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 JP Kelly MP
Mrs T Smith MP

Staff present:

Ms S Cawcutt (Research Director)
Mr J Gilchrist (Principal Research Officer)

PUBLIC HEARING—INQUIRY INTO THE ABORTION LAW REFORM (WOMAN'S RIGHT TO CHOOSE) AMENDMENT BILL 2016 AND INQUIRY INTO LAWS GOVERNING TERMINATION OF PREGNANCY IN QUEENSLAND

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 4 AUGUST 2016

Brisbane

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Committee met at 9.01 am

CHAIR: Good morning, ladies and gentlemen. Before we start could I request that mobile phones be turned off or switched to silent. I now declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's inquiry into the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and the inquiry into laws governing termination of pregnancy open.

I would like to acknowledge the traditional owners of the land upon which we are meeting this morning and pay my respects 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 member for Caloundra; Mr Joe Kelly, member for Greenslopes; Mr Sid Cramp, member for Gaven; Mr Aaron Harper, member for Thuringowa; and Mrs Tarnya Smith, member for Mount Ommaney.

I welcome witnesses and members of the public and thank you for your interest in the committee's inquiry. The purpose of this public hearing is to hear from invited witnesses about matters in the committee's terms of reference which includes examination of the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 introduced by the independent member for Cairns, Mr Rob Pyne, and consideration of aspects of the law governing termination of pregnancy in Queensland in accordance with the terms of reference provided to the committee by the parliament. Copies of the terms of reference are available from staff.

A few procedural matters before we start: the 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 witnesses that intentionally misleading the committee is a serious offence. Witnesses have previously been provided with a copy of the instructions to committees regarding witnesses from the standing orders and we will take those as read. Hansard will record the proceedings and witnesses will be provided with a copy of the transcript. This hearing is also being broadcast on the parliament website. I remind all those in attendance today that these proceedings are similar to parliament to the extent that the public cannot participate. Please also note that this is a public hearing and you may be filmed or photographed. Can I also remind witnesses to please speak into the microphone. As witnesses have been advised, the committee has read your submissions. This morning the committee is hearing from obstetricians and gynaecologists who have additional qualifications in the sub-specialty of maternal foetal medicine. Can I take this opportunity to welcome you, Dr Carol Portmann, and thank you for coming today. Would you like to make an opening statement of up to five minutes before we ask questions?

PORTMANN, Dr Carol, Obstetrician, Gynaecologist, Maternal Foetal Medicine Specialist

Dr Portmann: Thank you. I am a maternal foetal medicine specialist and have been since about 2004 and working in the Queensland system since 2000, in public up until about 2013 and privately since then. While most of my work is in the identification of high-risk pregnancies and care for women in those areas, a significant aspect of what we do is counselling women about pregnancy options when either the pregnancy is of serious risk to their medical wellbeing or the baby has a significant abnormality. That has been something that I have been assisting women with, as I said, since about 2000.

I moved over into the private sector because of, essentially, frustrations with the public system in the provision of service for termination of pregnancy and the difficulty created by the layers of bureaucracy in trying to manage how to arrange or, I guess, acknowledge the lawfulness of a termination of pregnancy. I think that one of the greatest frustrations that I had was how we had to write things and what we had to get people to say so that they met the lawful requirement, because a foetal abnormality in and of itself is not part of the legal requirements. It is all about the mother's

response to that. In some cases a mother makes a decision based on the information they have been given, it is quite a rational decision, but they are not going to be seriously psychologically affected by the continuing of the pregnancy, their loss is a loss whether it is 20 weeks or 40 weeks, but they just felt that it was more appropriate to deliver early rather than later, but we then have to go through a process of trying to find a psychosocial or medical reason to support that person's decision rather than just saying she is making an appropriate decision for herself.

I think that is pretty much all I want to say. From the other perspective, my biggest reason for wanting to support the removal of termination of pregnancy from the Criminal Code is that in all ways this is really more about a decision that a mother makes with her family supports and the doctor based on the information that the doctor provides and the information she provides to the doctor. I do not feel that the law is actually helpful in any of that process other than in limiting the way in which we discuss things and increasing the procedures that have to be gone through by that woman to prove lawfulness.

I do not believe that decriminalising is going to suddenly increase the number of people having terminations of pregnancy, because people will attempt to find a way to terminate a pregnancy if they feel it is necessary. What I believe decriminalising will do is allow women in those very marginal areas, those who are in very rural and remote areas, those people who are financially distressed with significant social issues, which may include domestic violence and drug issues, to actually be able to attend services that will support their other issues, not just their request for termination of pregnancy. I think we will get better counselling and more support for women if we can decriminalise and open up the procedure and the process to the medical profession and the allied health professions rather than having it hampered by the law and people's concerns about whether something is legal or not.

CHAIR: Thank you, Dr Portmann. In regard to your submission, the statement there is that in Queensland pregnancies ending in termination represent about 15 per cent of pregnancies. What is that statistic based on? Where have you drawn that from?

Dr Portmann: It is basically drawn on the numbers of live births, the numbers of predicted likely abnormal pregnancies and the numbers of procedures that go through private clinics. It does not include things that are difficult to record, for instance, spontaneous pregnancy losses, day 1 pregnancies all the way up to birth, it is very difficult to track those numbers. It is really a combination of the live birth, still birth rates and terminations of pregnancy in public and private systems and I have drawn a rough conclusion from that.

CHAIR: Following on from that, you make a statement that the private sector is unable to provide the counselling and social supports these women need and you referenced that in your opening statement. I am very interested in this debate between the public sector and the private sector and the South Australian model versus other models. Can you comment on that? Obviously you would be aware of the South Australian model where they do not have private providers. I would be interested in your thoughts.

Dr Portmann: I think one of the main things is that there is quite a divide in Queensland. If a person has a psychosocial, as we call it, indication—it is mostly to do with they are very young with no supports, little in the way of financial resources, they may be studying and away from their partner, they don't have supports—and they choose a termination of pregnancy, they will go to the private sector because they do not have enough grounds to seek help publicly. Sometimes we may see women with certain medical disorders because again when they seek help from a doctor it is felt that they do not meet the medical requirements to go and have treatment in the public system. It is quite a divide. If you have serious medical problems and a foetal abnormality the public system cares for it. Anything else it tends to be the private system.

CHAIR: Just to clarify, what I was more asking about was that there is real debate about whether a woman's interests are better served, if she was seeking termination, being able to access public services rather than private services where some have said it is profit based and there is a concern about motive. I was more interested in what you think in that regard. There are others who would debate that it is the state's responsibility to provide all services in a public hospital and how would the public feel about that. I am interested in your thoughts more about that.

Dr Portmann: I think the private sector can provide some counselling. Through Children by Choice and through the private clinics they have their own counselling services so there are individual counselling services as needed, but some women do not necessarily feel they need to have intensive counselling. What is not available privately are things such as more direct assistance for women with domestic violence issues, drug issues and certain medical conditions and ongoing psychiatric care after a termination of pregnancy. That is difficult in the private sector because ongoing care is difficult

in the private sector. I do believe that the public sector can provide that in a much better way. Whether that actually means a person may change their mind because they are now getting the support that they needed for the pregnancy, that may assist.

What do I think of the profit based issue, meaning that people who seek care in the private sector are being forced into something, I would say I disagree. I do believe that we carefully speak to women in the private sector and certainly the providers, the doctors, are not the people who own the company as such and so from our perspective it is all about women's care. We just cannot do everything for them in the private sector.

CHAIR: Dr Portmann, if you are supporting the private member's bill that the committee is currently considering, if you were to take the hypothetical of, say, that that is the new legislative environment within which terminations are occurring, what do you feel is the best balance between services that are provided publicly and termination services that are provided privately and how those two intersect? How do you feel that that would best work?

Dr Portmann: I think that both systems are going to stay in place. What I think should happen is that there will be a bit of a shift. We will probably still see about three quarters of the people coming through the private sector, because they don't need a lot of that extra support, but there is a 20 to 25 per cent group that I believe would be better served in the public system and those are particularly those in vulnerable social circumstances or with additional medical problems or psychiatric conditions. I would like to see that shifted to the public system. I think we are going to have to make some kind of a system and that Queensland Health will need to make a process so that hospitals and doctors are supported to provide that service.

CHAIR: A final question so I can let my colleagues ask some questions: if the 20 to 25 per cent that you mentioned in those vulnerable circumstances should be able to have access through the public system, what does that therefore mean? The 75 to 80 per cent of the remaining cohort are not vulnerable? You make the comment that there is no opportunity to provide the support services and care that vulnerable and marginalised women desperately need. Of the woman that you are seeing, what cohort of the total number of women who are seeking to access termination services represent that group and what represents women coming with many other complex desires and reasons for termination?

