and HHSs not accepting women for assessment and not on-referring to services. Of particular concern is the fact that many women cannot afford the travel costs and/or the costs of procedures done within the private sector. As we have heard, that is 95 to 98 per cent. That is because services are not accessible across Queensland through the hospital and health services. We think this is a deplorable situation and we do think access to these services needs to be consistent across the state. Access also needs to be without coercion and harassment. Women need to be able to access these services without public humiliation or shaming. We welcome the provisions within the bill to ensure this would not happen.

Mr HARPER: Does it go far enough—the 50 metres that has been recommended? Does Health Consumers Queensland want to see any expansion of that at all?

Ms Fox: It would be our provision that women in these challenging circumstances, who are making one of the hardest decisions of their lives, do not have to see these signs or see these people at all. I think it is an underestimation of women's intelligence and the choices they are weighing up to think they need to be faced with these messages and that that will in fact change their minds.

Mr HARPER: Do you have any commentary on late-term abortions at the 24-week stage that we have just heard of from the professor?

Ms Fox: As you would see in our submission, it is our preference that this would not be regulated. We see this as an issue between a woman and her doctor. There are not regulations of this nature for other medical procedures within legislation and we think that should lie within clinical guidelines—within, as we have already heard, the AMA guidelines and within hospital procedures that already exist within hospitals that are providing these services. We are aware of internal ethics committees where there is more than one doctor that signs off on these procedures past a certain date. We think it would be most appropriate for regulation to continue to lie within that structure. We are also pragmatic and we understand that this is a concern to the community. That is why our submission does not oppose these measures.

Mr JANETZKI: Thank you, Ms Fox, for being here. I am trying to get a feel for what you are hearing. Health Consumers Queensland represents users of the healthcare system. What are you hearing from your members in respect of the current status of abortion law in Queensland?

Ms Fox: I would affirm the previous speaker's statement that a lot of consumers do not actually understand that these procedures are illegal in Queensland or that there is currently the requirement for documenting that they might have a mental health condition that is a threat to their lives in order to protect them legally. Some are able to continue on their journey and have no awareness of that, but for some when they become aware it is very distressing. It obviously prevents them from accessing services in many cases when they need them. There is definitely a sense within the community that there is a time to look at this issue and it is long overdue. It is challenging, but these current bills do provide a unique and timely opportunity to address the issue.

Mr JANETZKI: We have heard a little about the Rockhampton and Townsville centre closures. What are you hearing from your regional members?

Ms Fox: That it is especially challenging and that the patchiness of services is just not good enough and a lot of concern.

CHAIR: Ms Fox, have you been approached—and, if so, has it been a significant issue with consumers coming to you—about access?

Ms Fox: We hear about it through our networks of consumers and other organisations. We are focused on statewide advocacy. We do not market ourselves as an organisation that people can necessarily come to for that individual advocacy and support, to be able to walk alongside them. That is a real gap in community and health services in Queensland. I would say that women in those circumstances would be more likely to seek support and assistance from organisations like Children by Choice.

CHAIR: But you are hearing that access is an issue?

Ms Fox: Absolutely.

CHAIR: What is often levelled is that 10,000 or 14,000 terminations a year would prove that access is not an issue. What would be your comment in that regard?

Ms Fox: At the moment I think women are accessing it by spending large amounts of money—I am sure you would have seen some of those figures—for both travel and the procedure. Sometimes they are assisted by relatives or other organisations. That is where they can begin to fit into those gestational time limits that currently exist. What we do not know is the number of women who are continuing with their pregnancies in circumstances that they would not have chosen. I agree with Amanda Bradley that internationally it has been shown that the numbers do not change. Again, the key to that is ensuring that we have good sex education and counselling services.

CHAIR: A criticism that has been levelled, both in the last inquiry and in this one, is that private clinics are profiteering and that it comes at a significant cost to access one of these services. Do you have any views about why, then, the two private clinics in North Queensland are closing?

Ms Fox: That is precisely our concern and the reason we would like to see these services more widely available in the public health system, instead of only for those who have the capacity and ability to pay. I cannot comment on the business viability of those clinics. I imagine it is both a business decision and a frustrating decision, given that they have tried to fill the gap in services where they have not been provided by the public sector.

CHAIR: Do you have a view as to whether such services should be provided exclusively in the public system, such as in South Australia, or whether it should be a dual system whereby both public and private are involved in the provision of such services?

Ms Fox: I think the reality of our state system is that we are in that dual, mixed public-private system and that there are health professionals who are currently working for those private organisations that may wish to continue. I think what we need to look at are the barriers to the expansion of public access. To our mind, that is around the illegality of the services.

CHAIR: My last question is around information and, from my point of view—and I am sure from everyone's point of view—enough information and to be informed. I am not just referring to that very important term of 'informed consent', but to be informed of any procedure is significantly important and I am sure would be an issue of serious concern to you. You probably hear back anecdotally from people often.

What we are hearing is that some say that when you talk about enforcing counselling, just to move to that issue for a second, women do not want that—they have the information they need or they have access to the information they need and they will make an informed decision—and then

you would have others say that enough information is actually not provided and that women are going through a significant decision in their life journey without appropriate advice and information. How do we balance that and do you have views or have you heard from your network about just what the quality of information is out there being provided?

Ms Fox: I have a background as a maternity consumer representative—some of you are aware of that—and I see this as very much fitting into that spectrum of care right across the preconception, childbirth, pregnancy, reproductive spectrum and exactly the same issues exist within the maternity system. It is about women having access to health professionals that they trust and that they trust the information that they are giving them both around their choices and their models of care—their options for care. If women feel like they are being given evidence based information and that they are a part of the decision-making process, then what can be a traumatic experience—say, a prematurely born infant or having to face a very difficult decision around a termination—can be a less traumatic experience and we would absolutely suggest that that needs looking at and is definitely an issue within our health system.

CHAIR: What needs looking at particularly?

Ms Fox: The idea of the importance of provision of evidence based information to women. Like we heard from Professor Permezel around the implications of having a child with Down syndrome, women need to hear all of their options and all of the potential outcomes and then make the decision that is right for them and their family.

CHAIR: Talking about evidence based information, you of course are referring to the quality of information but the quantity of information also?

Ms Fox: Yes, and how it is delivered. Unfortunately we do hear of women that are bullied and coerced into decisions throughout our maternity system. It is not good enough and—

CHAIR: By?

Ms Fox: By health professionals.

CHAIR: Okay, with particular views?

Ms Fox: Yes, and a lot of them are based on fear and based on misinformation and women deserve better.

CHAIR: I agree and that is partly why I am asking the question, because if you go with the argument that women are being provided with adequate information then why are so many women unaware of the current legislative environment within which they operate? That to me would say that all of the information is not being necessarily provided, and I had a conversation with a number of women recently who wanted to discuss the fact that they had had terminations. When I talked to them about how they felt about the current legal environment, they still were shocked. They had no idea about what the current law was. From my point of view whenever I have access to medical procedures I want all of the information and I think it is concerning to think that women are not being provided with that and having access to it. Thank you for the input and insight that you have provided.

Mr CRAMP: Ms Fox, welcome back. I have a follow-on question from the chair's last question. With regard to your information about women being bullied and coerced, I have sat here for two bills now around this subject. I would almost say that that is both ways—misinformation—and I assume that you are on the consumers' side rather than a particular side of this argument. Would that be correct?

Ms Fox: Yes.

Mr CRAMP: Would you think that there is a possibility that misinformation or lack of information would come from both sides of this argument?

Ms Fox: Definitely, and I think that is why women need access to a range of services, including peer support services, so that they can speak to women who have been through similar situations and also a range of health professionals that would be appropriate to support them make their decision.

Mr CRAMP: Do you think, and I am pretty sure I asked you this question last time, the regulator—this government or the parliament—should have some input into that information to at least ensure it is adequate and is comprehensive for all options on the table?

Ms Fox: I think the clinical guidelines framework is adequate. I do not think that it needs to sit within legislation. Especially if consumers are involved in the design of what that information looks like to ensure that messages can be understood, I think that is the most appropriate place for it to sit.

Mr CRAMP: Certainly not from a legislation but a regulation point of view, if the government put out all the information everything would be included—everything from termination to carrying through to birth through to adoption and through all those aspects. Would that be a fair comment?

Ms Fox: We supported the provision around that in the first bill around the need for evidence for counselling services.

Mr CRAMP: With regard to the first bill and your statement here, you asked that the committee recommend that both bills be debated and voted on. You are aware that this committee recommended the first bill not be passed?

Ms Fox: I am aware.

Mr CRAMP: What if that stands? If we just talk specifically about this bill, how much impact will this bill have on its own if it was passed on its own?

Ms Fox: It is my understanding—and I am not a legal expert but it is my understanding—that both bills need to be passed at the same time. I think from a Queensland consumer perspective, we just want this law changed. We think that it is timely however it happens and we would call on your support for that.

Mr CRAMP: Your organisation does not have a view that this bill on its own is going to make particularly great strides at all?

Ms Fox: We can see the reasons behind it such as the need to address some concerns within the community around late gestation. That is why we have supported it in conjunction with the other bill.

Mr CRAMP: Do you think it goes now to protecting a woman's rights?

Ms Fox: I am not sure that on its own it does enough to change the law, but again that is not my area of expertise.

Mr CRAMP: I notice your division 3 patient protection segment about exclusion zones. As has been noted before, we heard from a constitutional lawyer yesterday who was extremely helpful in understanding constitutional law around this. I am not going to go into the law, but I am just wondering what the consumers organisation thinks of a person standing outside a clinic and, as the example that came up, simply just praying—no hindrance, not on the footpath. Two things came up. A person who was a female witness stated that she will stand there and pray. Sometimes she will say to the person as they are walking past, 'Do you really want to do this?' If that person ignores her or goes forward, there is no problem; if the person stops and chats, they chat. I noted that she alerted police to the fact that she was there just in case there were any issues. What are your thoughts around this from a consumer point of view? I understand that it is a very emotive issue, but I am just wondering about it from a consumer association point of view. With both parties having rights under the law, are there any thoughts on that?

Ms Fox: I guess my first and probably main thought goes to wondering when this might happen in another circumstance. Are there any other procedures for which people—male or female—would be entering a health facility and—

Mr CRAMP: They are not entering; they are standing outside.

Ms Fox: No; if the person entering to receive the care was faced with someone in that circumstance, and I think that that is a shame.

Mr CRAMP: What about the organisation's view?

Ms Fox: Our organisation is focused on issues around individuals making decisions that are right for them free of any coercion based on information. We would find it difficult to support anything which was in any way a hindrance to that.

CHAIR: One final supplementary from me. With regard to consumers being given all of the information, obviously some procedures can be fairly serious. Even with plastic surgery, a plastic surgeon will say to you, 'You need to go away now and have a think about it,' whether it is fairly minor—a correction—or whether it is something significant, 'and then come back.' Do you feel then that given the veracity of the decision being made—which affects the body in terms of a surgical procedure—there should be a cooling-off period to ensure that proper information can be digested, as is often the case with significant medical undertakings?

Ms Fox: Again I think it goes back to the individual. For some there may be more negative implications, both being forced to wait and the experience of waiting but also having that autonomy impacted by the fact of having someone else say that they need to wait. Around the issue of information, I think the litmus is consumers need to be told all information which if not told may have otherwise changed their decision.

CHAIR: Does that include—and this is a particularly contentious point on this topic—gestational development?

Ms Fox: Sorry, but can you repeat the question?

CHAIR: Say if I come in and seek a termination, then I need to be shown stages of development?

Ms Fox: No, I would not agree with that.

CHAIR: Okay. You do not feel that that meets that standard that you just said—that is, if somebody did not understand that and then they found out about it later, which was the testimony we heard yesterday, that my decision may have been different had I have known that this is what a foetus looks like rather than just cells?

Ms Fox: I think that becomes a whole part of the decision making and around the condition, around the viability, around the impact on both their health and their baby's health of continuing with the pregnancy. I imagine that that level of information would come up in the natural course of the conversation rather than a more standalone part of the information provision.

CHAIR: Do you feel that there is a responsibility or a requirement, coming back to the member for Gaven's question, for the regulator—for government—to standardise or have input into the amount of information, even if it is evidence based or not? As you can understand, there is significant contention about what information should be provided and who should make that decision and that would be potentially a subjective assessment as to what is relevant or is not relevant to the conversation. I think my recollection last time was a former witness indicated that what would potentially answer that question is what are the needs of the woman through the conversation and what is she asking for and that would be provided et cetera whereas others have said that, no, standardised information and evidence based information should be provided as a standard provision.

Ms Fox: I think sensitive delivery of standardised information is the key.

CHAIR: Thank you very much. We appreciate that. That brings our questions to a close for the first session. The committee will now take a break and come back at 1 o'clock. Thank you.

Proceedings suspended from 12.26 pm to 1.05 pm

HILLARD, Ms Kylie, Soroptimists International, South Queensland Branch

CAHILL, Ms Fran, Soroptimists International, South Queensland Branch

CHAIR: I would like to welcome Ms Kylie Hillard and Ms Fran Cahill, representing Soroptimists International, as the committee resumes its consideration of the Health (Abortion Law Reform) Amendment Bill 2016. Ms Hillard, I believe that you will be making an opening statement of up to five minutes and then we will open for questions. Thank you.

Ms Hillard: Thank you. At the outset, I should declare any perceived interests. I am the president of Labor Lawyers Queensland and Ms Cahill works for a government department. Having said that, we are here in our own capacity as Soroptimists International and we represent the views of our members of Soroptimists International. I just declare that at the outset.

CHAIR: Thank you.

Ms Hillard: Soroptimists International is an organisation which, obviously, by its very name, has international standing. We facilitate equality for women and girls around the world in a number of forums. We have strong ties with the United Nations. We have ECOSOC status and we have a lot of ties with a lot of groups throughout the world and within Australia and Queensland.

In relation to reproductive health and reproductive safety, it is one of the principles on which we stand. As is apparent from our submission, we support the Health (Abortion Law Reform) Amendment Bill. I think it goes without saying that this would be coupled with the previous bill that would also decriminalise the current legislative regimes around people who perform abortions. We support the legislation amendment. Our members have a very strong view about the decriminalisation of people who perform these procedures, because our members are professionals. They come from not only legal fields but also health fields. We have nurses, doctors, social workers and a number of other members within our profession who have a strong view about this and we represent the majority of our members.

As is apparent from our submission, we recommend that there be an education scheme about the access to the termination procedures, whether in clinics or in public hospitals, which should be extended into rural and regional areas. In our submission as well we speak about the removal of the word 'abortion' as a stigma, but it is only language. At the end of the day, we are supportive of the legislation going through and do not view that as an impingement. A possible amendment is a 150-metre exclusion zone around clinics. In relation to any medical practitioners taking a conscientious objection, in our view there ought to be an obligation to refer women to other medical practitioners who perform the procedures so they are not left in a situation of trying to find somewhere, or source someone, having difficulty with access and also, by virtue of that, have the risk of later terminations as well. That is my opening statement. I do not know if Ms Cahill has anything to add to that.

Ms Cahill: From my way of thinking, as a representative of Soroptimists Queensland, we focus our projects, our advocacy roles, on women and girls locally, nationally and internationally. For us, there is no more important role for Soroptimists to play—to give voice to women, particularly in this area. We want to be the voice that often is not heard.

Ms Hillard: Thank you.

CHAIR: Thank you very much. Just to pick up on your comments about conscientious objection, you mention that your members include lawyers and doctors. Was there any discussion about the appropriateness or how best to balance the interests of those practitioners and their right to not refer when they may feel that that impinges on their ability to have a conscientious objection but how best to serve the interests of women who seek a termination?

Ms Hillard: I think what can be said is that the bill in its present form strikes a reasonably fair balance between an individual's right, who is a practitioner and who may take a conscientious objection for reasons that are known to them, against the rights of the individual to be able to access them. Of course under the bill a doctor had still a duty to perform where there is no conscientious objection, but it strikes a balance between those two views and those two positions. It achieves a fair way for women and girls to be able to access these sorts of medical procedures when they are needed as well as looking at the community rights and other community expectations about those objections.

CHAIR: You support the bill as it is currently worded? If there were to be a requirement to refer, that would be the Victorian model.

Ms Hillard: That would be. Yes, we support it in its present form. We have no objection to there being a conscientious objection. But we recommend that there be an addition of the referral to another practitioner, which would be consistent with the Victorian one. I notice that there are a number of other submissions from other organisations that are consistent with that sort of view as well.

CHAIR: Is your issue about access and timely access? Therefore, it would not really bother your organisation whether that was by being able to access a private or a public list of those who may be able to provide those services? Is it the means by which people might be able to be referred or is it just the access to that information that matters to you?