Dr Portmann: It is an about a fifty-fifty split, but within that 50 per cent of people who are in moderately vulnerable situations I think some of those are just not going to go through a public process because no matter how well we streamline things it is going to be a bit slower for them. Many of them just really want to be in and out. We are still going to see some people where we think it may be better or we can refer them afterwards onwards. They are not going to go through a streamlined public system. They just want to go through an anonymous private system. That is why I think it is more likely to be one in five rather than one in three, say. There are certainly a group of people, whom I do not believe are significantly vulnerable, who have made an appropriate decision for themselves and can appropriately go through a private system and not require additional supports.

Mr McARDLE: Dr Portmann, thank you for coming and for your submission. I want to drill down a bit further with regard to your comments to the chair looking at South Australia and the model they have there. The public system is a provider of termination services. You made the comment that it will be slower in the public system. South Australia seems to get around that, as I understand it. Are there other issues in the state system here in Queensland that are of concern to you that would not allow greater access by more women to termination services? Is it red tape, is it bureaucracy or other concerns that may be you have not told us about at this point in time?

Dr Portmann: Yes, I am thinking in the immediate decade. There is a health culture essentially in Queensland. I think we are going to find it difficult to find providers in the public sector—that is, providers both medical and nursing as well as administration—who would be happy to be involved on a regular basis. I think that is going to be the greatest delay in a streamlined provision of care.

Once we get that cultural shift moved over to where it is seen as part of medical care then I would suspect that we would be able to have a system like South Australia where it is considered part of routine medical care. I believe that that is going to take time and a significant cultural shift.

We also have a wider spread population and smaller hospitals with a lot of GP practices and hospitals that will not have the supports to be able to have a regular clinic. We are going to have to pick where and when people should be able to go. That also then delays care for people because they still have to think about transport and organisation.

Mr McARDLE: Would you agree that societal attitudes in Queensland in relation to the public health system providing termination services is a cultural hurdle to overcome?

Dr Portmann: Yes.

Mr McARDLE: You would argue that decriminalisation would start alleviating that concern and as time went by and generations moved forward that would diminish the concern and allow more terminations to occur because it would be more accepted in our Queensland society?

Dr Portmann: That is my belief. I think decriminalisation would be the first step because it removes that concept of illegality, unlawfulness, potential criminal charges and those sorts of things.

Mr McARDLE: The evidence we have heard in the committee from many people is that the woman who comes to a clinic for a termination is not aware of the Criminal Code existing. They have no knowledge it exists. One question I posed to a provider was how many women post being advised of the Criminal Code existing then walked away? We were told none. Is it the case then that it is more the medical profession who are concerned about the issue of the Criminal Code because—and my colleagues can pull me up here if I am wrong—it does not appear to be a general concept within the public arena?

Dr Portmann: I would say that that is true. We have had a few more questions since the discussion has arisen where some of our clients have been asking, 'Are you sure I will not be arrested for this?' I would say before that that people are not all that aware. Because the clinics exist people feel like they are protected by the fact that if a clinic exists it must be okay.

I agree that mostly it is medical but then it is the doctors' and the medical systems' response to society's opinion too. We are concerned that if members of the public find out that terminations of pregnancy might be occurring here or there that they will be reported and that might result in criminal action. It is still a societal thing affecting medical care.

Mr McARDLE: We have also been advised that in any jurisdiction in this nation there is always confusion with regard to the law concerning termination so Queensland is not unique in that. Whether you are in Victoria or South Australia they are quite distinct regimes to us and to each other. There is still confusion within the medical field as to what the law is. Would you agree with that?

Dr Portmann: Absolutely.

Mr KELLY: Thank for appearing before us, Dr Portmann. In one section of your submission you describe something as a sympathetic public hospital. What determines if a public hospital is sympathetic?

Dr Portmann: Obstetricians who are willing to see a patient to begin with and enough obstetricians to sign-off and perform a termination of pregnancy is a sympathetic hospital. It also requires medical administration. In general an obstetrician will see a patient, a second obstetrician will support that, but then it goes to the hospital administration that also needs to support the decision. You do need those levels of support. You also need to have nursing staff and, if it is occurring in theatre, you need anaesthetists and nursing staff or midwives who are all supportive of providing that service. If you do not have all of that then you will not have a hospital that will readily provide that type of care.

Mr KELLY: I note your comments in your submission around conscientious objection. Regardless of whether a legislature goes down that path or not, conscientious objection in my mind, as a nurse, places obligations on a clinician at the interface directly with the patient. What you are describing there could be an administrator, a medical officer or a nursing officer who never has direct contact with patients—never provides one-on-one contact with patients—that sets the culture of the place without ever having to declare that the reason they are driving that culture is because of their conscientious objection.

If we are saying, based on what you have said this morning, that we might see a 25 per cent increase in people being serviced in the public sector—which, to my mind, I could roughly say means a 25 per cent unmet need currently, which is disturbing—if we remove these sections from the Criminal Code do we need regulation or legislation or government policy to compel and deal with the access issues in the public sector?

Dr Portmann: At that point Queensland Health will need to step forward and create a system that will allow people to seek access. If individual hospitals are unable to provide that due to the conscientious objection of the obstetrician or some of the medical staff then that person is supported financially to go to the private sector but we should also have in place the social work and psychiatric care as needed. I do believe that that is going to have to happen. Something will need to be done so

that we do not just wipe out one aspect of this and leave the rest of the system as is. We are going to need to put something in place to ensure that if there is conscientious objection that stops an entire hospital from providing a service that an additional mechanism of referral to an appropriate place can be done, and can be done with minimal delay.

Mr KELLY: In your opinion would the very significant discrepancy in the numbers of terminations that are performed in the public and private sector be somewhat explained by the lack of sympathetic public hospitals in Queensland at the present time?

Dr Portmann: It is some of that. The hospitals are also quite geared up to a really different way of looking at things and provision of care for high-risk pregnancy et cetera. They are already dealing with a lot of work. These sorts of things do take a bit of time to put into place. If not done appropriately, it could potentially quite overload a system. It does need to be looked at to make sure that the individual hospitals are able to provide the service without that service diminishing another area of appropriate care.

Mr KELLY: The issue that has been cited often as sparking the need for this reform process was the case of the young couple in Cairns. In that case my understanding is that the male obtained medications via the internet and dispensed them to his partner. If these medications were not for abortion, let us say he read somewhere that Warfarin might help you to avoid a DVT on a long-haul flight and he got some of it and gave it out, would that be a breach of the Criminal Code or any other legislation that governs the importing, distributing, prescribing and dispensing of medications?

Dr Portmann: I do not really know what the answer to that question is. We are always concerned however when someone is importing a medication that we at least now have the TGA approval of and we consider to be a medication that a doctor should prescribe. I think Mifepristone is quite a safe drug for someone who is not pregnant. If you are giving it to someone who is pregnant you need to know how far along they are and whether it is an ectopic. It needs to be kept within the medical field in that respect. Telehealth, as is being set up in Australia, has very strict guidelines. I think the idea of someone being able to access this without any medical approval is inappropriate for their wellbeing.

Mr KELLY: In that case, if we remove these three sections of the Criminal Code, which were the sections that were relied on to charge and attempt to prosecute this young couple, in future if we had people turning to this unsafe practice of abortion, which they are probably doing due to difficult circumstances or a lack of access, would it be fair to say that that may still be in a situation where people would face some sort of penalty or prosecution for behaving in that way?

Dr Portmann: I do not know that I have the legal background to be able to answer that question. I think it would be like anything else. If you decided you were going to peddle Panadeine Forte because someone has pain and they could not get a script you would be found to be handling drugs that you do not have the right to prescribe. I presume that there would be some criminal action in those sorts of scenarios, yes.

Mr KELLY: I guess my concern is that we are removing these sections to offer some relief in that situation yet it will not fully deal with that situation. I just want to ask some other questions closer to your area of speciality. With regard to the decision to terminate a foetus that is diagnosed with Down syndrome or spina bifida, how is the woman assisted to reach a point of informed consent if they choose termination and how would you respond to some of the anecdotal claims we have received, I think via submission, of women and couples being pressured to terminate foetuses with these diagnoses?

Dr Portmann: Obviously it is very hard for me to speak for everyone. In general when we talk to women about a diagnosis of something like Down syndrome or spina bifida, we do try to provide them with information about what that means for the long-term wellbeing of the baby depending on the findings that we have—is there a heart problem; how high a lesion is the spina bifida; what are the expected outcomes in terms of disability et cetera? Where possible, we offer them referral to either genetic services or neurosurgeons or disability services. We ask them if they would like to speak to any of the public groups that are available for Down syndrome and spina bifida. We cannot force them to do that though.

Some people will decline wanting to speak to those people and feel that they undertook testing, for instance, for Down syndrome with the knowledge of what it already was. If someone declines further counselling then you cannot force them to have that further counselling, but I do believe that we provide that information. I like to think that we are non-directive, but I also will acknowledge that the way some doctors present things may sound more directive than perhaps they are meant to be and some people will only hear certain things. My normal way of speaking to a person is by saying,

'In these circumstances some people might want to think about termination of pregnancy. Do you want to talk about that?' The only thing that some people will hear is 'termination' and they will make a presumption that you are forcing that on them or that that was the only option that you talked about. We also cannot control for those sorts of things.

In some circumstances when we have a particularly sick looking baby then we may say, 'Really I think it is in your best interest to think about termination of pregnancy because your baby is very sick and is very unlikely to survive.' Again, you may appear to be pushing more, but I do not think anyone just sits there and says, 'Here you go. Here is your referral for a termination.'

Mrs SMITH: I wanted to focus on your submission where you say, 'Removal of abortion from the criminal code is unlikely to result in an increase in late termination of pregnancy.' I was only made aware recently that there were reports in 2010 after Victoria had decriminalised their laws that at the Royal Women's Hospital in Melbourne late-term abortions performed had risen six times, from one a fortnight to three a week. What would stop that happening in Queensland?

Dr Portmann: I think at that point it is really quite important to define whether the termination of pregnancy late is 20 weeks or 24 weeks and is it foetal or psychosocial as well? It may be that the reason there was an increase in late termination—I am going to use over 24 weeks—is that people are now aware that they could have a termination of pregnancy for a baby with an abnormality at a later stage which they or their doctors may not have been aware was a possibility before that, whereas here in Queensland we have had a system in place for a while now for the management of babies with problems over 24 weeks. I think there is reasonable information out there about that. I do not see that we can have a sudden increase. We may have a small increase in numbers of people where babies are diagnosed late for various reasons. We are going to see an increase in some foetal abnormalities because of new technology increasing our ability to diagnose things early, but that is a medical thing. I do not think it is going to have anything to do with decriminalisation.

From the aspect of psychosocial, I think what we are going to find is that, while there may be a slight shift in considering termination of pregnancy for psychosocial reasons for up to 24 weeks, I still think that we are going to find that our doctors are going to be uncomfortable providing that for over 24 weekers. Once you get to a viable stage then we would generally say, 'I'm sorry. I don't think we can provide that for you because this is a stage at which a child can now survive.' If you have a very, very significant psychiatric disorder and your psychiatrist is particularly worried, then that may come into play and it may modify some decisions. I do not think our doctors are going to be comfortable doing that much over 24 weeks unless it is a foetal abnormality or a serious medical thing like severe pre-eclampsia or something like that.

Mrs SMITH: At 20 weeks the baby is formed. Medical advances have been incredible in the last five to 10 years even. A lot of babies at 24 weeks are now surviving with neonatal expertise. In Queensland, if a baby is stillborn at 400 grams, there are death certificates and birth certificates. That can also happen at around 20 weeks. My question is in regard to community expectations, staying on this topic of gestation periods and late-term abortions. In the bill put forward by the member for Cairns, there are absolutely no comments around that. There are no safeguards suggested or recommended in his bill. It is purely about removing all abortion related issues from the Criminal Code. What are your thoughts in regard to the community expectations given the number of submissions and the number of presenters we have had where an abortion still does not sit comfortably with them when the baby is formed and viable from 20 weeks on?

Dr Portmann: A baby is not viable from 20 weeks. It is viable possibly with very intensive care from 23½ weeks, with a very high likelihood of disability. With incredible intensive care, it may be fifty-fifty at 24 weeks. People use the word NICU all the time. If you are an adult in an intensive care unit for four months, that is a dramatic thing, but we seem to treat NICU as just part of normal life now for a baby. We do need to keep in mind that this is not a simple process for a 24 weeker. Moving on from that question, the current law does not actually have gestation in it either. Nothing prevents anything now except us as doctors making choices about when we think it is appropriate to provide that care. There still remains I think the child homicide or infanticide law which means that, if you do anything deliberately to cause harm to a baby that could be born alive, you still can be charged. There is still something in the Criminal Code where if we think the conduct of the person results in a baby's death before birth that person can still be charged. It is not like everything is being removed from the system.

Again, every pregnancy over 24 weeks that will go through for termination of pregnancy is in the public system. That is not happening in the private system. It is already being governed by the internal rules of Queensland Health. There is a statewide guideline about it. We have our own internal oversight for that. I think we are quite capable—and we have shown it—of caring for these women.

We are not seeing people, as far as I am aware, turning up on the doorstep with a foetal death from a foeticide for a psychosocial reason at 28 weeks. We are not doing that now. I do not see that that is going to happen just because abortion is decriminalised. Doctors just will not do that.

Mr HARPER: Thank you, Dr Portmann, for your opinions. You certainly have some experience in this space looking at your submission. Section 313 I think, from your submission, is the part you wanted to retain, following on from that last question. We have heard both sides of the argument. I think it comes down to this now. In your opinion, should we follow the bill as it stands by simply decriminalising or do you believe there should be regulation around things like gestational periods, counselling and conscientious objection similar to the Victorian model?

Dr Portmann: I think that that regulation should occur within the health system rather than the legal system. My main concern about having gestational age cut-offs for certain things is that someone at 23 weeks and six days may suddenly feel very, very pressured to make a decision that they may not make if they were given more time, and they are pressured to make that decision because they have one day to make it. I am quite concerned that once you start putting limits on things people may be forced to make a quick decision that, given some time and knowing that they still have that option, they could think about it a bit more and decide, 'Actually I don't want to go ahead with this,' or 'I have really thought about it and I think it is appropriate.' That is one of my concerns about the criminal aspects of the legislation in that regard.

You cannot really cover for all eventualities. It is almost impossible to take into account everyone's individual circumstances and why this particular diagnosis was late or their particular circumstances for why they needed to delay something. I think that having rules set up within the health system where we can govern those—I believe that there are good systems in place. Doctors and nurses are likely to put forward if they are quite concerned about a process whether it be a doctor or a hospital system, particularly in this area. I think they are very likely to put forward if they are concerned and then Queensland Health can have a look at that, investigate and see if they think it was an appropriate concern or not.

Mr HARPER: In summary, you are saying remove it from the Criminal Code but have legislation under the Health Act to manage—

Dr Portmann: That is right. I also just feel a little uncomfortable with conscientious objection in the legal system. I am uncomfortable that a doctor may feel legally obliged to do something they are not comfortable with. I am just as uncomfortable that they are legally protected, but I strongly feel that they should not be pushed to do something that they are uncomfortable doing. I think having a referral pattern in place as part of a process through the health system is a better way to go.

Mr CRAMP: In your opening comments, you made the statement that in the public system there needs to be a process to support doctors if this legislation were to go through. Can you expand on what you mean by a support system for the doctors in this process?

Dr Portmann: One of the problems at the moment is that you have a select few individuals providing a service. If numbers were potentially to increase, you may see that those doctors are going to be overloaded, and that becomes a significant aspect of their practice which can have further implications on the other work that they do, as well as mental health implications for them. I think from that perspective the individual doctors need support, but what I meant was that we need to have a system in place where it does not fall on a couple of doctors or a couple of hospitals but where, once we streamline things, we have something in place where doctors can provide care for their patient locally, the patient can stay locally, they are supported through their hospital as providing an appropriate service and they are not marginalised by the local system because of the choices that they make.

Mr CRAMP: In regards to conscientious objection, you said there may be cases where an individual or a number of people in the public hospital system—I take it you meant the public hospital system—may influence the general opinion or practice of the hospital in regard to abortion especially. What about cases like the Mater public where it is clear that they are not going to offer abortion in this state? You stated that if a patient attends a hospital that has this practice they would not support a person receiving an abortion and that person should be financially supported to move to the private system. What are your thoughts on places like the Mater which is clearly not going to offer it as a public hospital? Does a person who goes in there knowing that it does not provide that service have access to financial support to be moved? Take the Brisbane Mater public. It is in amongst several other public hospitals. Should they have access to the private system if they want to use the Mater but they know the Mater will not offer those services?

Dr Portmann: I would like to think they should but they do not. Having said that, neither does anyone attending any public hospital where they are turned down by that public hospital, or not even turned down but not let in through the front door. They do not get financially supported. I acknowledge that, if we move on from where we are now, I think the Mater will have to have some kind of system in place for the people in their catchment area. Once upon a time, years back in the early 2000s, most of these clients went across the river to the next public hospital, but since budget restrictions mean that people stay within the hospital of catchment it made things much harder for them. That has had a significant impact. They now have to go back to their GP and the GP has to find somewhere for them to go.