Ms Hillard: I think that it would have to be both because, if you are talking about access to information, as is the present situation in Queensland for many practitioners, as we understand it, because there is the liability of criminal conduct, whether it is criminal, whether it is conscientious, there is not necessarily a referral pathway. There may be ethical obligations or duty obligations to refer on, but there is no mandatory obligation to do so. That can result in, for example, women being able to have difficulty in sourcing where they can go to access the medical procedures, delays in doing that, which increases the gestation period, which increases the risks of medical procedures as well, but also the means by which it is accessible. Whether it affects the clinic, or whether it is in a hospital, all of those are related. In answer to your question, I do not think that it can be one or the other. Our recommendation is around women being able to get access to these and not being left to flounder in a vacuum of, 'Where do I go from here?'

CHAIR: The intent of my question was, if that were to be achieved through different means—that the current wording in the bill as proposed stood but maybe there would be an amendment or there would be an ability to access that information publicly—such as you refer to a service and they can provide with you all the information about where you can go otherwise—

Ms Hillard: An accessible public database or a register. I think we mentioned a register in our submission earlier. Certainly, if that were publicly accessible, and broadly publicly accessible, it would be beneficial. Not everywhere in Queensland has the internet and not everywhere in Queensland has a reliable internet. How would that be accessible, for example, in certain cultural groups where English may not be their first language? In order to discharge one's obligations it would be preferable for it to be an obligation on a medical practitioner to refer on, recognising those CALD women's difficulties—the culturally and linguistically diverse women—and the regional issues and the internet issues and the accessibility, not to mention people who are under 18 and whether they are in a community that would be problematic for them.

Twofold would perhaps be most optimal—to have a referral to a doctor as well as publicly accessible information. Simply maybe making it publicly accessible only and not having that duty to refer may result in certain people not being aware of their rights. Is there anything that you want to add to that?

Ms Cahill: No. I would just like to take the approach that we often forget—saying that it would be publicly available. I am just taking the point that Kylie made. That does not take into account the number of young women in Queensland who will not have access, who will be struggling, where a publicly available thing is the last thing that they want to be able to do. Being able to access the medical procedure as necessary within what is available within their community would be ideal but, if they have to leave that community, we cannot just assume that it is easy to travel, that they have the money to do that, that they have been given the right sort of information. I think that we have to look at Queensland right across-the-board, not just metropolitan areas.

CHAIR: Which is a good point and leads into my next question, which relates to some groups who experience a disproportionate disadvantage, whether by location or other factors. I assume when you talk about terminology, 'termination' instead of 'abortion' would be your preference, but I will come to that.

Ms Hillard: Yes.

CHAIR: Whether termination services should be available in the public system, the private system, or a combination of both; do you have any views in regard to that from an access point of view?

Ms Hillard: As I understand it, because of the current criminalisation of the—

CHAIR: Under the bill?

Ms Hillard: Yes, under the bill. In relation to the access, there are different procedures and different methods and different techniques, as I understand it, that would be performed at different stages—perhaps at the gestation—and there are some risks associated with the woman, or the girl

who is undergoing the procedure. It is a medical procedure. There are always going to be risks. Safety is obviously paramount. Whether they always have to be performed in a public hospital or a hospital setting is something that an individual doctor perhaps is the best person to be equipped to answer that question. I notice that we have got some evidence from the Australian Medical Association as well coming up this afternoon so I would perhaps defer to that. There is financial disadvantage of, course, in accessing many clinics. They are not regionally located, generally speaking, and on the coast as opposed to centrally and if it was in a public hospital and it was more readily accessible in a public hospital some of those regional people might have better access. Some of those people from linguistically diverse areas and other cultural groups might have better access as well. Having said that, you cannot mandate whether it is a public hospital or whether it is a clinic, I would suggest, under the legislation because that is very much, it seems to me, a medical decision.

CHAIR: The reason I ask is because in South Australia I believe that you access it exclusively in the public system. They do not allow private clinics. That is why I ask. I appreciate that is not your area of expertise either so it was just for an opinion.

Ms Hillard: I think that we can say that if it was accessible in a public system it makes it more accessible for more women and that would obviously be something that would assist with some of those prohibitive factors. At the end of the day, if that was something that was going to prevent the bill from going through, our view is that general access to rights to termination procedures would be paramount to whether or not it took place in a clinic or a hospital.

CHAIR: Thank you very much.

Mr JANETZKI: Thank you for being here. As a Soroptimists International member and a Labor lawyer—I have been trying to get testimony or clarification from a number of witnesses in respect of international law principles—this may not be your field of expertise either, but I just would just love your opinion on the evidence we received yesterday in respect of international law principles, the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights. The evidence put yesterday was that unborn children have rights under those particular international law documents. My question is would you agree, and if not can you distinguish for the committee, the different sources of law that you would rely on to say that there are no such rights?

Ms Hillard: I suppose it is difficult for us to say because we have not addressed that in our submission and we can defer that to our region for a more comprehensive consideration. Obviously there are moral issues that are often raised around these sorts of procedures and these sorts of practices that happen, but equally there are moral issues raised around women who are forced to go through these procedures or forced to go ahead with pregnancies when they choose not to or when inception or the choice for inception is actually taken from them as well. I think that when one is looking at international law and international rights and views it has to be balanced against the individual's rights and views as well. Everyone has their own individual choices, their own individual rights. In terms of whether that can be something that founds this, I suppose at the end of the day other states have legislation around it, other states have decriminalised it and our fundamental position is that it should not remain criminal in Queensland and it should be done in a safe and appropriate manner in Queensland because they are happening now and they should continue to happen but in a safe way where doctors and professionals are not liable for prosecution. Is there anything you wanted to add to that?

Ms Cahill: No. I am in no position to have an opinion on the international law of an unborn child, but I am in a position to say that, let us be honest, a 14-year-old who has been raped in the middle of Queensland, an international law of the unborn child across-the-board view, sure, but we are looking at what is the position for that young woman? Decriminalising a medical procedure, for me, is far more important for us to be addressing at this point.

Mr JANETZKI: Leading into that, the education and access that you advocate for, and again we have had lots of conflicting testimony given on this, but this legislation does not propose things like cooling-off periods or right to no information or information of that nature. It does not mandate it. Do you see any benefit in mandating that type of information?

Ms Hillard: I think that at the end of the day when a person wants to access and undertake these sorts of procedures they are going to go see a doctor and a doctor has certain obligations about, 'This is what the procedure is. This is what the procedure involves. Here are the risks.', and give them appropriate information in that regard. That is the same for any medical procedure, whether it is this kind of one or not. At the end of the day, mandating—you must say A, B, C, D, E—is counterproductive perhaps to the discretion of the individual general practitioner to talk to the patient about what their unique needs are. They are in the best position to be able to assess that because

how something is explained to a child of 12 is not the same as how it would be explained to a child of 15 or 16 or an adult who is 25 or 45. Those things are on a case-by-case basis and mandatory restrictions around that I would suspect would be counterproductive to what individuals perhaps need.

Ms Cahill: Making the distinction between informed consent as to what is going to occur in this procedure, only the doctor can make those sorts of decisions or make sure that the appropriate information is available. In terms of what does mandated actually mean, I would be really interested in seeing what that actually meant as opposed to ensuring that for any medical procedure there is informed consent. I don't know what that distinction is, but I think if we are talking about a mandated list of things that must be delivered to a person who is presenting for a particular procedure, I would like to see how that could be dealt with.

Mr HARPER: Thank you both for your submission and for being here today. I wanted to touch on the proposed gestation period in your submission of 24 weeks where you have said –

Some of our members have expressed concern as to the appropriateness of termination procedures being undertaken, particularly when late in the gestation period and ethical issues that arise in this regard.

I want to get a bit more commentary from you on that. I see you have commented on the ethics committee. Can you expand on that point a little more.

Ms Hillard: At the end of the day we are a democratic organisation and we take our position based on what our majority members have put forward. The majority members have put forward what is contained in our submission. We obviously acknowledge, and it creates a balanced approach to acknowledge, that not everyone has the same view and if one comes to these things with a view that there is only one particular way that this should be and that is there must be human rights for women, it does not appreciate that there are other spectrums of views as well. We are not in a position to be able to say what minority positions are because that does not form part of our submission, but at the end of all of that, the majority of our members do support it and we still support what we have contained in our submission.

Mr HARPER: That sounds like a sensible, pragmatic approach.

Ms Hillard: Can you tell that I am a lawyer?

Mr HARPER: You go further and state that a medical oversight board be established. Who should be on that board?

Ms Hillard: It is interesting. We had that originally in our first submission and it ended up in our second one to some extent. Whether or not there is a board established, I don't know that any of the other people putting in submissions put that through, but what is apparent, it seems, is that we would always defer to what a practitioner or a medical organisation would say is an appropriate gestation period. Whether there was an oversight board, it would have to be medically informed. The evidence from the last inquiry seems to be, and the submissions still seem to be, that it is difficult to fix a particular point in time, but there has to be a point in time on a practical point of view and if we are going to look at Victoria as the model they have 24 weeks, other states have different periods as well. If there was an oversight board then the board would not be an ethical board, the board would simply be about maybe as medical knowledge advances the time of that gestation may change under the legislation. Once again, it is different in every state so it is a case of selecting which approach best matches the community needs in Queensland.

Mr HARPER: I wonder about your point that it should not have that representation. In your submission at 37.5 you state—

The board review the qualifications and training of registered practitioners to ensure appropriately qualified personnel carry out pregnancy terminations

Is that not the role of our current registered bodies like AHPRA and the Health Ombudsman?

Ms Hillard: I suppose that there is a difference though between what is an ethical oversight and a safe oversight. Those ones that we put in there at 37 really refer to, if I can coin the phrase, avoiding these backyard abortions. Under the bill as framed it has requirements that there be an appropriate qualified professional and those things are addressed in the current bill as it stands. If there were consideration of any other oversight about any of that it is targeted around safety of women, safety of girls and safety of the procedures. If the legislation goes through, the decision to undertake these procedures lawfully is already made by our government and is already made by our community in supporting it. Taking the step back and then imposing an extra layer of ethics at a point is not our intention, what we suggest is that there be safety around it and if there is a register, people who are qualified to do it, and as I understand it, and the medical people are here, they will be able to give evidence about it, doctors are trained in these procedures as well so there are safety things that are in place to do so.

Ms Cahill: The point that you made is who would constitute the board et cetera. All of those other boards are currently in place, but the procedures that they have oversight over are not criminal, are they? For me, the response, if we are talking about a structure that needs to ensure that there is safety, all of those sorts of things, what is in place now is certainly not for what is considered a criminal action. The bill as it comes, is it going to deliver safety? If it is not, certainly a board should be in place. That is what I feel.

Mr KELLY: In your answer to the member for Toowoomba South you made reference to a young girl in Central Queensland. I assume you are referencing the case of Q there?

Ms Cahill: No.

Mr KELLY: Then I have no further questions.

CHAIR: There being no further questions, I thank you for your appearance here today as witnesses and thank you for your submission.

MARKWELL, Dr Alex, Australian Medical Association Queensland

CHAIR: Welcome, Dr Markwell, and thank you for coming. Would you like to make an opening statement of up to five minutes and then we will open for questions?

Dr Markwell: Thank you to the committee for giving me the opportunity to provide evidence on the Health (Abortion Law Reform) Amendment Bill 2016. At the outset, I would like to state, as AMA Queensland did in our submission, that we largely support this bill. Doctors in Queensland have a duty to provide the best patient care that we can offer and Queensland's current laws regarding termination of pregnancy are a barrier to this. We welcome any change to the law that provides doctors with the legal certainty that they need to provide patient care. In order for this bill to have any relevance, however, it would still be necessary to amend the Criminal Code to ensure decriminalisation of termination of pregnancy. AMA Queensland understands that the easiest way for this to occur is to pass the earlier Abortion Law Reform (Woman's Right to Choose) Amendment Bill at the same time as this bill, for any amendment that achieves the same result would be supported by us.

While AMA Queensland supports this bill, we do have some reservations about section 20(3) of this bill. While we support the intent of the section, which is to ensure that a woman does not commit an offence by consenting to a termination of pregnancy, AMA Queensland believes it is logically inconsistent with section 20(1) and 20(2), which state that only a doctor or a nurse operating under the supervision of a doctor may perform a termination of pregnancy. AMA Queensland believes an amendment may fix this inconsistency and ensure that terminations of pregnancy are conducted in a safe environment by people who are appropriately trained to perform this procedure.

With respect to section 21, abortion on a woman more than 24 weeks pregnant, AMA Queensland believes that existing clinical practice and guidelines for termination of pregnancy are effective and we would support that those continue as outlined in this bill. With regard to section 22, duty to perform or assist an abortion, AMA Queensland respects the rights of medical practitioners to hold differing views regarding the termination of pregnancy. However, conscientious objectors should not use their objection to impede the patient's access to care or to treatments that are legal.

If this bill passes, AMA Queensland strongly recommends that the Queensland government should develop a public information campaign to inform doctors of their rights and also their legal and ethical obligations. AMA Queensland would be happy to be involved in the development of this material and to disseminate it to our members through our communications network. AMA Queensland supports any measures that protect patients and staff from harm, intimidation or harassment and, as such, we support division 3 of this bill, patient protection.

Finally, I take this opportunity to reiterate AMA Queensland's support for other measures to reduce unwanted pregnancies, including enhancing access to affordable and effective contraception, promotion of respectful equitable nonviolent relationships and reducing binge drinking among young people. I am happy to take any questions.

Mr McARDLE: Thank you, Dr Markwell, for coming back to the committee. I turn to clause 20(3), which says that a woman cannot be charged with an offence of performing an abortion. You refer to what are normally called backyard abortions, at the top of page 2. At this point in time, abortion is illegal in this state unless certain steps are undertaken. Are you indicating that there are backyard abortions still taking place?

Dr Markwell: We have published data in the current edition of the *Medical Journal of Australia* of the case that was brought forward against the young couple who imported mifepristone.

Mr McARDLE: In Cairns?

Dr Markwell: That is right. That is an example of a termination of pregnancy that had been sought by the patient, the woman, but without the oversight of medical professionals. That would be an example that we have seen already. Our goal is that any termination of pregnancy is supervised and overseen by appropriately trained doctors and nurses where it is appropriate. Particularly with the example of medical terminations of pregnancy, we have seen an example already where that has occurred. We would strongly encourage that this subsection be amended so that there is no inadvertent encouragement of that sort of activity.

Mr McARDLE: Do you have an idea as to how that would be worked?

Dr Markwell: I am not a legal draftsperson. We would be happy to provide consultation on that. Our intent is that it should not be an offence for any woman to seek an abortion or termination of pregnancy, but we felt that the wording of subsection 3 was inconsistent given subsections 1 and 2, which clearly describe the involvement of medical practitioners and nurses.

Mr McARDLE: At this stage I understand there are many practitioners throughout Queensland who will not enter into terminations because of the law as it currently stands. Would the AMA consider that if the code was amended to repeal those sections, greater numbers of doctors would be prepared to come forward and undertake terminations?

Dr Markwell: It is possible that where there is legal certainty there would be an increase in providers who are willing to be involved in this procedure. At the moment, it is very restricted in number. There has been an increase, I understand, with the TGA approval of mifepristone. Again, we do not have any publicly available numbers, but we know that there are doctors prescribing that medication, so the number of providers has increased. Yes, I would imagine there would be, but we do not have any data to support that.

Mr McARDLE: I understand from our first inquiry that a termination through a private facility can cost between $400 to $700 based upon where you go, where you live, et cetera. If it was opened up so more doctors agree to undertake that, what amount would come back by way of Medicare, if you can claim on Medicare, and what would be the out-of-pocket expenses in relation to a termination through a GP?

Dr Markwell: There are Medicare item numbers that are used currently for termination of pregnancy. I do not have those numbers in front of me, but I know that they are clearly described in the schedule. As far as what the differential would be between a rebate and what a private provider would charge, that would be up to the individual provider. I would not be able to speculate on what a gap payment would be for a patient. That is an essential aspect of treatment and care for women. Our argument would be that it should be affordable and accessible. That might mean that it is a combination of a public/private collaboration, as currently exists with many services in Queensland providing health. It may be that there are some private providers where it is appropriate and it may be that some services are provided in public hospitals, for example. I would not be in a position to comment on what the out-of-pocket expense would be for a patient if a decriminalisation of termination of pregnancy were to proceed.

Mr McARDLE: Many terminations occur before 24 weeks and they do not occur in the public health system in this state. Therefore, they would go to a private clinic in most circumstances. You would need to open up a range of medical practitioners or bring the public health system into play, wouldn't you, to make it viable?

Dr Markwell: I am an emergency physician so I do not practice in this area personally, but I understand that depending on the gestation it will determine where and how a termination will take place. With early first-trimester terminations it may be a medical termination is appropriate and that could be done in the community, but with access to hospital treatment if there were any complications. As a gestation progresses or as the gestation period becomes later, you will see some of these procedures being undertaken in public hospitals. I work at the Royal Brisbane Hospital, for example. I know that that is where some terminations of pregnancy in the later stages take place. There are currently public hospitals that do undertake this procedure, but it depends on the gestation, the complexity and many clinical factors, as you could imagine.