Mr CRAMP: My history is ambulance communications and logistics. I am very aware of how many public hospitals there are in the Brisbane area within easy reach of anyone who is seeking to go to the Mater. You are saying that perhaps it is a regulatory issue. We need to ensure that for this particular issue, which is obviously a significant issue, which is why we are here speaking about it, regulations would need to be in place so that people in the Mater catchment have the ability to go to an adjacent public hospital. My fear is that if a nearby public hospital is offering that service I would want to see people utilise the public system rather than the government paying for it in the private system. Would that be a reasonable approach to that situation?

Dr Portmann: Yes, although I can tell you that the public hospital that would accept the patient would be wanting to say, 'And the money with it, please.' You would have to have an appropriate transfer of budget or an increase in the budget for the hospitals that are likely to accept them to compensate for an increase in workload or a transfer of workload.

Mr CRAMP: You have highlighted a significant issue. Thank you for that.

CHAIR: I appreciate that we are over time and that Dr Gardener and Professor Ellwood are sitting behind you. I have two final supplementary questions and I know the deputy chair has one also. It is such a good opportunity while we have the three of you here to ask these final questions. In your submission and the line of questioning that is being pursued here around late-term terminations, the questions and focus on this is disproportionate to the number. I certainly see that that has come through very strongly. It is a very small number but it is proportionate I think in regard to the community sentiment and emotion which I think everyone also appreciates about this particular issue. You are talking about the ethical and regulatory guidelines. I am not a medical or health practitioner like my colleague the member for Greenslopes. I have seen the public health guidelines that you spoke of and found them very clear, but as a practitioner in the private system if the private member's bill were to be enacted what are those guidelines? If a woman came in at 25 weeks and said, 'I would like to seek a termination,' and there are no foetal abnormalities, what do you look at as a practitioner?

Dr Portmann: There are two different kinds of private in a way. The private clinics that operate, such as Marie Stopes and the old Planned Parenthood, are only registered or credentialed up to 20 weeks. That is a Queensland Health private hospital regulatory decision. That is all they can go up to.

CHAIR: So the bill would not address that—

Dr Portmann: That is already there and that is not going to change. The other aspect is level of experience. If you are talking about a surgical procedure, there are two of us who provide surgical procedures in Queensland up to 20 weeks and that is it—two. One of them is an old bloke and I do not think he will be here for too long. None of us are comfortable providing surgical abortion between 20 and 24 weeks because of a lack of skills—we would have to upskill—and also from my personal perspective a lack of wanting to do that.

That is not going to change. We are not going to suddenly see surgical termination of pregnancy up to that stage. In private hospitals, all of this would have to be an induction of labour because, again, you do not have doctors who can do surgical procedures up to that stage. That private hospital is going to have to agree that that is appropriate to do, so they are going to have their own systems in place. Again, I do not believe suddenly someone is going to turn up and arrange for a person to be induced and a nurse is not going to notice.

CHAIR: Is it fair to say that the law is stronger than guidelines and has a much stronger statement, though it is not necessarily always adhered to? If you look at Victoria, many people have called it the most Liberal state in this regard—I think the ACT and other jurisdictions have more open systems—but even they included a gestational limit. What do you put that down to in the legislation? What do you think fed that?

Dr Portmann: It may have been fed by a combination of community concern as well as probably doctors wanting to make sure they were not being obliged to do a late termination psychosocially and just have to sign it off. In some respects it may well have been the doctors saying, 'We do not want to have someone turning up and we feel obliged to provide something we are not comfortable with.' If we can put it into the law then we are a bit more protected. My perspective is that I still believe that we can do that as doctors ourselves and that we can clearly work with patients and say, 'We are not comfortable at this stage to do that for you in those circumstances.'

CHAIR: I have been very lucky and have a wonderful GP and a wonderful obstetrician and have tremendous respect for the judgements and the ethics of those practitioners. It is more in regard to the strong community sentiment and how we as parliamentarians who I do not think have the ability to simply take a clear position for or against—and some will—but I think it is balancing all those interests to make the public feel that the public interest has been served. I very much appreciate your thoughts in that regard.

My final question I have not personally had answered. I find it is a very emotive argument and it is one that is being used and I found it very uncomfortable. I am not a medical practitioner and I would like to have it clarified. In the final page of your statement you make the statement—

In the majority of circumstances in cases over 16 weeks gestation medication is given to the fetus to ensure it has passed away prior to the procedure.

A small number of stakeholders have disputed this and have used emotive and concerning words like inhumane and pain in the process. As a medical practitioner, could you please speak to that?

Dr Portmann: In terms of capacity to feel pain, we need to understand that pain is a concept of higher functioning and higher thought processes. The brain under 20 weeks is not capable of feeling something that can be considered to be pain. There are natural reflexes that babies will have, and we have certainly seen babies who have no brain who will move and kick and do things. Those are muscular reflexes. That is not the same as suggesting that they can feel pain.

The level of brain development would not suggest that a baby is capable of feeling pain. However, one of the reasons that we choose to perform what we call a foeticide over 16 weeks is because we still believe it is kinder to do that before doing a surgical procedure to ensure the baby has passed away before we do a procedure that is destructive to that baby. That is basically because we do not want any chance of pain. Even though we do not believe a foetus is likely to feel it, everyone feels more comfortable. Does everyone do that practice? I think a significant proportion of people do, but we are not talking about a large number of doctors or a large number of procedures anyway. There is only a few of us.

CHAIR: I appreciate you providing your expert opinion in that regard because, as you can imagine, with 1,500 submissions we have received troubling statements, claims and photos. I think it is important to factually understand what is occurring in that regard because it is one of the more difficult parts of the topic.

Mr McARDLE: Dr Portmann, I want to go back to the public health debate and where our public hospital system sits in this question. We agreed that culture in this state plays a part in what we do and do not do in the public health system. Would you agree that the policy of successive governments across Queensland has led to the public health system providing late-term abortions only when circumstances warrant it based upon our societal attitude in this state to abortion?

Dr Portmann: I think late-term abortion and the provision of it did not have much to do with government at all. It was basically through doctors who came forward and we started to identify foetal problems later and later. We were concerned that people might make decisions too early about a foetal abnormality before it has had a chance to evolve to show whether it was a real problem or not. The doctors came forward and said, 'We want to set up a system for late termination of pregnancy for foetal abnormality.' I do not think it was a government thing. It was more that doctors came forward and said, 'We are prepared to offer termination of pregnancy later for foetal abnormalities.' We created the limitations about the provision of service.

Mr McARDLE: Would it also be the case that the culture in this state has stopped successive governments using the public health system for first trimester terminations?

Dr Portmann: I think in that case it is mostly because women do not turn up to a hospital that early. They are not getting into a referral system quick enough. There is a significant delay in referral systems that has resulted in first trimester terminations of pregnancy not being something easily performed at a hospital. If you have serious medical problems, that is different because you need a

lot of input from a lot of doctors to work out what is safe for you, but there is no provision for a person to turn up at five weeks, get seen quickly, get counselled, receive medication and stay under the nine-week cut-off for a medical termination of pregnancy. There is no support for that within the system. Antenatal care does not work that way either. It is not part of the set-up of antenatal care.

Mr McARDLE: My final question is based upon objection of conscience or other grounds. There has been a debate about a doctor, or a nurse or a midwife who has an objection based upon conscience not to perform a termination or be involved in that process. There is also a requirement, at least in people's minds, that that doctor then has an obligation to refer to a doctor who does perform terminations. Is it as clear cut as that? For example, if a doctor does hold that belief that a termination should not occur because they do not believe in it, is it right for them to be obliged to refer to a doctor who does believe in terminations?

Dr Portmann: That is probably an area of ethics—

Mr McARDLE: Yes, I agree. You are a wise woman, doctor.

Dr Portmann:—that, by definition, is difficult. My personal feeling is yes, we do in every other aspect of our medical care. We all hold certain opinions about certain things. If someone came to you about gender dysphoria and you do not believe in it and you do not believe in those sorts of things, you should be obliged to refer that person on to someone who could give care. I do not understand why that would not hold in this particular circumstance.

Mr McARDLE: The balance here should fail in favour of the woman's right?

Dr Portmann: Yes, because you are here as a medical practitioner for that woman, not for yourself.

CHAIR: Dr Portmann, thank you very much for staying past the time allocated to answer all of our questions. Professor David Ellwood and Dr Glenn Gardener, would you like to come forward?

ELLWOOD, Professor David, Private capacity

GARDENER, Dr Glenn, Private capacity

CHAIR: Dr Portmann, you are welcome to stay obviously or leave the chamber. Dr Gardener and Professor Ellwood, thank you very much for coming before the committee today. Thank you for being very patient. I hope it has not placed you in a position where you have patients who are waiting for you. Would you like to collectively make an opening statement of up to five minutes or just yourself, Professor?

Prof. Ellwood: I will make an opening statement. Thank you for the invite. It might expedite things for me to say that there is very little of what Carol Portmann has said that I would disagree with. I probably have some minor differences of opinion about the conscientious objection question if you would like to explore that.