Mr McARDLE: At page 2, you talk about termination where the woman is more than 24 weeks pregnant. You refer to section 3.2.1 of the guidelines. The bill refers to similar guidelines, at section 21, where there are two doctors involved. You say there that the circumstances contained in the guidelines are closely mirrored in the bill. Do you have a copy of the guidelines with you? Could you indicate whether it requires specialist doctors on both sides, that is, doctor 1 and doctor 2 have to have equivalent training and knowledge? What do they have to consider: is it the medical details of the woman and the child, and the circumstances of the mother's current and future emotional, mental and social circumstances, et cetera?

Dr Markwell: That is quite a comprehensive question. I will do my best. The guidelines to which our submission refers and what I believe is mirrored in the bill is the Queensland Clinical Guideline, the guideline developed by the statewide network for obstetric care. That is not the exact title, but that covers the clinical area. The description of the clinicians involved refers to when there are complex cases and those are defined in the guideline. As the guideline currently is written, it describes that there are two medical specialists, one of whom must be a specialist obstetrician and, ideally, one of those specialists should be the practitioner performing or overseeing the procedure. The speciality of the second medical practitioner should be relevant to the circumstances of the individual case, so that would encompass the many complexities that you started to outline there. There are also other clinicians who may be involved, depending on the circumstances. In addition to the previously described obstetrician, there may be appropriate clinicians, including social workers, psychiatrists, obstetricians, general practitioners, maternal foetal medicine specialists or paediatricians and there

may also be other members of the case review, including lawyers, ethicists, religious officers or sexual assault workers. That is partly in order to ensure that the procedure that is conducted is not an offence against the Criminal Code. With the first, there must be one specialist obstetrician and then the other specialist depends on the circumstance of the woman currently.

Mr McARDLE: Do you think, based upon what you read out to me, that section 21B should be enlarged to incorporate the fact that there are a variety of doctors or specialists that need to be engaged based upon the necessity to view the needs of the woman, as opposed to simply saying at least one other doctor?

Dr Markwell: I think that clinical guidelines are complex and will change over time. The clinical guidelines as written cover the complexity of cases that may arise and the members of AMA Queensland are very comfortable with the guidelines as they are written. I think the bill as it is written provides scope for the circumstances as they change to be addressed. I think that making the bill more specific would potentially make it more restrictive. My preference and my members' preference would be that we stick with current clinical guidelines.

Mr McARDLE: Not the terms of clause 21?

Dr Markwell: The guidelines would still be compliant with the bill as it is written.

Mr KELLY: I want to ask about conscientious objection. I note your position as an organisation in relation to that. A number of submitters have suggested that there should be some way not only for doctors to hold a conscientious objection but also that they should somehow notify that publicly, either display it at their place of practice or through some sort of public registered identifying either those prepared to perform a particular procedure or those who are not. What is the view of the AMA in relation to those suggestions?

Dr Markwell: The overarching principle is that an individual doctor's objection must not impede access for that patient to achieve the care that they are seeking. The current legislation in Victoria and Tasmania are different, but they both address the issues around conscientious objectors. Our feeling is that either of those options are reasonable and acceptable. There are doctors in Victoria who chose to place cards in their waiting rooms, informing patients or prospective patients of their beliefs. Provided that the patient was still able to access care, that would be reasonable. The overarching principle is that, whatever the objection is, it must not affect the ability of the patient to access care.

Mr KELLY: Thank you for that. There has been a range of discussion about counselling. By that, I do not mean informed consent; I am referring to decision-making counselling. There have been some discussions, both in the previous inquiry and in this inquiry, about that being a mandatory requirement prior to a termination. Does the AMA have a view in relation to counselling being mandatory or nonmandatory?

Dr Markwell: I think it does actually play into consent, although I know that is not specifically what you are asking. As with any procedure or treatment, a doctor would spend time with a patient, explore the treatment or the procedure, discuss the risks or potential risks of progressing with that treatment and also the risks of not proceeding with that treatment. That is part of our normal processes. I would see that this would be no different—in that if a doctor felt they did not have that information, they could then refer to a service that could provide that information. If a doctor were obtaining consent for a procedure, they would need to ensure they were able to provide all of the information that was relevant to that patient.

Mr KELLY: Claims are often made that women who are seeking a termination are not given full information options. In a theoretical perspective, as a part of normal obtaining of informed consent, is it your contention that those women would be given all of the potential risks involved in the procedure, the alternatives to the procedure and what the long- and short-term consequences of the procedure would be?

Dr Markwell: At a clinical level, yes. There would be other considerations. We potentially would not go into a long process of discussion, but it would be important—and I believe it does occur—that, if you were having those discussions with a patient and the patient had questions you were not able to answer at the time of consultation, you would provide avenues for them to explore and seek further information. I cannot possibly know everything about everything a patient asks me and I would give the information as best I could, but I would also make sure they had access to further information where that is relevant to them based on what they have asked me.

Mr KELLY: That is not unique then to counselling related termination. There would be other procedures you do gaining informed consent where you might need to refer that patient—

Dr Markwell: That is right. It might apply for any number of procedures that I do not do routinely but I might be asked about. I think that would apply to this procedure as well.

Mr KELLY: In relation to your concerns about the section of the bill about who can perform a termination and the sections that seek to address the issue raised in the first inquiry, whereby an individual underwent a medical termination without involvement of a doctor, I believe your statement was that the organisation supports the intent but perhaps not the wording and the approach. To my way of thinking, the issue there goes to access. The question has to be asked: why was this person in a situation where they were seeking an unsafe procedure? Would it be the view of the AMA that, if the first bill in terms of decriminalisation was passed and the second bill was also passed with or without some amendments, that access would improve to a degree whereby people would not necessarily need to seek unsafe terminations?

Dr Markwell: We supported the first bill in our submission and we certainly support the second bill. Our hope is that where this procedure is accessible then patients will seek it appropriately through appropriate channels. I am not sure whether the patient that I mentioned before attempted to procure that medication prior to the TGA approval or afterwards—it is probably not really relevant—but the point is that they felt the need that they had to access it through those means. Decriminalisation is certainly important. It is important that both bills are passed in order to ensure that. We would be very keen to make sure that women who were seeking this treatment were doing it safely and with appropriate medical oversight. Hence, that is why we support subsections (1) and (2) of that section.

Mr KELLY: I note your specialty you mentioned before, but could you comment on the claims that have been made that in countries that have moved down a path of decriminalising abortion that in fact the rate of terminations has been able to be decreased through a range of measures of public health interventions, including long-acting contraceptions?

Dr Markwell: I do not have any figures to quote to you. We certainly at a state level and also federally in our federal position statement on reproductive health feel that termination of pregnancy forms part of many options regarding family planning and the overall holistic care of women. Our hope is that if this procedure were decriminalised then women would be able to access these services earlier, they would be safer and we would hopefully also see it as part of a suite of other options that I mentioned which will prevent unwanted pregnancies as well, which is also very important. Yes, ideally we would see that the numbers of complications of termination of pregnancy would reduce, but we would also see that women were accessing these services earlier and that they would have a better outcome overall.

Mr KELLY: I have a final question relating back to an earlier line of questioning in relation to informed consent. I believe it was your contention that doctors are able to either provide a full range of counselling or refer on for a full range of counselling. Given that is the situation, is there anything that footpath counsellors are adding to the knowledge base of a woman who is entering a clinic where abortions are performed that would not already have been canvassed and discussed either by the doctor or by the person they referred the woman to?

Dr Markwell: By footpath counsellors—

Mr KELLY: The people who stand outside abortion clinics offering advice. They term themselves footpath counsellors.

Dr Markwell: I am not sure that would be appropriate for any procedure. Our belief would be that patients seeking information about a treatment or procedure would seek it from the appropriately trained professional, such as the doctor or nurse as I described before.

Mr CRAMP: I have heard some of your statements and I also note the second paragraph of your submission where you say that you represent over 6,000 medical practitioners across Queensland. How many of them had input into this document and the previous one?

Dr Markwell: Do you mean our earlier submission?

Mr CRAMP: Let us just say this submission. How many of your members had the opportunity to provide feedback for this document?

Dr Markwell: I would not be able to give you figures. The process for any submission or position statement is that it is drafted by our policy officers and a small number of members, usually their councillors or their directors. That submission then goes to the broader council. It is then approved or otherwise.

Mr CRAMP: So it does not go to members for input and feedback?

Dr Markwell: It goes to members who are members of the council or for the subcommittees that consider position statements, yes.

Mr CRAMP: How many people would that be out of 6,000 people?

Dr Markwell: It would depend. As I said before—

Mr CRAMP: Would it be 1,000?

Dr Markwell: It would not be 1,000.

Mr CRAMP: 100?

Dr Markwell: No. Our normal process for any policy or position statement development was followed. We would never go to that number of members for something that has an established federal position statement, which we do.

Mr CRAMP: You go to fewer than 100 people, maybe fewer than 50 from the sounds of it, out of 6,000 members. I am just trying to get an idea. This is a fairly strongly worded statement. We have had a few groups come in saying 'our members'. Do you have any feedback from members who are passionately for or opposed to this position on abortion? Do you have any percentages within your association?

Dr Markwell: We have had feedback both on our first submission and I believe on the second submission from members who have been very comfortable with the position that we took. We have closely followed our federal AMA position statement which is also reviewed by members throughout the country. It is completely consistent with that and I believe it is consistent with the belief of the majority of members. We certainly have not heard otherwise.

Mr CRAMP: But you have not put that out for formal feedback to get any idea on that?

Dr Markwell: Position statements are widely available on the website.

Mr CRAMP: I am just trying to validate the statement because you have said 'our position' and there are 6,000 members. That is a lot of members. Having been involved in very large organisations myself and making sure that every document goes out to the membership for approval, even that opportunity, I am just trying to validate how wide the view is from doctors on something as important as this that is important to the legislature.

Dr Markwell: Our submission follows the federal statement, which has been in place for many years and is widely and publicly available.

Mr CRAMP: I note in here and in your statements today that you are obviously strongly in support of the first and second bill going through together. As you know, this committee recommended the first bill not be passed. Does the organisation have any viewpoint in regard to how effective this bill standing on its own will be? Will it make any significant difference? It is okay if you have not put that to them. I have asked this to previous witnesses.

Dr Markwell: Do you mean this bill being the amendment to the Health Act?

Mr CRAMP: Yes, this bill standing on its own without being in conjunction with the first bill.

Dr Markwell: My understanding is that, without amending the Criminal Code, this bill will not have any significant impact on how the procedure is treated in that it would still be considered a criminal offence.

Mr CRAMP: There is nothing loaded in that. I have asked previous witnesses. I am just trying to get a feel for the fact if it was to be judged on its own merit, which is a possibility.

Dr Markwell: The content of the bill we support, but our understanding is that it will not change practice unless the Criminal Code is also amended.

Mr CRAMP: Thank you.

Mr JANETZKI: Do you know the Victorian case of Dr Mark Hobart? Are you aware of that case?

Dr Markwell: Could you be more specific?

Mr JANETZKI: He gave testimony yesterday. He was a GP in Victoria who was cautioned by the Medical Board there in response to refusing to perform an abortion on demand for the purpose of gender selection. He was ultimately cautioned by his medical board. Has AMA Queensland contemplated a similar thing occurring in Queensland should this bill be passed? How would you approach such an issue?

Dr Markwell: Could I clarify the issue? Was it a request for—

Mr JANETZKI: He refused to conduct an abortion on demand out of a conscientious objection when the parents of the child suggested it would be undertaken for the purpose of gender selection. Dr Hobart refused as a conscientious objector. I am just trying to work out what AMA Queensland's position would be. What would your approach be to support doctors? How would you manage that in Queensland?

Dr Markwell: May I paraphrase just to make sure I have it right?

Mr JANETZKI: Please, yes.

Dr Markwell: My understanding is that Dr Hobart was asked for a referral for a termination of pregnancy. I do not believe he undertakes terminations of pregnancies.

Mr JANETZKI: That is right, and he refused to refer.

Dr Markwell: The issue about him refusing to refer is probably a separate issue. I will refer to the discussion about request for termination of pregnancy on the basis of sex selection. Is that okay?

Mr JANETZKI: That is fine, yes.

Dr Markwell: Certainly, there may be very, very specific and rare cases where there are very serious sex linked diseases where it may be relevant that there is some consideration of the sex of the foetus. I am not an expert in that area, but I know there are sex linked conditions where that may apply. Certainly, for any other reason, there would be no support. My understanding is that currently there is no support nationally for termination of pregnancy on the basis of sex, nor is there any evidence to demonstrate that that actually occurs.

Mr JANETZKI: If AMA Queensland were confronted with such a situation here, what would your approach be?

Dr Markwell: AMA Queensland would support and follow the national statement, which would be consistent with that.

Mr JANETZKI: We had some evidence just before from RANZCOG on the appropriateness of gestation periods for what we might call social terminations. The member for Caloundra raised the vast discrepancies in states in Australia and, say, in Europe, where it ranges again from 12 weeks to 24 weeks. I know you would not have heard the RANZCOG testimony, but in your opinion is 24 weeks the appropriate time frame for what you might term social terminations?

Dr Markwell: Our commentary around the gestational period more relates to the biology of pregnancy. From 24 weeks onwards, there is a very high chance of survival of a foetus when they are born. That is I think the basis for this being a cut-off.

Mr JANETZKI: Correct.

Dr Markwell: Our recommendation is that the current clinical guidelines that have been drafted by clinicians in Queensland, which we believe to be robust and very well considered, be followed for any terminations of pregnancy beyond 24 weeks and for other complex cases. I hope that answers your question.

Mr JANETZKI: Thank you, yes.

CHAIR: Dr Markwell, thank you for coming before the committee today and for your submission. We appreciate your assistance.

Dr Markwell: Thank you.

SEKAR, Dr Renuka, Consultant, Maternal-Foetal Medicine

CHAIR: Dr Sekar, thank you very much for your submission and thank you for appearing today. Would you like to make an opening statement of up to five minutes?

Dr Sekar: I am an obstetrician/gynaecologist and also a maternal-foetal medicine subspecialist. I am here to represent myself as a healthcare provider to women and also someone who works in the public sector. Given my subspeciality and my job, I have the chance of talking to parents and families with regard to their babies and what is the effect of genetics and family histories and so on. It is a daily discussion with families regarding the health of their babies and the unborn child and the outcome for their babies.

We are in a difficult situation almost every other day to talk about the outcomes and hence where to from there in terms of the options for their pregnancy. I also know that foetal medicine is a fast-evolving field, with ongoing development in the field of genetics, as we know, with the blood test that we do from free foetal DNA in mothers where before we have to do a needle test to check those tests. They have come into use very quickly these days. Other modalities of testing, such as foetal MRI, have helped us to understand the development of brain abnormalities much better in babies that we did not know much about in the past. They cannot be done earlier in the pregnancy. They need to be done at a later gestational age to understand the implications of the abnormalities so we can give the parents and families adequate advice about their babies and the outcome for their baby. This opens up the avenue for late terminations for foetal abnormalities.

That is why I think it is important to address the fact that the gestation age is important. We also know that we cannot put a limit on the age because diagnosis does not stop at 24 weeks or 26 weeks. Sometimes we would not find these abnormalities till 28 weeks. That is important for us to understand when we work in that field of medicine dealing with babies.

I thought it would be important to highlight that the law should make it clearer for both practitioners and patients who sometimes, due to the baby's abnormalities, request termination of pregnancy. It is not addressed at all. Congenital abnormalities or foetal abnormalities are not in the law at all. It makes it very cloudy for both the patient and the practitioner.

As we heard, the statewide guidelines have made it better in terms of understanding what we do at the Royal Brisbane and Women's Hospital. It does not mean that at the secondary hospitals and other hospitals, where they do not provide this, it clouds their ability to understand when to refer and how to do this. That leads to a delay in women accessing appropriate care and that prolongs their agony when they are already in a very stressful situation with their baby's outcomes. That prolongs that agony for a good two to four weeks.

We find the delays an issue because of the law and the lack of clarity. That is one thing that I think we would like to see changed to make it equitable for women in Queensland to access health care. They should not be disadvantaged living in Queensland rather than in Victoria.

The other thing I would like to say relates to conscientious objection. As obstetricians and gynaecologists we have many different choices to make. We choose to look after women. With that comes everything from contraception to termination. I understand that we can have moral values and ethical values, but as healthcare providers who work in the public system it is important to have clear and open discussions with our patients and that we are able to refer them if we feel we are not able to provide that care appropriately. I do not think there should be any delay in a woman accessing health care because of a conscientious objection to referral.

Conscientious objection may be in many, many degrees, but it is important that the college and the job description to which they belong will need to be reviewed to an extent. In a hospital of 10 obstetricians if 10 of them decide not to do this it will in fact be an issue for women to access that health care in a different hospital and it will cost money for her to travel to get that access. It is important to be clear in our conscientious objection.

Last but not least, I think that a good education regarding contraception is vital. The WHO has put out a statement to say that even with 100 per cent contraception there are six million women who fall pregnant. Nothing is 100 per cent. It is important to be aware that health education and easy accessibility to contraception and laws that make it clear for women's health is important to Queensland women.

CHAIR: You have commented on foetal abnormality, but the bill envisages—in conjunction with the earlier bill and the comments by the independent member who introduced it, Rob Pyne—that there would be easily accessible termination up to 24 weeks and then obviously under the bill there would be those requirements as you would have read. Do you have a view on termination up to that 24-week point that have no relation to foetal abnormality?

Dr Sekar: It does. There would still be foetus that are—

CHAIR: Removing foetal abnormality from the equation, do you have a view about whether they should be readily accessible and whether that should be in the public or private system? Do you have any overall views about what is proposed?

Dr Sekar: I think we need to take every patient and every case very diligently. As we know, these women are counselled well in advance before they get to this stage. If at 20 weeks a woman decides that it is an issue for them due to their circumstances I think that they should be able to access healthcare provision from the private or the public sector equally and they should not be penalised for it.

CHAIR: Coming back to the arbitrary point of 24 weeks, do you think that that is the appropriate point at which some additional measures, as contained in the bill, should be in place or do you feel that that is not the right line for that to occur or indeed whether they are required at all?

Dr Sekar: I think they are required. We know that from the Victorian law that they have set it at 24 weeks and the UK law sets it at 24. I have worked in New Zealand and they have it as 24. I think 24 is an arbitrary number because people worry about viability. Viability is changing, as we know today. Some 10 or 15 years ago it would have been 28 weeks and now it is 24 weeks. Where do we put our resources? Viability is the next question. It is important as practitioners to be aware that when we get to that viable period that there are two practitioners who are involved in that decision-making process. I think it is a fair comment.

CHAIR: Other practitioners of similar background to yourself have said it should not be 24 weeks, for the very reason that you talked about. Our understanding—

Dr Sekar: Yes, our statewide guidelines say 22 weeks. From 22 weeks we look after mothers. As I mentioned in my submission, what is the process and then the procedure following that? That can always be looked at. As I know that changes. There is a previable statewide guideline as well where there is clearly the period of viability. Less than 22 weeks is almost close to nil. At less than 23 weeks survival rates are almost close to nil. They think that from 23 to 23 plus six the issue may be different, but, again, it is with the parents.

CHAIR: The bill as proposed does not obviously include foetal abnormality as one of the reasons that would automatic allow a termination. Do you feel that basing it on the mother's condition is appropriate? Do you feel foetal abnormality of itself should be mentioned or prescribed in the bill as being a reason? What are your thoughts?

Dr Sekar: It would be important for people like us who deal with these mothers every day. I know the impact it has on mothers. We do it for maternal impact. It is important to also understand that you do not have to make it a maternal condition just for the sake of the baby. If you told the mother the baby will have massive and significant problems with developmental delay because the baby has holes in its brain—that is, the outcome is going to be poor—then I do not think that we need to get a psychiatrist to prove that she is psychologically unbalanced to actually access termination because it is very sensible what she is asking for. The outcome for her baby is so poor and she has three other kids and she lives in Longreach so she has to move her family. There are multiple issues. I think it would be important to address foetal abnormality in there.

CHAIR: What are your thoughts on whether you would then list what meets the threshold of foetal abnormality to allow a termination? Others have commented that that would not be a helpful thing and in fact could be highly offensive, depending on what that is. What are your thoughts?

Dr Sekar: It is opening up a can of worms, but I think it is important to address that the abnormality can be trivial. If you ask people about their conscientious objection to anencephaly most of them are pretty much okay to say yes. At the same time, are people okay to say yes to trisomy 21 or a cleft lip and palate? They do not understand the stigma attached to a cleft lip and palate for that family.

It is important to not mention what the abnormality is because abnormalities are abnormalities no matter what they are. What that connotation means to that family is most important. That is what is ultimately important. There would be people who would continue and have palliative care for their babies and would not want a termination of pregnancy. It is the mother's request, it is not what we offer. They come back to us. We always talk about continuation of the pregnancy and adoption. When they come back and ask if there is any other option, that is the issue. We cannot be the judge of what they are going through in difficult situations.

CHAIR: I very much appreciate you may not have been able to hear the earlier testimony of witnesses we have had here. I appreciate you probably had some other things that you needed to get done and patients to see. Professor Permezel, the President of the Royal Australian and New

Zealand College of Obstetricians and Gynaecologists, which you may well be aware of, appeared before us. One of the comments that he made in regard to this topic was that he felt—he had a differing opinion; not uncommon, I am sure, in the medical field as it is in the legal field—that you do not need to include foetal abnormality in the bill because really the risk of injury to the physical or mental health of the woman was an adequate threshold. Perhaps if we take Down syndrome—and my colleague the member for Greenslopes has mentioned this many times in questioning—I appreciate that to one family that might be, 'That is my child. I am happy to have that child,' but to somebody else it may be an issue. He felt that the threshold of physical or mental health of the woman and her wellbeing was an adequate threshold. You are saying that you do not believe that a woman should have to make out that that is an issue if she just feels that that is a problem for her.

Dr Sekar: That is what I think. You can argue the decision both ways. At the end of the day, the law should be clear when it is decriminalised. I think it would be clearer that you do not have to go through every box. At 24 weeks you do not have to make her see a psychiatrist unless she has a background psychiatric history and then we would definitely get help from a psychologist, a psychiatrist and a social worker. They are all involved in that decision-making and help the mother to go through it.

You do not have to have a connotation to say that you can have it if the mother requests because if there is an abnormality in the baby that indirectly affects the psychological wellbeing. We do not have to prove that, is what I am trying to say. It does have an impact because it has a psychological, emotional, physical and social impact. It has a lot of impact on the families and parents. How much are we going to stress that that is the most important? Do we have to tick all those boxes before they do that because at the current level we have to?

CHAIR: Is there some test of reasonableness for what is a foetal abnormality and what is not? A very dear friend of mine does operate constantly on cleft palates. The results that can now be achieved for them and some other abnormalities are extraordinary. Is there a reasonableness test for what would or would not constitute quite a developed or late-term termination?

Dr Sekar: For an abnormality? Is that what you are asking?

CHAIR: Yes, or is it your view that it should just come down to what that woman feels is appropriate?

Dr Sekar: They are picked up pretty early in the piece. You do not have to wait until 28 weeks.

CHAIR: I am just thinking what the bill envisages which is 24 weeks and post.

Dr Sekar: Usually abnormalities are picked up at the 20-week morphology scan. That is when we pick them up. They are picked up very early. Even if it is an isolated finding, they can be associated with genetic syndromes—up to about eight to 10 per cent of cases. In that case we do talk about associated abnormalities as well. It will be a bit difficult to draw a line and say, 'This is when you should do this.' It may not get to 24 weeks because these abnormalities are picked up pretty early.

CHAIR: Dr Sekar, you have lots of experience. I could keep asking questions but I want to give my colleagues an opportunity.

Mr CRAMP: You have provided a pretty comprehensive submission and identified some real issues. I want to clarify some outcomes around that. You may not have any. You talk about the ethics committee process at the RBWH. You say that it is time consuming, taking between five and 10 days which can be critical as the pregnancy continues. There has been talk from previous witnesses about cooling-off periods when a woman decides to terminate for whatever reason, looking at a mandatory period—probably not five to 10 days, to be honest. As I recall, to the best of my knowledge, it was less than five days for a cooling-off period for a woman to take time to think about her decision and gather the right information. What are your thoughts on a cooling-off period? I have a question around the five to 10-day mark. Should there be a cooling-off period in your opinion for these women?

Dr Sekar: Absolutely. They always have that time. I think it is important that we always give them time to go home and think about it and to come back. It is important to give them that time. Some women would think for 48 hours. Some women would take up to a week. That is their choice. We always give them a referral to come back and see us. Most of the time we get a phone call because they have our contact numbers. They come back to us. As soon as we give them so much information it is difficult to process all of that information immediately. It does not happen over just one day. It depends on the abnormality. We may have to do more tests sometimes and that takes more time. As we do more tests, we might pick up more issues, in which case more than one specialist might have to be involved in talking to this mother. It is not something that they have a scan and they decide on the day. It never happens that way. It usually takes time.

It depends on the abnormality. It depends on the process. There is an ongoing continuum. That is what informed content is all about. It is not just signing on the dotted line. It is understanding the process of what this means to the mother. At the end of it, if she comes back and says, 'We have gone through this process and this is what the outcome is because I have spoken to the cardiologist about the fact that my baby only has three chambers and it is not going to survive,' or 'The brain is too poor that the baby is not going to have quality of life,' that will take a good two weeks before they even understand that process. It is never an immediate same-day process. This is on top of that initial diagnosis.

Mr CRAMP: I respect what you have just said around variances. Would you see there being a minimum cooling-off period? It could be as long as the woman wants. Should there be a minimum time of two or three days?

Dr Sekar: It really depends on what the parents feel. We cannot draw a line and say, 'You can only grieve for two days.'

Mr CRAMP: I am not talking about a maximum; I am talking about a minimum time to go away and think about it.

Dr Sekar: It depends on the parents. It depends on where they come from. That is the other issue. Queensland is such a vast state. Some patients travel eight hours to come and see us. It is not to be taken lightly. These decisions are not made lightly. We give them enough time to think about it.

Mr CRAMP: At the risk of sounding like a broken record because I have asked previous witnesses this, there has been talk about making a fully informed decision for women and I keep bringing up the question of whether the regulator, the state, has a role to play in ensuring that the provision of information is not biased either way—that we have a comprehensive view of all options available for the mother. I understand doctors play a very important role in that, especially specialists. To avoid the views of either side of this very passionate argument, would the state, as a regulator, be able to put forward comprehensive information that would allow for advice on abortion, on carrying through to full term and on adoption—put all of the options on the table. I would be very interested in hearing from someone with your experience. Do you think that would be beneficial and helpful to doctors when they provide information or would it not play a part?

Dr Sekar: If it is clear and transparent, it would probably help.

Mr CRAMP: That would be the expectation.

Dr Sekar: It would help.

Mr CRAMP: Governments get scrutinised more than most.

Dr Sekar: At the end of the day we have to be cautious as well about what is out there and how people interpret that information. That is where the problem is. It is all done in good faith but the interpretation of what is said and what people can construe is the other part of the problem. If it is clear and it is open then it gives doctors that confidence to talk about it openly, not having the worry of being penalised and having to appear in the criminal court. That is probably why most of them hide behind conscientious objection because they know that by law they can be protected, whereas if it is not then people will talk about it a bit more. It will probably open up more accessibility.

Mr CRAMP: I want to clarify something about the ethics committee process. Are you saying that the two-doctor option would be better instead of having to form a committee every time someone wants to have a late-term abortion?

Dr Sekar: Yes.

Mr CRAMP: That is what you are getting at.

Dr Sekar: Yes. That is exactly it. There are six specialists. I am sure all six of them have important work to do. They will have to meet every so often. Charles is one of the ethics committee members from Legal Services. They are all busy. It is important to get all of these specialists in one place. To be there for half an hour or 40 minutes to discuss two or three cases is time consuming.

Mr CRAMP: What about the qualification of the doctor? I believe it was a RANZCOG representative—and my colleagues can correct me—and a few other specialists who stated that it should be at least a relevant specialist to the patient's need, not just a GP.

Dr Sekar: Yes. That is how it usually is—at least with the patients that I see.

Mr CRAMP: My last question is on a very interesting subject—the issue where minors are pregnant. It is a difficult area of law. From a doctor's viewpoint—and this is not a legal question for you—in a normal parent-child relationship where for whatever reason the minor is pregnant—it is

varied, but there might be cases of rape or things like that where the parent themselves are not to blame or not involved—how important is it for parents to have a say? Should parents be given more power? That is bordering on legal issues, but how important is it for you as a doctor to see parent involvement if it is a normal parent-child relationship?

Dr Sekar: Usually we do.

Mr CRAMP: You encourage it.

Dr Sekar: We do, absolutely.

Mr CRAMP: Should there be stronger laws around that?

Dr Sekar: If she is not in a good family situation, you want to see who the next closest person to her is. You cannot really put a strong word in and say it has to be the parent. It has to be someone who supports this person. She is already in a difficult situation. If she does not have a good relationship with her parent, then you want to see the next person in the family she would be close to and could talk to. That is the person who is going to support her through this. That is the support system that we will be tapping into in this difficult situation so that she is not left alone.

Mr CRAMP: You talk about psychiatric injury. Should there be compulsory counselling for minors in these situations regardless of the situation?

Dr Sekar: They get counselling automatically when they do this and they are automatically referred to child services.

Mr CRAMP: But it would be indefinite. There would be no time constraint. This is leading somewhere.

Dr Sekar: I do not think we can draw a line and say, 'This is the time frame and limit.' It really depends how much they need—

Mr CRAMP: What about adults? Should they be at least offered counselling?

Dr Sekar: They are all offered counselling.

Mr CRAMP: Some witnesses have come forward and said, 'No. It is up to them,' or 'People walk out happy after a termination and they do not require it.' I am not saying that it should be compulsory, but should the offer be compulsory across the state?

Dr Sekar: I am absolutely certain that, if a mother or a woman is requesting termination, there is nothing happy about it to start with. We do not know the situation that she is in. They are not very open about their family and the social situation they are in. That is why I would possibly think that the connotation of 'social termination' should be out because there is nothing social about a termination of pregnancy. It is a very difficult time for a parent and a woman. By the time she gets to where she gets to she will be definitely given some form of counselling by her GP or a psychologist. There is enough counselling available and they would always tap into that resource. When we see mothers in a very difficult social situation, we always give them ample support from both psychology and social work to help them through that process, and we always bring them back. There is always follow-up with them to see what is happening. That process is available through other GPs as well.

Mr HARPER: How many years have you been practising, Dr Sekar?

Dr Sekar: As a doctor or as an obstetrician?

Mr HARPER: As an obstetrician.

Dr Sekar: I have been an obstetrician since 1992.

Mr HARPER: You are well versed and you can speak with a degree of authority, internationally as well.

Dr Sekar: I started off in India and then did my RANZCOG in New Zealand. I started my maternal-foetal medicine there and completed it here.

Mr HARPER: Obviously you have dealt with a lot of cases over that time.

Dr Sekar: Yes.

Mr HARPER: Broadly speaking, do you think women nowadays make a fully informed decision before seeking medical or surgical termination? Do they get enough information as you would currently see it?

Dr Sekar: I think there is enough accessibility via the internet which is big difference from 15 to 20 years ago.

Mr HARPER: Dr Google.

Dr Sekar: They are able to understand and read a lot of things. They are aware of what is internationally available and what is available in the nearby states. They are pretty much aware of what is going on. When they come up with what they want, it is for the doctors and the providers to also understand the circumstance in which they request that termination and to support them and to provide ongoing support and always discuss contraception because that is ultimately what it is. As a healthcare provider, I think that is important. I am sure they are getting reasonable access to information.

Mr HARPER: It is interesting that you mention contraception. Not everything is 100 per cent safe. In your time in practice, have you observed that most of the situations that you have dealt with are simply unplanned pregnancies?

Dr Sekar: What I deal with is usually foetal abnormalities and difficult social situations where they do not have the money to access termination in the private sector.

Mr HARPER: I am concerned that we have heard today that the private sector will be closing in regional Queensland—Rockhampton and Townsville. That will impact greatly on the other services that are available.

Dr Sekar: The public sector, and that goes down to conscientious objection again. If they choose to take a job in a hospital, I think it is important that the job description in terms of what you would be required to do and what the college is going to mandate and say what you are going to do as a healthcare provider for women is absolutely clear.

Mr HARPER: I note in your last paragraph that you talk about exclusion zones. I hope we do not see what is happening outside of private clinics happening outside of public hospitals if this goes ahead.

Dr Sekar: Thank you.

Mr HARPER: We have a lot of health professionals. I like the way you worded that actually—that everyone should have the capacity to go to work safely without being threatened or intimidated or harassed. The RBWH policy talks about terminations beyond 22 weeks which is when you convene your ethics committee. Is that under the Queensland clinical guidelines? That sits within that framework?

Dr Sekar: Yes. I was instrumental in writing those guidelines.

Mr JANETZKI: Thanks, Dr Sekar, and thank you for everything you do for pregnant women and babies in Queensland. I have only one question. I asked it of one witness yesterday and I have been waiting for the right time to ask it today. You noted the challenges in practice when you have people exercising a conscientious objection and those who choose not to exercise that objection. With your experience, do you foresee challenges in the health system where in one area of a hospital everything will be being done to save a newborn child at 22 weeks and then in another area there may be terminations on demand at 24 weeks? In practice, do you foresee any challenges with nursing staff or with medical practitioners in addressing those various roles that they are playing in the health system?