By way of background, I should say that I am not here representing Griffith University and neither is Dr Gardener, who actually has nothing to do with Griffith University, nor am I representing my hospital nor Queensland Health. We are speaking on behalf of ourselves plus a group of like-minded medical practitioners within the maternal foetal medicine subspecialty and also those who practise high-level obstetric ultrasound and provide foetal diagnostic services. It is really a collective view of a group of senior medical specialists within the state.

From a personal perspective, I have been a provider of termination of pregnancy services for over 30 years. I have also been involved in a number of different jurisdictions and have seen changes in laws around termination of pregnancy. I began my career in Australia, in New South Wales. I worked in the ACT for 18 years and was involved in helping to discuss and draft some of the legislation there regarding the termination of pregnancy and also provided advice to the group involved in drafting the legislation in Victoria when I was in the ACT. I have certainly had a significant involvement in this question over many, many years. In fact, going back to my medical student days, I was involved in the national abortion campaign in the UK in the 1970s. I think I can speak from a fairly wide experience.

In our submission we focused primarily on the question of termination of pregnancy for serious and/or lethal foetal abnormalities. That is really the area that we spend our time working with. Those of us who put our names to the submission are very strongly of the view that when a woman is faced with the devastating news that there is something seriously wrong with her baby that is likely to lead to a major disability or indeed lead to death of the foetus or of the newborn, the decisions around discontinuation of that pregnancy really should be between her and the treating team and particularly the doctors looking after her.

We did also make a strong statement that we believe the Victorian law got things right in terms of removing termination of pregnancy from the Criminal Code but also recognising community concerns around gestational age. I, again, agree with Carol Portmann's observations that at the moment within the legal framework within which we work in Queensland there is nothing about gestational age, although practices within the major public hospitals do differ below and above 20 weeks gestation and there are often gestational age cut-offs that are arbitrarily used by the committees that review requests for terminations of pregnancy. I do think it is a legitimate community concern—and this came out very strongly during the debate around abortion law reform in Victoria. It is a very difficult question about where should that line be drawn. Twenty-four weeks is often talked about as being the point of viability, but there are many babies born at 24 weeks that are non-viable for various reasons whether it is to do with foetal growth or the stage of development they are at. I have just returned from Japan where their borderlines of viability have dropped to 22 months. It is a very different style of practice in a different country.

I think any gestational age cut-off—the debate around viability or non-viability is arbitrary. I think if we draw a line it is really because of community expectations that there is a line drawn somewhere. That is really the reason why we are saying that we would support legislation that mirrored the Victorian approach to this. That is probably all I would like to say in my opening statement.

CHAIR: Dr Gardener, no further statements?

Dr Gardener: No. You may be wondering why I am here. I asked David if I could come along. My position as a maternal foetal medicine specialist is that I practise solely in the Mater. I thought if there were any questions that were relevant to wearing a Mater hat—and I would state very clearly when I am wearing a Mater hat and making a comment as opposed to making a comment that is a personal comment as a maternal foetal specialist.

CHAIR: Professor Ellwood, two countries and I think you mentioned four jurisdictions. What is it about this issue that you are obviously very clearly passionate about to have been so involved in campaigning in this regard from a young age?

Prof. Ellwood: I suppose I deal on a daily basis with women in crisis faced with the news that there is something unexpected and seriously wrong with the baby that they were hoping to have. I now do work exclusively in the maternal foetal medicine area. I have certainly worked in the past in the field of provision of termination of pregnancy services earlier in gestation when the reasons for requesting termination of pregnancy are essentially psychosocial, economic, domestic—a wide range of other issues. I do strongly support the principle of a woman's right to choose termination of pregnancy under those circumstances.

Within the maternal foetal medicine specialty, as I say, we deal with this question on a daily basis. I think it is managed incredibly well within our subspecialty from a very strong set of ethical principles. I do not believe that termination of pregnancy within the Criminal Code adds any value to the process. I think, in fact, it gets in the way of good medical care.

CHAIR: Professor Ellwood, when I had my 18 week scan or 19 week scan, as you routinely do—and I will own that I was very lucky obviously and I have two healthy children. Had I received a result of severe foetal abnormality I would assume that I was having that scan to understand that and then would have had options to follow on. I did not need to ask those questions. However, if that had occurred and there had been a significant foetal abnormality, what are my options then? You feel that the current law is placing impediments in the way of a woman having the opportunity to choose. What is the process for that woman then?

Prof. Ellwood: I think the first thing to say is it is very different depending on where you are in Queensland. It is very different depending on the access you have to different public hospitals and different providers. I work exclusively at one of Queensland's major tertiary hospital, the new Gold Coast University Hospital. In that environment we are required to go through the tortuous process of several levels of bureaucratic review and essentially creating a story that continuation of the pregnancy is likely to cause serious psychological harm to a woman when the reality is the decision is being made because the baby has a very severe and/or lethal foetal anomaly. This involves referrals to psychiatrists and persuading a committee of individuals that continuation of the pregnancy is going to cause serious harm to the woman.

CHAIR: As a woman who had a private obstetrician and had a strong trust of that obstetrician and could talk to him obviously about very personal things, as you need to, if I had indicated to him a very difficult emotional decision and I made that decision, he would then have had to have referred me to a psychiatrist?

Prof. Ellwood: I think it depends where you are.

CHAIR: In Brisbane. We are talking about Brisbane.

Prof. Ellwood: I think that practices within private hospitals are different from practices within public hospitals. Certainly the process that I am describing at my hospital I think is virtually the same as at Royal Brisbane and Women's Hospital.

CHAIR: You make that distinction because it is much harder? You are saying that the threshold is much higher in the public system as opposed to the private?

Prof. Ellwood: That is correct.

CHAIR: Dr Gardener, did you have anything you want to add to those comments? You deal obviously with women with complex foetal abnormalities. Are you seeing additional distress because of that threshold?

Dr Gardener: Sorry, could you clarify the question?

CHAIR: When you have a woman who is placed in that position, given that your specialty is around foetal abnormality, is having to go through that process because of the current legislative regime adding additional pain and difficulty to a woman who may seek a termination due to abnormalities?

Dr Gardener: I think it is the lack of clarity and access that creates additional trauma to women already in a traumatic situation. In our institution we do not provide termination of pregnancy, so women who make that difficult decision to go down that path then are really in a difficult position to access even a service that will consider it clearly. I think there have been changes over the years to make that better. During the 13 years that I have been working at the Mater we went through a process where some women seeking termination of pregnancy beyond 20 weeks actually travelled

interstate and that added an extra burden on top of their already existing problem. I think the layers of bureaucracy that are built to protect the hospital, the doctors and the patient against a crime create barriers for women to access medical care that in other states of the country would be deemed acceptable.

CHAIR: Thank you, both.

Prof. Ellwood: If I can add to that, it is the lack of clarity that is a significant problem. Just to pick up on something that you asked Carol Portmann, we often in the foetal diagnostic area go through a very long process. You talked about the 18 week ultrasound—and it may well start at that time and then there is a referral on to a subspecialist such as myself or Dr Gardener and further investigations. It may be several weeks before there is some clarity about exactly what the problem is and what the prognosis is, and that may involve counselling from several different other specialties in paediatrics, paediatric surgery—whatever the problem is. Then when the discussion begins around the possibility of termination of pregnancy, the first point is that this is actually a crime in Queensland and that there is a very significant amount of bureaucracy around this and several hurdles. In my institution we need to go through essentially three layers of approval. Women who have already spent weeks on this merry-go-round of investigations and uncertainty about what the outcome is going to be are then suddenly faced with this additional burden. I think that is inhumane.

CHAIR: Do you have an idea what percentage of terminations sought in Queensland fall into the area that you are both specialists in: foetal abnormality?

Prof. Ellwood: It is a difficult question to answer. We do not have very good data on that in Queensland. In relation to termination of pregnancy beyond 12 weeks of gestation for reasons of foetal anomaly—and really 12 weeks is about the earliest time that any diagnosis of foetal anomaly is made—the numbers within my own hospital would average less than one per week. We are probably talking about 30 or 40 cases a year in a hospital that has over 5,000 births a year. It is a relatively small number of the terminations of pregnancy. We have better data on the post 20-week terminations of pregnancy, although there is still no requirement for those reporting stillbirths or neonatal deaths beyond 20 weeks' gestation to specify that this is a termination of pregnancy. We do know that those numbers across Queensland post 20 weeks would be somewhere between 50 to 70 cases a year.

Mr McARDLE: Professor Ellwood, you raised a question about the objection point I raised with Dr Portmann and you made the comment that you had some different points of view on that. Can you elaborate on those points?