Dr Sekar: I think you said trying to survive babies or revive babies at 22 weeks. That is not happening. Just to let you know, we are not going to spend our resources in resuscitating 22-weekers. We do know that there is almost close to nil survival before 23 weeks and following that there is always discussion with the parents. It is not only the survival; it is the morbidity we are going to give that parent. All those discussions go into it. It is important to talk about all of that. It does not happen on one side of the ward or anything. It is mostly educating your staff about what to expect. If a mother came and delivered a baby at 23 weeks or 22½ weeks, we are going to treat the baby exactly the same. In what way is this baby different? In no way is this baby going to be different. In fact, the mother who has gone through the process of understanding termination of pregnancy is well prepared and would actually want to spend the time with the baby because they have had the time to think it through, rather than have a shell-shocked mother who comes and delivers a 22½-weeker.

Mr JANETZKI: And there is adequate support for medical practitioners faced with all of these ethical dilemmas? There is the necessary support?

Dr Sekar: Not in all hospitals. That is the problem. I cannot talk for other hospitals or other staff members. I can only talk about where I practise. We do a lot of education to midwives and other colleagues about what we do and what is involved so that people understand this better. I think it is lack of understanding, to an extent, that makes everybody worried and scared. Once you talk about these things and make it clearer, I think people do understand the need and how to go about these things. It does not mean that all hospitals in Queensland are the same. We are aware of some hospitals under Queensland Health that probably will not even refer. They have a conscientious

objection to referral. That is quite concerning. As a medical practitioner, clearly you have breached your duty of care to that patient. You can conscientiously object to do certain things but not refer a patient who requests a form of treatment. That is probably going to bar on almost unethical behaviour. I think that is where the issue is.

Mr KELLY: There is a section of your submission called 'Other specific problematic areas', and the first section is titled 'Pregnancy in a minor', and you raise a number of issues in relation to that. Will those issues be remedied or dealt with by the bill that is currently before the House?

Dr Sekar: In the bill it does not state an age. If the bill decriminalises, I think that in itself will help people understand that process a bit better, instead of just trying to send them away to tertiary hospitals. These younger patients need to be dealt with in their own local hospitals because that is where the entire family support is and we do not want to take them away from that.

Mr KELLY: Is that section of your submission broadly relating to the case of Q?

Dr Sekar: This was another patient that I had, not Q.

Mr KELLY: You talk about some issues in relation to ethics committees. If both bills pass, will there be anything preventing or precluding a hospital or health service establishing an ethics committee anyway and saying, 'That is our policy and that is the way we are going to go forward'?

Dr Sekar: The ethics committee was set up because of the law surrounding termination of pregnancy in Queensland, to protect the practitioners.

Mr KELLY: I understand that, but under this bill, moving forward, would there be anything to prevent a hospital or a health service determining that they would not set up an ethics committee—

Dr Sekar: I cannot talk for the hospitals.

Mr KELLY: But is there anything in the bill preventing that from occurring?

Dr Sekar: The bill does not say that you have to have an ethics committee.

Mr KELLY: So we could be in a situation moving forward whereby a hospital makes a decision that they will establish an ethics committee anyway and we still have the same issues you have raised here in your submission?

Dr Sekar: This is only done in three major hospitals in Queensland, because of where maternal foetal medicine units are set up, bar the Mater. It will only be in the three hospitals, so we would definitely have a clear understanding. We can always liaise with the hospitals once the law is clearer, rather than try to set up another ethics committee, because that is the whole idea, not to delay.

Mr KELLY: I want to go to the line of questioning from the member for Gaven. The member is raising suggestions that there should be some sort of role for the state in terms of mandating the information that is provided to a patient who is seeking a termination. Would it be your view that that type of information should be locked up in legislation, or would that type of information be better left in the hands of practising clinicians to change, amend and update as developments occur?

Dr Sekar: You just have to explain this again to me.

Mr KELLY: One model would be that we as a legislature determine the information a woman will receive regarding terminations and we pass a bill saying, 'This is the stuff you will tell a patient every time they come to see you.' The alternative is that you as clinicians continue to do what you do now, which is to give patients information based on latest clinical research et cetera.

Dr Sekar: That is how medicine is practised, so why should it be different?

Mr KELLY: In your answers to the chair you talked about the family context and being non-judgemental. You mentioned if a family presented and the foetus had, say, a cleft palette—I think that was the example you used—and that may create some disturbances for the family and there may be some justification, even though that is not a fatal abnormality. I accept the evidence that has come before this committee that termination based on gender is rare, but, given that statement around cleft palette, could it also be argued that the gender of a foetus may similarly cause distress for a family?

Dr Sekar: It is very difficult to say that, though—unless you have an issue with X-linked disorders in the family, because there are certain X-linked disorders that run in families and that might be the reason they would ask for it.

Mr KELLY: If that was not the reason—

Dr Sekar: They do not even have to go anywhere for that. I think people do go to the States to procure gender selection.

CHAIR: I have one more question. I know that we have kept you here, but it is very rare that we have a doctor who is actually working in the area of late-term abortions and, while disproportionate, I think the amount of time we spend talking about it—it is obviously a significant concern in the community's psyche. There is one key concern that has been raised consistently by those who are very fearful, I think it would be fair to say, of legislation that they fear would allow termination of a healthy, viable foetus up to full gestation, essentially. Do you think it is conceivable that, for whatever reason, a woman could come post 24 weeks and wish to have a termination and meet the guidelines, whether a risk of injury to the physical or mental health of the woman—it could be relationship breakdown; it could be something else, however rare—and the bill would allow that?

Dr Sekar: You can never be 100 per cent certain, and you cannot conceive of every single situation. I think it is important to understand that if a woman would not want a pregnancy it would be earlier in the picture rather than late, and at a later gestation they would almost always continue with a pregnancy or adopt. I think asking for a termination at 35, 36 weeks would be difficult. Given the fact that two obstetricians would need to accept to go ahead with that, like in many other fields of medicine, I do not think there would be an agreement between two practitioners for that at 36 weeks gestation where it could well be that the baby could be adopted out.

CHAIR: You would consider that that is an appropriate safeguard against that rare—

Dr Sekar: It would be very, very, very, very rare, because you think if a mother does not want a baby it would be pretty early in the picture. She is not going to turn up at 36 weeks and say, 'I've had enough of my pregnancy.'

CHAIR: Are there further safeguards that should be considered around ensuring that could not occur, to allay those concerns which have consistently been presented to the committee or promoted publicly around these bills?

Dr Sekar: I think we have to take a step back. Late terminations in themselves are less than one per cent—we see less than one per cent of patients—and the percentage of late terminations, over 28 weeks, is even less. It is purely for the fact of undiagnosed or recently diagnosed foetal abnormality. Just giving the law that 24-week mark does not necessarily mean that a mother at 25 weeks is going to turn up on our doorstep and say, 'That's it. I do not want this baby,' and two people will have to agree anyway. If she does not get that agreement, she cannot access that anyway. There is a safeguard in that you need two practitioners to agree to this woman's decision. They need to assess that. I think it will be very, very rare, and I do not think that is actually an issue. An issue is more for these mothers who are struggling to get this done. We cannot penalise those mothers just for this one off-chance situation which probably is very rare.

CHAIR: For terminations before 22 weeks you set out the process in detail. I found that very helpful to try to understand that process. Thank you for doing that. It mentions here that two specialists, a document chart and the patient chart are then taken to the director of obstetrics and gynaecology, who reads the chart and signs the support documentation. I do not like using the words 'just a tick', but if those two specialists have recommended that that termination occur, is it a fairly procedural matter when it comes to the director of obstetrics?

Dr Sekar: Yes, because it is for the nursing midwifery staff and everyone to be aware that it is a procedure. It is a hospital procedural matter rather than anything else.

CHAIR: So your guidelines obviously—

Dr Sekar: It is in the statewide guidelines.

CHAIR:—just flow through the process once it is in the process, but you are saying it can be a bit slow?

Dr Sekar: Yes.

CHAIR: That is the problem?

Dr Sekar: Yes, especially over 22 weeks, because it takes them to refer to us. I mean, these patients are not our patients who are booked to birth here, because then we are involved with them directly. Most of the time these are patients who are referred from secondary hospitals or hospitals that do not provide this service. That is the delay. Because of the fact that the law is so different around the Criminal Code, people find it difficult to refer earlier. That causes the delay. By the time they get to us they are 23 or 24 weeks and then we assess them and we get all the information. Then they see a psychiatrist and then arrange an ethics committee. That is an extra 10 days on top of the original three weeks that she has already waited, knowing that the baby has an abnormality. You can imagine the stress that we see in these mothers and the situation they go through and the process. I see this every day. It is just heartaching, the wait these mothers have to have.

CHAIR: Finally, you mentioned that some facilities—an earlier witness mentioned that—have a conscientious objection. Other than something like Mater Private, which obviously has a religious reason for doing so, how does a public health facility, rather than an individual, have a conscientious objection? How does that occur? Is it because if it is a small facility there might be only one or two?

Dr Sekar: There is a facility. They have put in their submission. It is in the submissions. It is a Queensland Health hospital.

CHAIR: Okay.

Dr Sekar: Refusal to refer.

CHAIR: That obviously feeds into consideration around conscientious objection. Thank you very much, Dr Sekar and Mr Hartley, whom you had here as you legal counsel, for appearing before the committee. We appreciate it.

MARGERISON, Dr Colinette, Clinician, True Relationships and Reproductive Health

CHAIR: Dr Margerison, thank you for joining us today. Would you like to make an opening statement of up to five minutes? I am sorry that we are joining you late.

Dr Margerison: That is okay. Yes, I would like to make an opening statement. I am a medical educator and clinician from True Relationships and Reproductive Health. True is a not-for-profit organisation that provides expert reproductive and sexual health care. We provide delivery of clinical services as well as adult education and professional education. We would like to acknowledge that there is a very poor uptake in Australia of long-acting, reversible contraceptives, which are the most effective form of contraception available to women, and also acknowledge the awareness from the World Health Organization of figures showing that, even if all couples use contraception effectively in every single encounter, there would still be six million unintended pregnancies around the world each year.

In terms of the specifics of looking at the points raised in the new amendment, we believe that abortion services should be integrated into the health system, as has been suggested by the World Health Organization, either as a public service or through publicly funded not-for-profit organisations such as ourselves, and acknowledge the status of legitimate health services to protect the stigma that can occur in the discrimination against women and healthcare providers.

In regard to points relating to women having concern that they may be committing an offence by performing or consenting to assisting an abortion, we want to recognise that there is an opportunity here to protect women in this area. With regards to conscientious objection, we recognise that conscientious objection by any doctor is a right that doctors should have but, equally, it should not hinder a woman's access to pregnancy options.

In addition, we feel that there are opportunities to strengthen the existing regulations in terms of safe zones. We would suggest those safe zones be extended to a greater radius. We know that there have been instances of violence that have occurred outside abortion clinics within Australia, specifically in Victoria in 2014, and we feel it is really important in terms of patient care but also health care professional care that we are able to have safe zones. Finally, better access in terms of abortion will lead to better outcomes for both termination care in our community and mental health outcomes for women, couples and families.

CHAIR: Thank you for your opening statement.

Mr KELLY: Dr Margerison, on page 2 of your submission under section 2 the second paragraph states—

Section 20 could potentially protect a woman against allegations of illegal procurement, such as the Cairns case of R v Leach and Brennan.

Dr Margerison: Yes.

Mr KELLY: Are we to interpret from your submission that it is the view of your organisation that the bill does not provide full protection, or are you not able to say categorically that it provides protection for a woman against allegations of illegal procurement in that situation?

Dr Margerison: I think it is the second point; that we are not able to say categorically that it would provide protection.

CHAIR: Dr Margerison, given the nature of your organisation, I am very interested in your thoughts on the provision of quality information to women about their reproductive choices and sexual health care. You did talk about this briefly in your opening statement. It is mentioned here that you have nine offices and five reproductive and sexual health clinics across Queensland. Do you have any broad comments to make in regard to the quality of information that women are receiving when they are presenting to their doctor or a private clinic seeking a termination or considering a termination? We have received wideranging commentary which is obviously very inconsistent as to the quality and provision of that.

Dr Margerison: I think that is part of the problem. The information that has been given to women is very wide ranging and very variable in terms of not just termination care but also contraception. Part of the feeling here is that by improving access to termination what you improve is access to quality contraception care and access to education for health professionals as well as for the general public. There is a difficulty in providing good education regarding termination because of the criminal nature of the process. Currently there is a reluctance for certain organisations to make good education available.

CHAIR: If we envisage a situation which is envisaged in the bill where we are operating in a very different legal environment and termination were to be considered a health procedure which a woman could seek from her GP or get a prescription depending on the stage of gestation, do you feel that there would be or should be some role for government about the sort of information that is provided, or do you feel there should be a role restricting who provides that information? The reason I ask this particular question is: how do we ensure in this area more than any other because it is so highly and emotively contested the impartiality of information so women can genuinely make an informed choice?

Dr Margerison: All women should be entitled to receive good information from a non-judgmental source, and by enabling this to be a health issue that is what we should be able to provide through general practice and through hospital care. Again, I think that comes back a little bit to education in terms of health professionals and ensuring that the education that is given is very patient centred and very non-judgmental. We need to be able to do that, and I think by still having a situation where abortion is criminal we are not fully able to give good health professional education. In terms of regulation of that information, again I am not sure it necessarily needs to be government regulation. There needs to be good guidance and that guidance probably ought to come through professional medical bodies such as the RACGP and True so that we are all on the same page in terms of the information we are giving to women.

CHAIR: Dr Margerison, there has been criticism of private termination clinics having a vested interest and that it is not in a woman's interest to present at such a clinic and be provided with information and counselling there. Do you think that criticism is fair? Do you think they are unable to provide impartial information and advice and that it should be done elsewhere?

Dr Margerison: I should declare that I also work for Marie Stopes.

CHAIR: That is probably a good declaration to make. You have insight, then, so that would be helpful.

Dr Margerison: I probably should have said that in my opening statement. I am talking today on behalf of True, but I should declare that I do also work for Marie Stopes as a provider of medical termination and I also provide medical termination in general practice.

CHAIR: That changes my question, then, given that you have that experience. You would have insight—I declare that I have not been in one of those clinics—into the process and impartiality of information. Is it the same information that a GP would provide or direct them to? How do the environments change?

Dr Margerison: I am speaking personally now rather than on behalf of True. As a healthcare provider, whether I am working at Marie Stopes or working in general practice or working at True, I would provide the same care for my patients regardless of where they attended. It is not about the site in which I am working. It is about my provision of care as a non-judgmental practitioner rather than the location in which I am working or who pays me at the end of the day for that work.

CHAIR: Thank you, Dr Margerison. You are a good sport to put a few hats on.

Mr McARDLE: Doctor, there is a lot of contention around the Criminal Code, and I note in your submission that you want the code repealed as it relates to terminations. Do you feel that doing that will allow or cause more GPs to enter into the field of termination?

Dr Margerison: I think it takes a long time to create some of those changes that would encourage more GPs to provide termination, but I think the fact that termination is in the Criminal Code is a stopping point at the moment for some GPs. In terms of making changes by changing the Criminal Code and making this a health concern rather than a legal concern, that will open up the options for some GPs who do not feel they could take that option at the moment—in particular, GPs who are in more rural and remote areas who potentially could be providing a very helpful service to patients who have ongoing needs following termination. By being part of that process from the very beginning, they can probably provide a better service for their patients. I think there is more of a likelihood that those GPs would provide this service if it were not in the Criminal Code. Again, I think it comes back to the ability to educate. It would be much easier for education to happen around this area of medicine if it were not part of the Criminal Code.

Mr McARDLE: Do you envisage that, if the code were repealed as applicable, there would be an increase in the number of terminations?

Dr Margerison: I do not think so. I think the numbers would probably remain fairly similar. I obviously cannot say that is a definite, but I doubt there would be an increased number of women wanting termination. I think it would improve the access. For women who at the moment are having

to travel very long distances, it might mean there is less impact for them in terms of the distance they have to travel and in terms of their ongoing care. If they have travelled for many hours to get to a termination service and they then obviously have to travel back to their home town, they are not able to have the same kind of health care as they would if they had simply come to their local GP. Again, just talking in terms of my work as a GP, I have found that the patients whom I see who are part of my practice anyway will receive good ongoing care because they will often come back to discuss things with me, whereas patients who come from a distance to see me for a termination I obviously cannot give the same ongoing care.

Mr McARDLE: You refer to section 20 and the case of R v Leach and Brennan. I think you made a comment that it may well resolve the issues in that case but you could not be certain. Is that because of the wording in section 20 or the facts in that case?

Dr Margerison: I think that is quite difficult to answer, but I think the concern was more with regard to the wording.

Mr McARDLE: You think the wording could be too narrow?

Dr Margerison: Yes, although I accept that the facts in that case were difficult as well, but I think it more related to the wording. I am sorry, I find that difficult to answer completely.

Mr McARDLE: That is okay. I think what you are saying to the committee is that the section wording is too restrictive and it may still capture the circumstances in that case as being an offence; is that right?

Dr Margerison: Yes. Obviously that case has its own difficulties so the likelihood of there being a case exactly the same is limited anyway, but, yes, you could still have people who found themselves with allegations of that illegal procurement.

Mr McARDLE: That is okay. I think what you are saying to the committee is that the section wording is too restrictive and it may still capture the circumstances in that case as being an offence; is that right?

Dr Margerison: Yes, but obviously that case has its own difficulties, so the likelihood of there being an exact case the same is limited anyway. However, yes, you could still have people who found themselves with allegations of that illegal procurement.

Mr HARPER: Thank you, Dr Margerison, for your submission and thank you for declaring that you work with Marie Stopes. How long have you worked in that profession? How many women would you estimate you have treated in your time in that role?

Dr Margerison: I am a UK trained doctor. I have been in Australia for nearly five years, working at Marie Stopes for almost four of those years, working in general practice for four and a half, and working for True for two years. Obviously prior to moving here I worked in general practice and sexual health in the UK. Since moving to Australia, how many patients have I treated for termination; is that the question?

Mr HARPER: Yes.

Dr Margerison: I see approximately 10 patients for a medical termination every week at Marie Stopes. I probably see another two per month in general practice.

Mr HARPER: It was concerning that we heard today that Marie Stopes will be closing in Rockhampton and Townsville. I am a regional MP and, obviously, that will have an impact on women's access to services.

Dr Margerison: Yes.

Mr HARPER: I believe it is only the surgical side of it though, not the medical, if I heard correctly today.

Dr Margerison: I am sorry, I do not know exactly. At Marie Stopes, I do not have a role involved in organising services, so I am not sure exactly what the situation is there.

Mr HARPER: That is fine. The reason that I wanted to ask about your history and how many women you have treated in that time was to get a general feel for whether you think women are currently given enough information before they make a decision. Should there be a cooling-off period? We heard yesterday that that should be considered as part of this bill.

Dr Margerison: I think there has been some really good research done by the World Health Organisation with regard to the ability of women to process the information and make that decision, by taking into account the concerns that they might have for their own future, for the future of any children that they already have and for the living situation in which they find themselves. They have

shown that most women are able to go through a series of questions in their own minds without necessarily needing to have somebody else to give that nondirective counselling for them. Having said that, I think it is really important that that nondirective counselling is available. I think what they have shown is that not everybody will need somebody else to counsel them; they can actually manage to counsel themselves, if you like. However, nondirective counselling should be available for all women. Certainly where I work it is the case that all women would be offered the opportunity to have counselling. They also have the opportunity to speak to at least two health professionals when they come to a clinic and have counselling with health professionals if they want or need it, as well.

Mr HARPER: Thank you for that. In your experience in dealing with these women whom you treat, have you found broadly speaking that a high percentage of them come to the clinics due to unplanned pregnancies? Is it a contraceptive thing, is it something that we need to tackle in terms of education or is it around failure to—

Dr Margerison: It is a genuine mixture. I do see large numbers of women who have had contraceptive failure or who have been given bad contraceptive advice. There are certainly women who come who have found themselves pregnant when they were told that actually they could not become pregnant. That was advice given to them by health professionals. I have also seen numerous different kinds of contraceptive failures. There are equally women who have not been using contraception and have found themselves to be pregnant. That certainly happens, as well. However, there are quite large numbers who have either been told that they did not need a contraceptive or have had a contraceptive failure. In the time that I have been working in Australia, I have certainly seen contraceptive failure of vasectomies and Mirena. We would highly recommend those options to all women as being good contraceptives, but they do fail; admittedly not very often, but it does happen.

Mr HARPER: Thank you very much, Dr Margerison.

CHAIR: Dr Margerison, thank you very much for appearing via teleconference to the committee today. We appreciate your assistance. Our time for questions has expired. The committee will take a break and resume at 2.30 pm

Proceedings suspended from 3.05 pm to 3.34 pm

COPE, Mr Michael, President, Queensland Council for Civil Liberties

CHAIR: The committee will now reconvene to consider the Health (Abortion Law Reform) Amendment Bill 2016. I welcome Mr Michael Cope, the President of the Council for Civil Liberties. Thank you for your submission. Would you like to make an opening statement of up to five minutes?

Mr Cope: Yes, briefly. I do not have a lot to add to what is in the submission. The council, of course, has been a long-term supporter of law reform in this area. Therefore, we warmly welcome the debate that these bills have brought on. The underlying logic of the council's position on this issue is really a decision of the Supreme Court of the United States in Roe v Wade, which acknowledges that the foetus has some rights but those rights are, for most of the period, less than the rights of the living woman. However, the closer the foetus comes to viability the greater the right of the state to intervene in protecting its interests. Of course, Roe v Wade deals with that in a three trimester way.

Some years ago, we changed our position to be that, in light of essentially modern medical developments, 20 weeks should be a cut-off; up to 20 weeks, there should be decriminalisation; and after that, there should be some control. As we say in the submission, a few years ago we had a seminar on this topic as a result of which we had some discussions with certain doctors practising in this area who argued that 20 weeks was not appropriate, given the level of types of testing that occur at that stage. At that point in time, we adopted the Victorian model, which is the model that we argue for in the submission. Essentially, it is the model reflected in the bill although, as I say, we would argue that the criteria after 24 weeks are too narrow and that the criteria as set out in the Victorian legislation is preferred. I do not really have anything else to say by way of opening.

CHAIR: Thank you very much. I invite the deputy chair to ask questions.

Mr McARDLE: Mr Cope, yesterday we heard from Professor Aroney. He referred to clause 24(2) subclauses (a), (b) and (c), if I recall correctly.

Mr Cope: That is the protest.

Mr McARDLE: Yes. He informed us that he believed—and there was no doubt—that 24(2)(c) would breach the constitution in that you cannot legislate to prohibit a protest. I note that in your paper you refer particularly to 24(2)(a) and (b), but not really to 24(2)(c). Do you have an opinion on Professor Aroney's comments?

Mr Cope: I suppose there are two things to say. The first thing is that in my paper I am talking about the Supreme Court of the United States' jurisprudence, which of course is quite different from our jurisprudence. I am not by any means a constitutional expert. The first thing to say is that the High Court has an implied right of political speech, but it is not, like the American law, an individual right. It is a restriction on legislation. In this case, the High Court would ask two questions. First, is the law directed to a legitimate objective? I think we would say that it is, which is protecting people who are trying to use the service in what is essentially a private matter. The second question it would ask is: is the response proportionate or reasonably adapted, which I think is the phrase that they use, to achieve that objective? The jurisprudence in this area is quite narrow, so quite frankly I do not know what the High Court would say. There is a case in Queensland involving the Vagrants, Gaming and Other Offences Act, but that was a Court of Criminal Appeal decision applying the same law. I am not aware of the High Court really talking about this sort of situation.

Our position, as I set out in the submission, in a sense is really asking the same question that the High Court would ask, which is: is this proposal reasonably adapted to achieving the result of protecting people who are using the premises? We think it is. In the United States, for example, the law that the Supreme Court struck down provided a barrier of 30 feet, which I think is 18 metres. Basically, the Supreme Court said that this should be dealt with by the police using their ordinary powers to arrest people for obstructing the footpath. It sounds like the equivalent of a move-on power that our police would have. I do not know that the High Court would go there. The jurisprudence here is not about individual rights, like in the First Amendment.

The answer to your question is that I really do not know. What the High Court would do is try to do the same thing that we are trying to say, which is that you have to balance people's right to free speech and express their view versus the rights of people to enter those premises on what is essentially a private matter. It is that versus the general right of freedom of speech. We would argue that the 50-metre barrier is a reasonable way of dealing with that. Whether the High Court would agree, I do not think anybody this room or anybody else knows, apart from the seven people who sit up there and will have to decide it.

Mr McARDLE: He raised a point, looking at clause 24 in particular, that 24(2)(a) is concerned with harassing, hindering, et cetera; (b) is about being seen or heard by a person; and then isolated (c), a protest. I think I recall him making the comment about standing holding placards but not

breaching (a) or (b). He then draw the analogy that if you look at other protests that take place, for example, the green activists that take place outside Rio Tinto and BHP Billiton, that would be a protest. He felt that if you impose that here, a protest here, it would then set a precedent that those protests would also be illegal. Again, that is not my logic; I am trying to—

Mr Cope: I understand his logic. I suspect on the basis of the US Supreme Court decision, the first two of those would probably pass muster. They talk about a law that prohibits people from harassing people; a general law, as I understood it. I did have the judgement on my iPad, but I forgot to bring it. They also talk about stopping people from getting access to the premises. That is a common law nuisance in many respects, but of course trying to get an injunction for that sort of thing is ridiculously expensive and you cannot get an injunction against the world, anyway. I agree with him, certainly, that from a constitutional point of view (c) is the one that would be most likely open to challenge. However, it does come down to the question of whether it is reasonably adapted to achieve the objective, which as I say is no doubt to protect people who are trying to use the facility. I take his point. It is a good point that might have broad implications that might incline the court to strike it down.

Mr McARDLE: The other point he made is that that particular subsection could be severed and that would not impact upon the thrust of the bill.

Mr Cope: No doubt. As I say, I would find it difficult to see, because I think that (b) and (c) would pass the US Supreme Court and their jurisprudence on this is much tougher than that of the High Court. I think that (b) and (c) would certainly pass the High Court.

Mr McARDLE: Clause 22 is the issue of having the right to object based upon conscience. The proposal does not require a practitioner, nurse or doctor to refer to a practitioner or nurse who actually undertakes the termination. Do you concur with that? Do you leave it, then, to the relevant AMA guidelines and other guidelines to guide practitioners and the like to what they should do in those circumstances?

Mr Cope: The submission simply deals with the point about a medical emergency, in which we say that the right of conscience should not apply. In relation to questions of referral, it has never been discussed at a meeting of the executive council that I am aware of and I suspect there would be very differing views about it. Therefore, what I am about to say reflects my thoughts on the issue and is not necessarily a formal position, because we have not discussed it. I actually think it is a very difficult issue. On the one hand, I think that it is very difficult to justify, in a situation where you are not talking about a threat to somebody's life, to force somebody who conscientiously thinks that they are aiding in a murder to provide assistance in that course, as they see it. On the other hand, in certain circumstances, in smaller country towns and the like, getting access to those services can be very difficult.

The argument that somebody like Frank Brennan has made about that is that he, of course, does not support a law that requires referrals. He says, 'The government should spend money making sure that people know where these services are available to counter that problem.' Certainly, in the era of the internet, you would have thought that the information could be out there or perhaps would be more out there in a more liberalised regime. Like I say, I find it very difficult. I tend, on balance, to favour what Frank Brennan says.

Mr McARDLE: If I have an objection based on my conscience or religious beliefs, why should I then be asked to turn against those beliefs and refer to a doctor who will terminate when I will not myself?

Mr Cope: Yes, I understand the question. We could have a discussion about the relationship between people's religious beliefs. We get to the same issue, for example, with gay weddings. Our view about that is that your right to conscience does not go that far. If you are selling a cake to anybody, you should sell the cake to anybody who comes in. The point of difference, as I see it, is that you are requiring somebody who conscientiously thinks that they are assisting in murdering somebody. If that is the point of difference, then the question becomes, 'Are you entitled, in those circumstances, to compel them to assist or not?'

Mr McARDLE: Not assist.

Mr Cope: But referral is assisting. That is their argument. That is how I take the argument to be.

Mr McARDLE: They are still a party to an abortion.

Mr Cope: Yes, they see it as being a party to what they see as a murder. As I say, I think it is a very difficult issue but, on balance, I tend to think that they should not be so long as the sort of things that Frank Brennan talks about are done and that is that this information is made readily available. Maybe the government has to pay some money to achieve that objective. It is certainly a position that he has taken and was discussed in Victoria. As I say, I find it a very difficult issue.

Mr McARDLE: Thank you very much indeed.

CHAIR: Following on from that and your comments in regard to clause 22, your submission talks about the law ought to reflect the position that a person is not entitled to exercise a right in such a way as to do harm to another person. Do you think that that threshold of doing harm is met by requiring an individual who has a conscientious objection to assist, as is worded in the bill, by requiring that referral?

Mr Cope: That is the difficulty, is it not? You have two things here. First of all, as I say, I think there is a difference between somebody having a conscientious objection, for example, to selling a cake for a gay wedding. I think that is not in the same category as this. The argument that is put against it is that, particularly in small towns, people may not know how to get access to these services and that that is causing harm. Can that be dealt with by the sort of things that Frank Brennan suggests—information campaigns and governments supplying information and other people supplying information? As I would have thought, in a more liberalised environment, perhaps there would be more advertising of these services, anyway. Like I say, I personally find it a very difficult issue to come down to but, on balance, I think that at the very least the first port of call should be what Brennan is suggesting—that people should publicise the services and make the information broadly available. If that does not work, then perhaps you would have to revisit it. That is my view.

CHAIR: Thank you. I appreciate that. Father Brennan appeared before us in our first inquiry and he spoke at length. I know that he has written at length about conscientious objection. I am more interested in your personal view—and I appreciate that it is your personal view because you have not talked to the council—as to whether requiring an individual in those circumstances to refer could go so far as to be considered to harm that individual because of the depth of their views. I think that was the tone of the—

Mr Cope: I thought you were talking about the person who was wanting the referral.

CHAIR: No.

Mr Cope: That is part of the point of asking somebody to assist in something that they conscientiously consider to be a murder. That is the difficulty with it, because that is what you are asking them to do. Of course, we live in a society where we respect people's rights to freedom of worship. It is a serious step to require somebody to do that, I think. It has to be balanced somehow against those other interests. As I say, I think on balance the starting point is to not take that step—at least initially. I was going to say that in Victoria they did it anyway. I do not know whether anybody has tried it to see what happens.

CHAIR: Thank you.

Mr JANETZKI: I want to take you to an earlier comment and maybe a bit of a philosophical discussion. You quoted Roe v Wade and US jurisprudence. I do not want to put words in your mouth, but you talked about the rights of the unborn on a continuum in that, as you said, the closer to viability, the rights of the unborn grow ever more significant. Can you just expand a little bit on that in the Roe v Wade case? I obviously know of it, but could you just explain—

Mr Cope: In Roe v Wade, they take a three trimester approach. In the first trimester, the state has no right of interference whatsoever. In the second trimester, they acknowledged some level of right of interference and then the third trimester is the position that is being argued for in this bill. That was based on the medical science when they delivered that in 1974, 1975, or whatever it was. It is the same concept. It is saying that, at the very early stages, in relation to the right of the foetus versus the rights of the woman, the woman's rights prevail completely but, as you move closer and closer to viability, even the right of the state in this context to intervene to protect the foetus increases. It is a question of how you work out what that continuum is on that logic.

The rights of interference in the second trimester are not very significant. I cannot remember what they are, but that is the logic of it. I think to some extent the court left the working out of the details of that to state legislatures—so different rules. That is why we have continuing debates in the United States about what is legal in those sort of circumstances. The detail of what is in the second trimester in the judgement is not very much at all. I think they only just set out broad guidelines and basically say that the first trimester should be decriminalised and then they left the detail to individual legislatures.

Mr JANETZKI: We have heard a lot of detail over the last couple of days and I have asked this a couple of times. It is often quoted that, in the UN Declaration of Human Rights and the covenant on political rights, there are rights that exist there for the unborn. Those same documents are sometimes used by the opposing parties for their own arguments. What is your view on that jurisprudence?

Mr Cope: The first point is that I agree that people use different things for different purposes. We often refer to international instruments, but that is one of the difficulties in doing that. I would prefer to approach this issue from first principles—although we do and have—than particularly relying on what international covenants have to say. I think it is in your first report. There is a lot of debate about what they mean. As I say, I would prefer, because there is a large debate, to just focus on what the first principles are.

Mr JANETZKI: Professor Aroney gave evidence yesterday in respect of the implied freedom of political communication, which the member for Caloundra spoke to. His argument was well made. As we have discussed, there are some reservations in relation to limb (c) of clause 24. The dean of the law school of Notre Dame raised our attention to section 78 of the Criminal Code, which prohibits any restrictions on the exercise of political liberty. Does the council have a view on the application of that provision in this context?

Mr Cope: I cannot think of what 78 says off the top of my head. The Criminal Code is an ordinary statute. The current government passes a later law, it gets overridden. The question is—

Mr JANETZKI: Or are you aware of when section 78 would be applied or has been applied in Queensland's history?

Mr Cope: No, I cannot help you with that, I am afraid.