Prof. Ellwood: I respect anyone's right to be a conscientious objector, and that really goes beyond termination of pregnancy, but I also think that we need to design a health system to ensure that we can live together, those who conscientiously object and those who do not, and will not respect each other's views and work together. I think legislation that is punitive in relation to conscientious objectors is not particularly helpful. I would rather see us ensure that we have a health system designed to ensure that women can access the services that they require without requiring somebody who is a conscientious objector to do something that they are not comfortable with doing. I think it is possible to design a system like that.

Mr McARDLE: You would feel that, if a doctor or midwife or nurse does have an objection based on conscience or religious grounds, they should not be told they must refer to another practitioner, or is that going too far?

Prof. Ellwood: I think within the various codes of ethical conduct for medical practitioners and good medical practice there is a duty of care to inform somebody that they conscientiously object and to perhaps give them some indication about how they might access somebody who can help them. I think requiring somebody to refer for termination of pregnancy when they object to that is, I think, taking things too far.

Mr McARDLE: That would run against their own conscience, would it not, in essence?

Prof. Ellwood: Yes. I think it is possible to design a system that works very well without being punitive in that way.

Mr McARDLE: Professor Ellwood, you made the comment that the Criminal Code gets in the way of good medical care. Are you saying access to good medical care, or are you saying it prohibits those who are perhaps in DV situations or remote areas accessing medical care?

Prof. Ellwood: My reference was to the care that I want to provide to a woman and to the rest of her family when they are making a very difficult decision around termination of pregnancy—going back to what I said earlier about this journey they have already been going on for several days or

weeks of waiting for test results and hoping that things are all right and then finding out they are not all right—to then have to go through another period of time which might take a week or more and explaining to that woman that we need these different levels of approval I do not believe is providing good medical care. At a time you have reached the point where a decision is made, for most women what they want is to then move on to the next stage and have the procedure that they have requested. I think that the additional delay and the uncertainty of not knowing what the outcome of that process might be—I have certainly had the experience where hospital committees have taken a number of days to make a decision and requested additional information, requested additional counselling, an additional review—is incredibly burdensome for women in a very difficult and vulnerable situation.

Mr McARDLE: Is that occurring in Queensland at the moment?

Prof. Ellwood: Yes.

Mr McARDLE: This is the late-term abortion process?

Prof. Ellwood: Yes.

Mr McARDLE: Can you run through what does happen in a Queensland hospital to the best of your knowledge with regard to a woman who comes with a late-term abortion question? What is the procedure they have to go through to get the tick-off, shall we say, to terminate the foetus?

Prof. Ellwood: Generally in public hospitals the question only arises in relation to foetal abnormalities, so it is primarily a question to do with foetal diagnosis and a decision around the severity or lethality of the abnormality. I can describe the process at my own hospital where, if I have seen somebody and had the discussion around termination of pregnancy and the woman has requested that, beyond 20 weeks of gestation I will then get a second specialist to see her to make the same assessment that I have made that the continuation of the pregnancy is likely to cause significant harm to the woman. There is then a referral to the head of the department to convene what at my hospital is called an ethics committee. The ethics committee then considers the request. I will go to the committee to present the case and to discuss the reasons for requesting termination of pregnancy. There may be then a request from the committee for further information or for the woman to receive another assessment. It might be a psychiatric assessment or it might be a social work assessment. Then once the committee has made their decision that is then referred on to a senior medical administrator within the hospital to give the final approval.

Mr McARDLE: Professor Ellwood, if the Criminal Code provisions were removed how would that process change? In the circumstances you have just outlined to us I have taken your comments to mean that these are very serious medical questions about the status of the foetus we are talking about, so how would taking out sections 224, 225 and 226 alter that process?

Prof. Ellwood: I think there are two differences, and again if I refer back to my experience in the ACT. I worked for many years and in fact ran the department at the only public hospital provider of terminations of pregnancy in the ACT. Even though termination of pregnancy was removed from the Criminal Code in the ACT, the hospital retained the process that I am referring to of the ethics committee which would then review requests for late termination of pregnancy. The reason for retaining it was to ensure that there was some collective ownership of the decisions that were being made around termination of pregnancy and that the entire department was comfortable with the decisions that were being made.

There are two differences about the process: one was that there was clarity about what the law permitted, and at the moment there is a complete lack of clarity about what the burden of proof is that requires you to establish that continuation of the pregnancy will cause significant harm; the second difference was that it really was a collegial, collaborative process designed to ensure that the decision-making was appropriate and that there was collective ownership of the decision-making. It was also a process that was completed usually within a day or two, and certainly there was never the requirement to obtain a psychiatric opinion that the continuation of this pregnancy would cause significant psychological harm to a woman. It is a construction that we have to go through because of the current legal framework.

Mr McARDLE: Would you agree, though, that given the gestation period of the foetus, even if the sections in the Criminal Code were removed the issue of an assessment as to the mother's health and wellbeing psychiatrically would still be one of the yardsticks that may well be considered in determining whether to terminate the foetus?

Prof. Ellwood: There are certainly situations in relation to late termination of pregnancy where the indication is maternal mental health and it is not to do with foetal anomaly. Those cases are relatively uncommon, but certainly from time to time I do deal with cases such as that. We are in the speciality of maternal foetal medicine so we deal with maternal disease as well as foetal disease, but that is relatively uncommon.

Mr McARDLE: Would it be right to say, however, that given your speciality if the Criminal Code provisions were removed there would not be a significant difference in the process undertaken with regard to a public hospital—or a private hospital, for that matter—terminating a pregnancy because of the overwhelming concern that doctors have to ensure they get the diagnosis right and they get the outcome right? The hierarchy you have explained would still exist, would it not?

Prof. Ellwood: I do not think the process of review would necessarily change. In fact, in Victoria it has not changed. The Royal Women's Hospital still has a termination review panel. I think they do that for gestations above 24 weeks or above 22 weeks. I am not sure what their cut-off is; it might be 22 weeks. They have retained that process for the same reasons that I have outlined. The ethics review process in the ACT that we retained was essentially an advisory process. The authority to terminate the pregnancy rested with the medical specialist; it did not require a higher level of authority.

Mr HARPER: Thank you both for coming here today. If I can summarise, you are basically saying that we should be going down a similar route to Victoria, perhaps with some flexibility around the gestational period of 24 weeks?

Prof. Ellwood: Yes. My own personal belief is I would rather see termination of pregnancy removed from the Criminal Code without a gestational age cut-off. I think the pragmatic political decision to have not necessarily a gestational age cut-off, but some differentiation between below and above a certain gestational age that puts a higher level of review I think meets community expectations.

Mr HARPER: I am glad you mentioned the ethical review. There is a need for some regulation apart from this bill; is that what you are saying? Just being simply decriminalised, removing those sections, there is need for some regulation there?

Prof. Ellwood: I think virtually all jurisdictions have some process of review above 20 weeks' gestation. That happens in Western Australia, Victoria, New South Wales and it still happens in the ACT. I would agree with the point that Carol Portmann made. I think that can be part of a Queensland Health policy around how these services are provided. I do not think that needs to be part of legislation.

Mr HARPER: I do have some grave concerns because with modern technology, gender selection comes into this. This is where we perhaps need to have a discussion and get your thoughts on that. I have certainly read of cases where terminations have occurred because of the foetus simply being the wrong sex. What are your thoughts on that?

Prof. Ellwood: I personally find the whole question of gender selection abhorrent. I think it is possible with modern technology for somebody to request termination of pregnancy for reasons of gender selection without being open about the fact that is the reason why they are requesting it. It is possible to use non-invasive prenatal testing to determine the gender of the foetus and then seek termination apparently for other reasons, but certainly it is a practice that I would want to have no part of. I think how you actually regulate that is a difficult question.

Mrs SMITH: Thanks to both of you for coming in today. Professor Elwood, there were reports last year from Queensland Health that there were 27 live births that occurred through failed abortions or abortions that were not completed. I ask how in this day and age that can possibly happen; how can it go wrong?

Prof. Ellwood: If I understand the basis for your question, when a pregnancy is terminated at above 20 weeks of gestation, and 20 weeks or 400 grams is the cut-off for registration of a birth and a death in Queensland—I mean, there are some nuances around the law, but generally it is 20 weeks and 400 grams—a birth can either be classified as a stillbirth or as a neonatal death. The Queensland Health policy requires the practice of feticide to be discussed with parents above 22 weeks gestation, but not all women will accept that as part of the process and there is no requirement for them to accept that. Somebody may choose to terminate a pregnancy for what is essentially a lethal foetal abnormality such as anencephaly or trisomy 18 or trisomy 13 and choose not to have a feticide procedure done and following induction of labour that baby is very likely to be born alive. In fact, the legislation in Queensland says that really any sign of life means that that baby is classed not as a stillbirth but as a neonatal death.

I do not know all of the details of all of those 27 cases that you are referring to, but within the current Queensland Health policy there are many babies who will be born alive following induction of labour when the indication is that the baby has a lethal foetal anomaly. In the same way as babies born at 23 or 24 weeks who are not resuscitated will be born alive and classed as a neonatal death. It is not a failed termination of pregnancy, it is just the way that the process was carried out and the choices that that woman made.

Mrs SMITH: We have heard a lot of the health professionals talk about that this should fall into the health regulations, it should not be in the Criminal Code. Please do not think I am being provocative in putting this to you. Doctors at the end of the day are human and fallible and I guess there would be a couple of rogue doctors out there practising as we have seen over the years. By staying in the legal system does it not provide safeguards against those one or two doctors who are not following ethic beliefs or values? Over the years there has been that terminology that it is a bit of a boys' club and doctors would protect each other rather than expose poor practice. I am just putting that to you as a view of the community and that over the years there have been doctors who have lost their registration because they have not done the right thing by their patients and that is why I ask about having safeguards outside the health area.

Prof. Ellwood: Look, in any profession there will be rogues. I don't think we have a boys' club any more. Our specialty is very much a female specialty now—very much so. I think community expectations of the quality of the health services that we provide and the ethical basis on which medical practitioners work generally are extraordinarily high. I do not believe that you require to make a medical procedure a crime to protect the public from rogue practitioners. I think there are other ways to do that. We have a very strong medical regulatory system: mandatory reporting, a health complaints process and many, many other safeguards. I do not think it requires us to make a procedure which is performed many times every day in Queensland a crime when it is really a medical procedure.

Mrs SMITH: That is the next point: a lot of people who have put submissions in would say that this is not actually just a medical procedure because then there is the argument of when the foetus is actual life. There are a whole range of views out there, both from people who have submitted plus from the community. This is such a sensitive area. We have had this discussion with many doctors. When do the rights of the unborn kick in I guess would be a question I would ask you and therefore this is not a normal medical procedure. What are your comments on that?

Prof. Ellwood: I would say that Dr Gardener and myself probably spend an awful lot more of our time each day dealing with high-risk pregnancies where our intention is to provide whatever help we can to the woman and to the baby to ensure an optimal outcome for the pregnancy and that includes various types of foetal therapy. In fact, I am currently caring for a large number of women through pregnancy who have significant foetal anomalies where they have chosen not to terminate the pregnancy. My own personal views about when I would or would not want to terminate a pregnancy that was my own would just not really come into my own personal beliefs about this. I believe it is a woman's right to choose whether she continues her pregnancy and that is something that should be discussed with her doctor and not with a lawyer.

Mrs SMITH: Dr Gardener, you have been at the Mater for 13 years. Did you actually serve some time under Dr David Tudehope?

Dr Gardener: Yes, I did.

Mrs SMITH: Recently I understand you led the team at the Mater performing spinal surgery on a 24-week in utero baby.

Dr Gardener: Correct.

Mrs SMITH: That was the first in Australia?

Dr Gardener: That's right. You may not be aware, but the Mater is the biggest care provider for maternity services in the country and we are the largest maternal foetal medicine unit in the country as well, spending most of our time looking after women and their babies with diagnoses sometimes of lethal and nonlethal abnormalities. The Mater has a philosophy of providing alternatives to care in that regard and that is one example of potentially improving the outcome for babies with spina bifida, but there are many other procedures we do for the foetus, other surgical procedures, and sometimes we cannot change the course but we can provide important support during the pregnancy, the birth and then ongoing.

Having that alternative care path I think is very important to be maintained in the community, but it is not for everyone. Not all women will choose to continue the pregnancy. I personally feel strongly that women, after considering all their options, need a clear path to be able to follow with respect to their option of termination of pregnancy.

Mrs SMITH: In your role there in the last 13 years and obviously most recently, the medical advancements that have happened even in your time will obviously continue in the future with better technology and research that is happening. The goal at the end of the day is that we will be able to identify disabilities earlier and earlier through pregnancies. I have mentioned throughout the course of the inquiry that the Mater provides public health services but is not linked to Queensland Health. It is a very strong Catholic based hospital, still, I believe, run by the nuns and they have that fundamental Catholic position on termination. Equally you would have a number of colleagues who would not have the same views as yourself. I ask this in relation to the conscientious objector position: where the Mater sits, where it is fundamentally against their ethos, as we move forward and if these laws were to come in, is there not a potential that the hospital could end up being taken to court or have action taken against it? What are your views working in that environment and with your colleagues? How do you think that should be addressed or covered, the conscientious objection question?

Dr Gardener: Firstly, I would say that I do not think there is a particular mix of religious views in doctors who work at the Mater compared to other health institutions that I am aware of. Secondly, I would echo David's view that I think that the issues can be managed harmoniously in that the organisational level of conscientious objection is one thing and then there is the personal medical or midwifery or other health carer level of conscientious objection. The Mater's position has been very consistent, clear and stable. It has not changed. It has been a very, I think, safe system to work within over the years that I have been there. When we talk to women about the Mater's position they understand it. It is not ideal in some circumstances for women to have to leave our service and access care elsewhere when we have developed a trust and that care model. However, that is how it is and it is when they leave our service that the question of referral comes up and how that is managed. I think there is a very subtle but important difference between a referral for termination of pregnancy and a referral because we are unable to provide a service that a woman has requested. We feel a duty of care to provide any health information about that woman to whoever carer she may then access. I hope the panel recognise that difference.

I think that is different to being materially involved in referral for a particular procedure. The Mater performs many procedures that are not available anywhere else in Queensland. We receive referrals from Queensland Health facilities for foetal surgery that are not performed anywhere else. That referral does not insist that we perform the procedure. It is an assessment. We will decide if we perform that procedure. If a woman leaves our service with a view that she is seeking termination of pregnancy, whether that occurs or not is not the decision of the Mater, it is actually the decision between the woman and the service provider that takes over her care. I think that is an important distinction and one that personally sits comfortably with me and, I think, one that sits comfortably I know with the Mater because we want to make sure that whoever that woman then sees does not have a situation of information about her care not being provided, not being shared. It is very important that any aspects of her health are passed on in a normal referral sense such that whatever happens it is safe for her ongoing care.

Mrs SMITH: If I can just ask another question in regard to complications arising from terminations, how often does that occur and at what degree or severity are we looking at with either pre 20 weeks or post 20 weeks?

Prof. Ellwood: That is a big question, but I think it is important to say that late terminations of pregnancy, beyond the first trimester, are relatively uncommon. They are generally performed by very experienced providers. Virtually all of the post 20-week terminations of pregnancy would be in the major tertiary maternity hospitals such as the Gold Coast, Royal Brisbane and Townsville.

There are complications of any birth. I am not aware of any concern about complications of termination of pregnancy that would be an argument against performing the procedure. It would be very unusual to identify a situation where the termination of pregnancy itself carried any greater risk than the continuation of the pregnancy.

Mr KELLY: With regard to terminations where there is a foetus delivered with signs of life and, based on your statements earlier, a mother has made a decision to proceed in that manner and presuming that the foetus has a fatal foetal abnormality and will not survive for particularly long post delivery, is there research that suggests that it is beneficial for a mother and a father to have contact with a baby that has only a short time to live or no time to live in terms of assisting them to heal and move forward with their grieving process?

Prof. Ellwood: There is a lot of research around bereavement care for all forms of perinatal loss, whether it is stillbirth, neonatal death or loss from termination of pregnancy. If your question is what is the best approach to this I would have to say that I think that the evidence is conflicting. The approach that is generally taken is that for each women there is a lot of discussion in advance of the termination of pregnancy about what she would like to do and what she feels is appropriate. At my hospital we provide exactly the same level of bereavement care following termination of pregnancy as we do following stillbirth for any other reason.

For some women they choose to do all of the things that might be done following a stillbirth which might include naming the baby, obtaining hand and footprints, photographs—all sorts of ways of remembering the baby. We regularly hold non-denominational services within the hospital. They are open to women who have had perinatal loss for many reasons. Many women who have chosen to terminate pregnancies will come back to those services.

There is no one approach. It is very much discussed beforehand and planned with the woman and whatever she really wants to do. That is also respecting a whole range of different cultural approaches, whether they are Aboriginal or New Zealand Maori. There are all sorts of different approaches. We engage in whatever is required.

Mr KELLY: Would it be true to say, if we move to stillborn births, that the practices post birth in terms of allowing that attachment and bereavement process have changed quite significantly over the last 20, 30 or 40 years?

Prof. Ellwood: Yes, they have.

Mr KELLY: We have moved away from separating the child from the mother at birth very quickly to now allowing the mother and the father to form that attachment?

Prof. Ellwood: Completely, yes. It is not a requirement for women to. Using what are called the cold cots or cuddle cots babies will often stay with their parents for many days following stillbirth. For some couples the time that they choose is much shorter. We really work with the family to provide whatever they require.

Mr KELLY: Foetuses that are delivered showing signs of life are afforded palliative care for the period that those signs of life are existent, are they not?