Mr JANETZKI: Okay. Is there any chance of perhaps getting a response from the council on section 78?

Mr Cope: I can have a look at it, if you want.

CHAIR: Can you take it on notice?

Mr JANETZKI: Can you take that on notice? I would love to get your opinion of the application of section 78 to the issues raised here.

Mr Cope: Yes.

Mr KELLY: Thank you, Mr Cope, for coming today. I refer to the first section of your submission where you suggest that the council favours a broader level of discretion post 24 weeks. It seemed to me that—and I was not aware of this prior to these inquiries—that the current status in Queensland is that if a woman seeks a termination at any point in the pregnancy on the basis that the foetus has an abnormality, that is not legal.

Mr Cope: That is right.

Mr KELLY: The first bill, by removing those three sections of the Criminal Code, seemed to fix that issue. This bill introduces the 24 weeks period. The test is based on the status of the mother rather than the foetus. Is that what you are attempting to deal with by that statement?

Mr Cope: Yes, because the concern is that the current test is—

> Reasonably believes the continuation of the woman's pregnancy would involve greater risk of injury to the physical or mental health of the woman....

That does not, it seems to me, cover the situation where the reason for the termination is some serious abnormality that has been discovered by testing. That is the point of wanting to have a broader test than that test. That goes back to the consultations we had with doctors a few years ago. Their principal concern, at that stage, is the tests taken at 20 weeks that reveal serious normalities. There is no necessary reason an abnormality is going to cause any harm to the mother. If you read the Victorian Law Reform Commission's report, on which our legislation is based, it also talks about those issues. As I say, we would prefer the Victorian formula, which would allow those sorts of issues to be taken into account.

Mr KELLY: Based on your earlier commentary about Roe v Wade and the approach taken in the United States, you were talking about decriminalisation up to the point of 20 weeks, I think.

Mr Cope: No, it is trimesters. It is not—

Mr KELLY: Two trimesters?

Mr Cope: The first trimester, basically, it decriminalises. The second trimester, it did not say very much about the detail of what the law was, but it is based on this concept of increasing the right of the state to intervene to protect the foetus. That is the underlying logic of the decision. My recollection is that they basically left the second trimester up to be determined by legislatures.

Mr KELLY: Does the council have a view on whether there should be a legislated point at which prior to that point abortion is decriminalised?

Mr Cope: Yes, 24 weeks. That is the Victorian model. That is the model that we support, yes.

Mr KELLY: But is it a criminal offence after 24 weeks?

Mr Cope: I did not think it is a criminal offence after 24 weeks.

Mr KELLY: It is just guided by different—

Mr Cope: We see this as a health issue. It should be in the health legislation. It makes it legal. I suppose if it is not legal it potentially could be some sort of an offence or it could be some sort of civil remedy perhaps as well. But I suppose if it is not a specific offence it could fall in one of those ravines of the code dealing with medical treatment. It is possible it could still be an offence in some way. I have not really thought about that. We are certainly not suggesting it should be made an offence.

Mr JANETZKI: There was one more issue I wanted to discuss. We received testimony yesterday from a doctor in Victoria called Dr Mark Hobart. I am not sure whether you are aware of Dr Hobart's circumstances.

Mr Cope: No.

Mr JANETZKI: He was a Victorian GP that refused a referral for an abortion for gender selection to a specialist. In the end a complaint was made and he was cautioned by his medical board for failing to make the referral. I wanted to dive back into the rights of conscience just for a minute. If I understand your position correctly, or the council's position correctly—

Mr Cope: On this I am just talking personally.

Mr JANETZKI: Cake making would not activate a right of conscience in that scenario, and I accept that I have only given you a very, very small view of the entire case. But you would still believe that would be an opportunity to exercise a right of conscience because there were also obviously countervailing responsibilities he had, one, as a medical practitioner, but then his refusal to refer caused some concern with the medical board because he has an obligation at one level but then he has a right of conscience on the other. How would you balance those competing responsibilities?

Mr Cope: My understanding is that in Victoria they passed a law which compels. That was the discussion that Frank Brennan was involved in down there.

Mr JANETZKI: That would override then any right of conscience in your view?

Mr Cope: That was the purpose of the legislation, yes. In those sorts of scenarios where you have people who are—anyway, I will think on it.

Mr JANETZKI: So there are limits to the rights of conscience?

Mr Cope: No. As I said, my own personal view is that on balance, at least until there is some evidence that people aren't getting access to the service in a substantial way, it should not be illegal. Those sorts of examples where people are—it doesn't matter, does it? If you are asking me about what the law is in Victoria my personal position would be that that should not be the law there and nor should it be the law here because I do think that on balance it is a big step and there might be other ways of ameliorating the potential harm to women who want to access the service and at the very least we should try that first. At the moment I would not support the law in Victoria which he has obviously been disciplined under or whatever has happened to him. I don't know the facts of the case.

CHAIR: Mr Cope, thank you very much for appearing before the committee today and thank you for the submission.

WHITE, Professor Ben, School of Law, Queensland University of Technology

WILLMOTT, Professor Lindy, School of Law, Queensland University of Technology

CHAIR: Professors White and Willmott, welcome back before the committee. Thank you for your further submission. I know that you know the drill, but if you would like to make a combined opening statement of up to five minutes and then we will open for questions.

Prof. Willmott: Thank you again for the invitation to be here today. I acknowledge the traditional owners of the land on which we meet this afternoon. My name is Lindy Willmott and I direct the Australian Centre for Health Law Research at QUT. I make this presentation on behalf of my colleague, Professor Ben White, and myself. In this opening statement we would like to reiterate two issues that we addressed in our first appearance before this committee and make two brief points about the new bill. Firstly, we emphasise that from a technical legal perspective the regulation of abortion in Queensland is flawed. For this reason alone the law of abortion should be amended. There are problems with the law itself: uncertainties and inconsistencies and issues around its interpretation. Unless sections 224 to 226 of the code are repealed these problems will continue: 1, the law as it has been interpreted in Queensland does not match what section 282 of the Criminal Code actually says. People should be able to look at the Criminal Code to know their legal rights and duties. The current law fails this test. 2, the scope of the defence is unclear. While we are reasonably certain that the Menhennitt ruling applies here, it is unclear whether the defence will broaden with further case law in other states. Further, different judges in Queensland have said different things about how difficult or easy it is to satisfy the defence under the code. 3, the lawfulness of medical terminations and liability under section 225 is unclear after the Leach decision. 4, there is a lack of authoritative decisions. Queensland law is pieced together from a relatively small number of decisions and some reasonably brief judicial remarks. Take, for example, the comments of McMeekin J in the Central Queensland hospital case about when a minor will have capacity to make a decision about terminating a pregnancy. Justice McMeekin indicated that a minor would not have capacity to terminate a pregnancy, unless she had the capacity to understand the alternative decision, namely, continuing with the pregnancy, as well as the emotional and physical demands of raising a child. With respect to His Honour, if this were the test for capacity, many adult women seeking to terminate a pregnancy would not satisfy it. Finally, the court should not have to approve termination of a non-Gillick competent minor's pregnancy. This should be a decision for the child's parents in consultation with the doctor.

Turning now to the values that should underpin the law on this topic, this issue of regulation of abortion is a value-laden topic so we make clear the values we believe are important and should underpin the law regulating abortion: 1, the law should be clear and certain; 2, our laws should be enforced; 3, the law should promote the wellbeing of its citizens and ensure its citizens are not harmed; 4, the law should promote autonomy; 5, the law should promote justice and equity; 6, the law should reflect contemporary community attitudes and standards. For the reasons articulated more fully in our submissions, we believe that the current law does not promote these values and is inconsistent with some of them. We are deeply concerned that this is the case.

We will raise only two brief points about the new bill, but we would be happy to elaborate further on these points later if the committee would find that useful. Firstly, the bill provides only limited protection to women seeking a termination in clause 20(3). We believe that the protection afforded by the provision is too narrow and a woman should not commit an offence for procuring her own abortion. Secondly, clause 22 provides that no-one is under a duty to perform or assist in performing an abortion. In our view, there should be an obligation on the doctor to inform the woman of a conscientious objection and refer her to another doctor who does not hold a conscientious objection.

In concluding, we make the following comments: the Queensland law on abortion is outdated and should be reformed. We included our proposals for reform in both of our submissions. Central to our proposed reform is the repeal of sections 225 to 226. There are serious problems with the current law, including its lack of certainty and the adverse consequences of this uncertainty for women and their treating doctor. All laws must be clear and certain, but this is even more critical in a difficult area such as this. Quite aside from these technical problems with the legal framework, we believe that the law should treat abortion as a health matter, not a criminal matter. We urge the committee to recommend reform of the laws to take them out of the Criminal Code and to be regulated as a health matter. Again, we say that women are responsible decision makers and should be legally entitled to make this profoundly important and difficult decision. Thank you.

CHAIR: Thank you very much. Professor Willmott, you just spoke then about how strongly held people's views are about this topic of termination. Is that perhaps what explains the point here you make: 'As a final point, we note this submission represents the views of the authors. It is not made on behalf of all members of the Australian Centre for Health Law Research.' Is that in recognition of that? Is that why you made that point in your submission?

Prof. Willmott: I guess it is implicit in that. The more technical reason why we made that point is that our centre is comprised of 20 full-time academics in the law faculty at QUT. Many of them signed this submission. We did not talk to all of them. After the first submission was made we did not chat to all of them. No-one came up to us and said, 'We are concerned that you purported to be speaking on behalf of all of us,' which we did not purport to do. It is just, I suppose, a function of noticing that in the first report our views were referred to as views of the centre and we just wanted to make clear that there were three people writing this submission. As it happens it was supported by a number of other academics, but we did not want to give the impression that we were speaking on behalf of the 20 academics within the Australian Centre for Health Law Research.

CHAIR: I did want to clarify that because your letterhead is the Health Law Research Centre so I would have made that assumption. I just wanted to give you the opportunity to explain the intent behind that so thank you for that. The next point is with regard to clarity and certainty. Is it your view that the bill that the committee is currently considering would deal with that confusion in its entirety, partially; what is your view?

Prof. White: I guess I think the opening thing to say is the law as it currently stands we think quite frankly is broken and so a bill like this inevitably improves the clarity and certainty that goes with law in Queensland. One area where we were I guess interested in clarification from the committee is it does not mention repeal of the relevant provisions which criminalise. We think it is important this be dealt with as a health matter rather than a matter of the Criminal Code. There is no specific provision in here repealing those provisions.

CHAIR: That is my next question to you, because you are professors of law and I am not. What is your view of the interaction between the current bill and the earlier bill given they are two separate bills?

Prof. White: I think the easiest thing to do is for the Queensland parliament to say what it means. If the view is that those provisions should go, I think it is clearest and safest to do that. Indeed, I think our policy position is to treat this as a health matter and having residual criminal offences in the Criminal Code we think sort of casts a different light on that. I think it makes sense that whatever regulation that is proposed in relation to this issue be contained within the single piece of legislation, be within health legislation. I think there is a practical reason for that too if we think about that it is important that the community can know and access what law is and if they are trying to juggle between what does the Criminal Code say on this and what does the Health Act say on this I think that is an impediment to being able to know an act on the law. Whatever position is taken, it needs to be treated entirely as a health matter and needs to be contained within this legislation.

Prof. Willmott: Can I add to that, please? An example of piecing together two pieces of legislation not quite working is illustrated really well with the guardianship legislation. The guardianship legislation was enacted after a very fulsome report by the Queensland Law Reform Commission and we had the Powers of Attorney Act 1998 and then two years later we had the Guardianship and Administration Act 2000 and as a result of them trying to fit those two pieces of legislation together there was an unintended consequence of that. I endorse the comments that Ben just made then. I think it would be very helpful for all of the legislation to be in the one piece, one act, so we are not guessing does this reform sections 224 to 226 or does it not. From reading the second bill I did not think that it repealed sections 224 to 226.

Prof. White: You mentioned the other bill. I think for a matter of simplicity it would make sense for those things to be put together if that is the intention that those Criminal Code provisions come out. We support that proposition. I think it makes sense for that to be done in a single bill. Again thinking forward as academics, the courts have to grapple from time to time with how did this come into play. It becomes a very challenging exercise if you are scanning through a range of different bills and acts considered in different ways. I think the simplest way is to put together in a single bill the entire proposal and then that is considered and enacted by parliament in that way.

CHAIR: Would it be fair to say that you would consider it a less than ideal approach to law reform in this area to have separate bills that are currently standing independently and being considered independently of one another?

Prof. White: As a matter of clarity, I think it makes sense for the same issues, the same topic to be considered in a single bill by the parliament.

CHAIR: It is not a role of the committee to anticipate the processes of the House. It is not within our purview to combine those two bills. That will be a decision for the House. I am interested in your views of the bill that we are currently considering. Taking the first bill out of the equation and if this bill stood purely on its own and there were no repeal of those sections what would be your professional view on the practicalities of this legislation should it pass in its current form but on its own?

Prof. Willmott: In my view, it would have the effect that it would be more difficult in Queensland for a person in the first 24 weeks gestation period to obtain a termination than after 24 weeks. My understanding is that if this bill were passed the Criminal Code would continue to govern a woman in the first 24 weeks. Abortion would be unlawful under 224 to 226 and the defence would be in section 282. If you were post 24 weeks, my understanding is that this new bill would operate.

CHAIR: Would that be your view too, Professor White?

Prof. White: Yes, I think that is right. The other point I would make is that there seems no reason to take that approach. If there is an opportunity to consider these issues together, I think that is a far better policy position. Abortion should be regulated as a health matter. We should deal with the entire issue in a single piece of legislation.

Prof. Willmott: I would add that one of our criticisms of the current regime is the uncertainty. If there is any possibility of uncertainty that would not be a good way forward. We have been considering how this would work with the current code if this were the only bill. We have been working with legislation for quite some time and if we are struggling to work out what the implications would be, I do not think that is ideal.

CHAIR: Just continuing on with the clarity and certainty point. In your submission on page 3 you cite as an example the case of the Medical Board of Queensland v Freeman. I was interested that you chose that case. I certainly understand the point that you are making around the issues to do with clarity and certainty. I agree that there is significant uncertainty that exists now. On reading that case to me it was about the appropriateness of the treatment and the decision that that medical professional took. Even if you change the legislation, you can still have somebody mistakenly interpret that legislation. Why did you choose that example?

Prof. Willmott: Madam Chair, that is a good question. I guess when I read that case—and it was some time ago now—I remember reading a part of the decision which said that the particular doctor who was looking after the patient was not entirely sure whether or not she satisfied the criteria to get an abortion in a public health facility. Then another doctor gave evidence saying that because the patient may have been suicidal in his view she would have satisfied the criteria. I suppose what I took from that is that it is not a good situation if specialist doctors are uncertain in Queensland as to whether or not the criteria are satisfied.

It is understandable. If you read the clear text of the Criminal Code you have the offence provisions coupled with the language of section 282 which sets a very high level needed to preserve the woman's life. That is interpreted by case law to be somewhat broader. The plain reading does not suggest that that is what it means. I suppose my point is that a specialist can be mistaken for not understanding what the law is.

CHAIR: It could occur under any piece of legislation, but I take your point that it is exacerbated by the particular situation now and the intersection between the code and common law. I take your point. You raise a very interesting point in your submission at page 6 in relation to clause 20. This is something that I certainly had not considered. That is the role of pharmacists and how the legislation, as it is currently worded, will intersect with their role. You make the point that the committee may wish to explore whether legislation should refer to any potential role played by pharmacists. Could you expand on that? It is certainly the first time I had seen that come up in a submission.

Prof. White: When writing that submission our thoughts were to try to think about the people who may possibly be involved. One of the challenges in drafting legislation is thinking about where you are drawing lines and not unintentionally leaving out people who may be deserving of protection under the law. In relation to medical terminations we considered that pharmacists may have some involvement.

I suspect pharmacists would be better placed to give evidence about the nature of their role. We saw it as our responsibility to raise this question for the committee's consideration. It may well be that pharmacists are able to give information about the role that they play and an assessment can be made whether that role is intended to fall within this protection and whether it in fact does.

CHAIR: Given that—I imagine your answer will be no—you did not have a particular view from a drafting point of view about clause 20 which might be of assistance to the committee and how that could be amended?

Prof. White: No, I think that is right. We did not have a specific view. I guess our concern was to make sure that if this becomes lawful it would be unfortunate if a particular cohort of people—pharmacists, who are going about their business in accordance with what is otherwise lawful—fell outside the protection.

Mr McARDLE: The Victorian legislation does cover chemists and nurses, does it not, and it actually deals with supplying a drug. Would you envisage—not that wording per se—that incorporating that theme in this bill would provide protection for them with regard to them supplying a drug to eventuate or cause a termination?

Prof. White: I guess the point I would make is that medical termination is a recognised form of termination. There is specific consideration of that given in Victoria to make sure that was covered. Our point was to raise that for the consideration of the committee to make sure that if that is how terminations occur in Queensland—and we understand it is; others can speak more fully on the practice of it—that whatever is in the bill proposed would cover that.

Prof. Willmott: In relation to technical matters and the best way of affecting the change which is desired we would very much defer to the parliamentary counsel.

Mr McARDLE: But you would say to us maybe consider as an aspect of our report going forward determining whether or not chemists should be included in the legislation to protect them in event of them being involved in a termination process?

Prof. Willmott: Yes, that is correct.

Mr McARDLE: It was raised with us by the AMA that clause 20(3), which deals with a woman not committing an offence by performing an abortion on herself or consenting thereto or assisting thereto, is inconsistent with subclauses 20(1) and 20(2) in that an abortion can only be performed by a health practitioner. Then subclause 20(3) says that a woman does not commit an offence against this section. There is some logic to that. When one looks at the explanatory notes there is no reference as to where this section came from. Do you see a need for section 20(3)?

Prof. Willmott: I certainly see a need for any amendment to make it clear that women should not be committing an offence to procure their own abortion. We raise a concern that subclause (3) appears to protect a woman only if the procedure was terminated by someone who was not qualified to do so—that is, within the ambit of clause 20. Our submission would be that, in whatever form the legislation is amended, it should make it clear that women who procure an abortion should not be committing an offence.

Mr McARDLE: Is subclause 20(3) of the bill, as it is now, insufficient to cover that eventuality?

Prof. Willmott: In my view it is because it seems to be limited to actions falling within the ambit of clause 20.

Mr McARDLE: So it is too narrow you think?

Prof. Willmott: Yes, that is how I read it.

Mr McARDLE: An organisation gave evidence here that clause 20 may not cover Leach and Brennan. A woman in that circumstance may fall foul of subclause (3). I put to them that because the terms are narrow it is too narrow and the facts in that situation may not be covered by subclause (3). Leaving aside Leach and Brennan, you would say that the terminology in subclause (3) needs to be widened to ensure that a woman in any circumstance cannot be convicted or charged with an offence?

Prof. Willmott: Yes, I would agree with that and I would reform section 225 of the Criminal Code.

Mr McARDLE: With the Criminal Code we have spoken about 224, 225 and 226. What else would you amend potentially to ensure the conflict does not exist between this legislation and the remainder of the Criminal Code—282 or other sections along those lines?

Prof. Willmott: Our submission would be that sections 224, 225, and 226 should be left out.

Mr McARDLE: The parliament wipes them, leaving this bill in place. I recall going back to your earlier papers on the first bill and you raised other sections of the Criminal Code too that in an analogy you could draw have an impact upon termination. Are there other provisions in the Criminal Code you would need to amend to ensure you capture or remove all elements in the code that could impact upon a termination process?

Prof. Willmott: I would have to take that question on notice. In relation to section 282, I think that that would have to remain because it provides a defence to the provision, which I think is section 313, about the unlawful killing of a child about to be born. If there were a late-term termination section 282 would provide a defence. Off the top of my head, I would be very reluctant to say that section 282 is not needed unless there is a full investigation of the circumstances in which section 282 would operate.

Mr McARDLE: The House is master as to how it deals with these bills. The House can determine to do them together, one at a time or join them as one. That is quite possible. Your evidence is that if sections 224, 225 and 226 remain law, but the second bill goes through we are in fact in a worse situation because we have sections 224, 225 and 226 concerned about up to 24 weeks and this bill 24 weeks and post, is that right?

Prof. Willmott: That is correct.

Mr McARDLE: The danger is, whereas you would allude to the fact that it is murky, it could become pitch black, if that scenario arises by way of interpretation. The history in this state of how the law has looked at termination is not clear cut. We draw upon the common law in Victoria and other jurisdictions as well. That could be a worse case scenario from your perspective by way of the legal provision going down a very uncertain course let alone doctors becoming more confused now as to what the position would be?

Prof. Willmott: I think that is a fair assessment. The one caveat I would make is that it would at least make the position a little clearer in relation to the gestation period post 24 weeks.

Mr McARDLE: Which is very small proportion of terminations in this state?

Prof. Willmott: Yes.

Mr KELLY: Just picking up on that point, clearer post 24 weeks if the grounds for termination, as you have suggested in your submission on page 8, were followed or as currently written in the bill?

Prof. Willmott: I think both proposals are clearer than what is currently operating under the code as interpreted by the case law.

Mr KELLY: If the first bill were to pass, it would remove that situation whereby a termination could not be performed solely on the basis that the foetus had an abnormality.

Prof. Willmott: I should get out the first bill. I did not know that we would be questioned in relation to the first bill.

Mr KELLY: I am happy to move on because I am mindful of the time. There has been discussion in both this inquiry and the previous inquiry about the need for a cooling-off period between the point where a woman approaches a doctor requesting a termination and when that termination occurs. From a legal perspective, are there any issues in relation to legislating a cooling-off period in this specific area of health? Are there any precedents or any places where that occurs?

Prof. Willmott: I am aware that there are cooling-off periods in some commercial contracts. I am also aware that there are some cooling-off periods in the context of euthanasia legislation. I am unaware of any cooling-off periods in the context of termination of pregnancies. I would be very reluctant to be recommending for there to be a cooling-off period in any legislation around termination of pregnancies. I think it is really important to support women who are considering a termination procedure. I think it is wonderful to support them by providing them with information and with an opportunity of counselling should they want that. However, I think it is a different proposition to mandate a cooling-off period.

I think women are very responsible decision-makers. I think this is an extremely difficult decision for women to make. I do not think it is a decision that they would make lightly. They may wish to have a cooling-off period. The doctor might say, 'This is a lot of information to take in. I have given you some more information. You might want to go away and think about it,' and they may choose to do that. To mandate that they go away and wait a period of time I think would be a very unhelpful thing to have in legislation.

Mr KELLY: The definition of health professionals who can perform a termination under this legislation does not seem to include midwives. Should that be another group that is considered?

Prof. Willmott: I have no submission to make on that point.

Mr KELLY: In the case in Cairns—which I think this bill is attempting to deal with—it would seem to me that the police made a choice to pursue a prosecution under those sections of the Criminal Code that deal with abortion. It would seem to me that they possibly could have attempted to do something around the Drugs Misuse Act. Does this bill provide safety from any prosecution for a woman who finds herself in that situation in the future?

Prof. White: I return to our overall position. This should not be regulated as a matter of criminal law. It should be regulated as a health matter and contained in the health legislation. As part of that, the criminal law provisions should be removed. I think approaching it like that and regulating it as a health matter provides the best protection for the situation you have described.

Mr KELLY: Is the case of Q and the Gillick issue that you mentioned in your submission dealt with in this legislation?

Prof. White: That is not specifically tackled in this legislation so far as we could see. That is something that we think would be useful to consider. As I think we mentioned last time, the reasoning in those two Supreme Court decisions, although made very quickly and under difficult circumstances, we do not think is justifiable. The analogy to Marion's case is not a good one. We note that Queensland is the only jurisdiction in Australia which imposes a requirement to go to court so far as those two Supreme Court decisions are concerned. Having the court available where difficult issues arise is always very important. Taking that power for parents to decide away in all cases and mandating court authorisation is problematic for the reasons we have mentioned. To change that would require either a Court of Appeal decision or legislation. This bill does not currently address that. In our view, that would be a step forward to tackle that issue given that without that it is likely that people are going to feel the need to go to court in circumstances which we think is undesirable.

Prof. Willmott: We think this bill could be improved if it clarified, firstly, that a minor who has decision-making capacity should be able to obtain an abortion and, secondly, alter the law that Ben has just referred to which currently requires a non-Gillick competent minor to go to court to seek consent to a termination.

Mr KELLY: Your submission makes suggestions around the grounds for termination. The legislation does not deal with Gillick competency. We heard evidence yesterday that there may be constitutional issues in relation to protests outside facilities. We have another bill dealing with other sections relating to this. One of the things you said in your introduction was that the problem that we are trying to address here is legislation that has been pieced together. It seems to me that we have two pieces of legislation that have been pieced together, not completed. You made submissions to the first inquiry. Was your organisation consulted about this legislation? As legislators, if we support this legislation, are we going to have to make significant amendments to improve this legislation?

Prof. Willmott: We were not consulted in relation to either bill. You make a really good point. It is so important to get everything in the bill right the first time. There is a great deal of expertise around Queensland that the parliamentary drafters and parliament and politicians can draw on to have input into what a good bill would look like. There are also quite a few models now in relation to abortion legislation that can be drawn on. In relation to your point about restricting access to facilities, I am not sure I am aware of the other piece of legislation that you are referring to.

Mr KELLY: We had advice yesterday from Professor Aroney from UQ that sections of the bill may not survive a constitutional challenge.

Prof. Willmott: I see what you are saying. I do not purport to be a constitutional expert, but what the committee, the parliament and the drafters would have to grapple with is balancing the genuine constitutional right to protest and to make their political views known with the right of a woman to be able to obtain health care in circumstances where she is not harassed or intimidated. It is a balancing of that right. There might be constitutional issues to make sure that balance is correct, but there are legislative models. There are many jurisdictions where this balance occurs. There has been constitutional testing of this balancing of interests internationally. I think it is something that can be worked through, but you are absolutely right. It is a balance that we have to correct, but I think it is possible to get that correct.

Mr CRAMP: You are not alone in suggesting a 24-week gestation period is the point of viability. We had a witness here today who is a specialist at the Royal Brisbane and Women's Hospital who noted that the state guidelines currently state 22 weeks as viability. Whilst I am not talking about wrong or right, I think it raises a question about advancing science and that medical advances present a danger to setting an exact point of viability. I am not after an answer, but do you think it would be a

reasonable approach to not look at an actual point of viability but, for want of a better term, have a moveable feast from time to time upon review. Would that be a better approach from a legal perspective? How would that work?

Prof. White: The Victorian Law Reform Commission looked very closely at this and engaged with a range of evidence and other things. I am conscious that medical technology and science et cetera advances. Our view on 24 weeks is based on—you have mentioned the view of one specialist. The guidelines that you are referring to—

Mr CRAMP: Hospital statewide guidelines.

Prof. White: There are differing views on that. One of the difficulties is where to draw that line. We have reached a view on 24 weeks.

Mr CRAMP: Is that set in stone or would you take on the medical profession's viewpoint on that?

Prof. White: I think evidence based policy-making and evidence based legislation is important. Issues of engaging with evidence rather than relying on anecdotes are very important in this decision-making process.

Mr CRAMP: There is the potential for permeability in regard to that. As we see science move forward, there is an opportunity to review that from a legal perspective. From your view of the law, that would not pose a problem.

Prof. White: All I would say is that I do not see any reason why not—science changes. Laws get reviewed. I probably would not say anything more than that.

Prof. Willmott: The only thing I would add is that it is good to be reviewing medical evidence, but if you wanted to change the law I think you would also need evidence that it needs to change. If there is evidence that there have been late-term abortions to such an extent in such circumstances that require a legislative response, then that is something that you might want to consider at that point. There are two aspects to that. You made a point about viability. There is another point about what is actually happening. Is there data about late-term abortions?

Mr CRAMP: There is. Overall, without creating an argument, I think the set difference is there already. There are different points of view. However, the medical profession is saying that there is a statewide hospital guideline that viability is 22 weeks. We would have to weigh that up when considering late-term abortions. That is what I am saying.

Prof. Willmott: I understand what you are saying. What I am trying to say is that my understanding of the evidence is that 95 per cent of terminations occur in the first 14 weeks, four to five per cent are performed between 14 and 20 weeks, and one per cent are performed later than 20 weeks. Even though there might be movement in terms of the science of viability, parliament should be looking at whether there is an issue about a large number of late-term abortions before there is a need to be moving gestation periods in legislation.

Mr CRAMP: I accept and respect your view. I do not look at numbers. I look at the fact that every life potentially is a life. That is not from any viewpoint on this argument. I am saying that each individual case is a case. I consider everything important regardless of whether it affects 4,000 people or one person. I will not judge something on how many people it affects, but I respect your view on that.

Moving on—and correct me if I am wrong—in your submission there is a lot of viewpoint on the rights of the woman, and rightly so. Have you noted anywhere your views on the rights of the foetus and at what stage? I am looking at paragraph (d) in relation to autonomy. You are absolutely correct that a woman has a right to exercise autonomy over her body. I am wondering about the rights of a foetus. We have heard from both sides of the argument.

From a legal standpoint, from your view—you have taken the time to put in a submission—where do you see the rights of a foetus or an unborn child starting? At what stage of pregnancy or is it in fact at birth, noting that, regardless of whether one or both bills are passed, termination can occur right up until the day of birth as the legislation currently stands? There are some reasonings, but it has been put to us by previous witnesses that arguments can be made to make terminations fit into those reasonings. Where do the rights of an unborn child or foetus start in your view?

Prof. Willmott: As a matter of law?

Mr CRAMP: Yes, I am not asking your personal view.

Prof. White: As a matter of law, it is when a child becomes a person capable of being killed when he or she has proceeded in a living state from the body of the mother—section 292 of the code.

Mr CRAMP: What are your views on death certificates being issued past 20 weeks and for over 400 grams?

Prof. White: That is not something I have looked at.

Prof. Willmott: Can I make one comment? I think you may have been suggesting that termination can occur currently right up until birth.

Mr CRAMP: Under the proposed legislation, you were talking about the first bill, but there are some provisions in the second bill for medical reasons. It has been put to us by previous witnesses that patients can fit into different reasons but effectively it can be abortion on demand. I am wondering what your thoughts are on that, because under this proposed legislation you can abort up until the day of birth.

Prof. Willmott: I would not mind making a comment or two about that. The first is that under the legislation—the law which currently exists—you can terminate right up until the time of birth if that is necessary for the preservation of the mother's life. That is a position that I would absolutely support. Termination under the proposals would also be allowed up until the time of birth if that was necessary to preserve the mother's life.

Mr CRAMP: What about for other reasons such as social reasons? We have had a lot of talk about social reasons. What are your viewpoints on that? As professionals in the legal field, do you have a viewpoint on that?

Prof. Willmott: There are a couple of points. Any proposals for reform are based on values, and we tried to be intellectually honest by putting on the table what we thought our values should be that underpin the legislation, and they are articulated at length. I think you suggested that late-term abortions occur for social reasons. I would suggest—

Mr CRAMP: I did not suggest that. I was just saying that we have been advised previously that it can occur for any reason, for physical or mental reasons. For mental reasons especially it was suggested that patients can be fitted into that category.

Prof. Willmott: I hear that you have received a great deal of evidence in relation to the proposed reform. I would like to make one point in relation to the topic of evidence, and that is simply to flag how critical it is to have reliable evidence. In that regard we were delighted to see that the committee commissioned an independent review of the evidence about public opinion and published that in its first report. We would also encourage the committee to be very careful, with respect, with the source of the evidence that they receive. Receiving anecdotes or receiving case examples is one thing, but receiving evidence from a more reliable source is something that we would be encouraging the committee to do—for example, studies and systematic reviews.

The other point we would make is that evidence provided to this committee should be tested, whether that is through peer review, expert panels or the courts. I am not aware of evidence in relation to social abortions carried out in the later terms of pregnancy.

Mr CRAMP: Do you support social reasons in the short term? This is my last question—just yes or no.

Prof. Willmott: What do you mean by social reasons?

Mr CRAMP: Financial or socio-economic reasons or without a reason—I am just wondering.

Prof. Willmott: In our submission we suggested that women are responsible decision-makers in relation to health matters and therefore we believe that women should have the right to make this very important and difficult decision up until 24 weeks. Post 24 weeks we have set out what we believe to be a reasonable criterion.

Mr JANETZKI: Has the Australian Centre for Health Law Research undertaken comparison law analysis in relation to abortion laws across other jurisdictions, whether they be in Australia or internationally?

Prof. Willmott: We have a book that we have edited, *Health Law in Australia*, that has a chapter on abortion which is a comparative analysis of the law in the various jurisdictions in Australia.

Mr JANETZKI: We have had some discussion here about the interaction of the two bills with the code. If you were to wipe the slate clean, in your opinion what is the best practice law in a jurisdiction of which you are aware? I am happy for you to take it on notice.

Prof. Willmott: I think the Victorian legislation is a reasonably good model, and I think there are some aspects of the ACT legislation which are worth considering as well.

Mr JANETZKI: Internationally any thoughts?

Prof. Willmott: That would have to be on notice. Actually, Canada has an interesting regime where it is not regulated. It is just considered to be a health matter.

CHAIR: Professor White and Professor Willmott, thank you for appearing before the committee again, for your second submission and for being flexible in staying late. The time allocated for this public hearing has expired. If members require further information from witnesses, we will contact you. If any questions on notice have been taken, the secretariat will contact witnesses to confirm the question taken and when the response is due. I now declare the hearing closed.

Committee adjourned at 4.52 pm