Prof. Ellwood: I think it is important to go back to the legislation. Any sign of life essentially means the person observing the foetus believes they have seen a sign of life. It may be a single reflex muscle movement.

Mr KELLY: Who can that person be? Could it be a nurse assisting?

Prof. Ellwood: Whoever is there at the birth. It will be a midwife or a midwife and an obstetrician. It will varying depending on the gestational age. Even babies below 20 weeks will sometimes be born with a heartbeat following a short labour, but they will not live for very long. They will live for a very short period of time.

Occasionally a decision is made to end a pregnancy early in the knowledge that a baby has a lethal anomaly but the parents are requesting to be able to spend some time with their baby alive—take for example something like anencephaly or trisomy 18. I have certainly had cases within our hospital recently where we have perhaps ended pregnancy earlier than full term but much later than a termination of pregnancy might normally be performed because the family have requested to spend some time with their baby alive.

Mr KELLY: Dr Gardener it has been over 25 years since I have cared for somebody with spina bifida—and congratulations on that fine work—is it true to say that there is a very vast range of effects of spina bifida on people from very minor through to quite dramatic?

Dr Gardener: It is a complex anomaly. The type of spina bifida that we are talking about repairing in utero is the type that would generally lead to lifelong complex disability that involves problems with movement, problems with bladder and bowel function and sexual function, psychological and emotional effects and more.

Mr KELLY: I accept that this is the first time the surgery has been done, but it will become potentially and hopefully more common as we go forward. The decision about how to move forward in relation to that surgery is very much driven on an individual and case-by-case basis based on diagnosis et cetera, is that right?

Dr Gardener: Correct, yes, and with oversight from our US colleagues who are supporting us in this endeavour.

Mr KELLY: There has been comment made to this committee that how can we be in one room trying to save the life of a baby who has been delivered at 24 weeks and in another room performing a termination? Could you comment on that?

Prof. Ellwood: In terms of a baby born at 24 weeks gestation following preterm labour—whatever the circumstances are that have led to the birth of that baby—we absolutely have a duty of care to provide whatever care we can although there is a significant debate worldwide around what is reasonable practice around these borderlines of viability. Generally within Australia the practice is to consider that in that 23 to 25 week gestational age window it is an ongoing discussion between the parents and the neonatal team about whether ongoing care is appropriate. Certainly outcomes now for neonatal care at that gestational age are good enough for us to support that type of care.

Terminations of pregnancy at the same gestational age are almost always done because the baby has a very severe and/or lethal foetal abnormality. It is a very different outcome that you are looking at for the two babies. As you say, they may well be being cared for in the same institution and indeed by the same people but we are looking at very different outcomes.

Mr KELLY: You said that we should—and I may be paraphrasing your words incorrectly here—consider a gestational limit based on community expectation and concern—

Prof. Ellwood: The pragmatist in me recognises that there are community concerns and perhaps community expectations around some kind of gestational age difference in the legislation.

Mr KELLY: And the clinician in me recognises that absolutes in health care are usually fairly restrictive rather than helpful. Given that, how do we deal with the situation whereby we draw an arbitrary line and say before this you can do one thing and after that you cannot do another thing? As legislators how do we deal with the situation that a clinician may very well find them assisting a person after that arbitrary line and need other options?

Prof. Ellwood: I guess there are two ways to do this. There are certainly examples around the world where there is a gestation age limit to termination of pregnancy. Below that limit termination of pregnancy is possible and above that limit termination of pregnancy is not possible regardless of the reason.

In Victoria the way they chose to go was to have a different level of approval. Below 24 weeks gestation essentially the decision is made between the woman and her treating doctor. Above 24 weeks gestation it requires a second opinion from a medical specialist and both had to support that. What has happened within Victorian health policy is that they continue to have the termination review panels to look at the later terminations of pregnancy.

I am not a legal expert. Although I have provided medical advice to those drafting legislation around termination of pregnancy, I think there are a number of different ways of doing it. I think I said earlier that my personal belief is that any gestation age cut off is arbitrary, but the pragmatist in me says that I think that is probably the best way to go to achieve what I believe is correct which is the decriminalisation of abortion.

Mr KELLY: The final statement in your submission reads –

… we support introducing legislation in Queensland that mirrors the Victorian situation, and at the same time we call for removal of abortion from the Queensland Criminal Code …

Could you advise if this private member's bill does that—that is, removes this from the Criminal Code and mirrors the Victorian legislation?

Prof. Ellwood: Is your question: do I believe that the current private member's bill achieves that?

Mr KELLY: Does the private member's bill that we are being asked to consider both remove abortion from the Criminal Code and establish legislation that mirrors the Victorian abortion legislation?

Prof. Ellwood: My understanding is that it removes termination from the Criminal Code but it does not mirror the Victorian legislation.

Mr CRAMP: Dr Gardener, I would like to ask you a question first. I follow on from Dr Portmann's comments around the fact that if a woman is unable to be provided care under a new regulatory system she should potentially be provided funding to attend a private medical facility by the government. What currently happens if a woman in your catchment area comes in and you cannot offer her the services for whatever it may be—in this case, you do not offer a service for termination of her pregnancy? What currently happens with regard to her referral?

Dr Gardener: Usually there is a GP involved who has referred to us in the first instance. The GP, not in all cases, may actually have, being the primary carer, a better understanding of the woman's family circumstances and know more about her diagnosis of foetal abnormality than we do having had a short period of time involved with her case. We would usually discuss the situation with the GP. In the cases where the woman has elected to have a termination or has requested a termination, the GP would make inquiries about how she might access that service. That is not to say that not all GPs actually will be prepared to undertake that process because of conscientious objection.

The other pathway women may access termination is that, if we cannot provide care and there are complex problems, they may need care in a public facility such as the Royal Brisbane, Ipswich, Logan, other surrounding hospitals. I do not see it as necessary that if one hospital cannot provide a particular service they have to be farmed out to the private sector.

Mr CRAMP: No. That has been my experience in the ambulance service. We are easily able to facilitate that at another public hospital.

Dr Gardener: The process now is for that woman to access another hospital that can provide that service, but there is nothing that compels that hospital to provide that service. There are no guarantees of a woman accessing another hospital that is not our own and actually receiving that service. Again, I reiterate that it is similar to those patients who are referred to us for services. That is how it works.

Mr CRAMP: Thank you for that. I open this question to both of you. I have asked this question to several medical experts and doctors who have come before this hearing and also to some of the non-medical groups. Should information be given to a woman before she decides to seek termination or not to seek termination in that there has been a lot of commentary around misinformation from all sides of the argument and from experts as well? I have suggested that perhaps as a regulator the state government needs to consult with the medical fraternity and all parties and provide documentation similar to the ACT—we were provided with an example from the ACT—where a woman is provided mandatory information in book form, in booklet form or in some sort of documented form to at least assist and guide her. That would at least ensure that we, as a regulator, have provided women with some base information to start with and then they could move on to medical specialists perhaps.

Prof. Ellwood: I feel well equipped to answer that question having been involved in drafting the information that was provided in the ACT which goes back to the previous legal framework before termination of pregnancy was removed from the Criminal Code. That was when again, as a result of a private member's bill, there was a desire to mandate that that information was provided.

Again, I perhaps draw distinctions between two different types of termination of pregnancy. When women who are undergoing termination of pregnancy later in gestation for the diagnosis of a foetal abnormality are provided with a massive amount of information during the counselling process that would far exceed anything that would be contained within a pamphlet produced by Queensland Health. The documentation that was required to be given to women in the ACT was aimed primarily at early terminations of pregnancy, which are the great majority of terminations of pregnancy. Again, as a medical practitioner, I think that the correct ethical standpoint is that all information that is required for a woman to make her decision should be provided and should be provided in that consultation between her and her medical practitioner.

Mr CRAMP: Do you think you could guarantee that it always is?

Prof. Ellwood: I cannot guarantee that it is always provided. I am also not sure that you can provide that information in the form of a pamphlet. There are lots of examples. Our own college, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, provides a large amount of patient information sheets about an enormous array of procedures. Some of them are very useful and provide useful information, but I do not think it is any substitute for the discussion that really needs to go on between a woman and the medical practitioner that is providing the service.

Mr CRAMP: I would tend to agree. I know you and your colleagues would have some great specialisation and obviously very beneficial information to provide to patients. I am more looking at a base consistency as a starting point. If you have any further commentary around that, I would appreciate that.

Prof. Ellwood: Again, I think it is something that could be handled within—we have a very good system of statewide guidelines for most medical procedures in Queensland. We have patient information sheets about virtually everything that we do within hospitals. I think it could be provided within that framework rather than within the legislative framework.

Mr CRAMP: My colleague the member for Mount Ommaney spoke about the 27 live births that occurred last year. Dr Ellwood, your commentary was that you obviously did not know the details of the births, and that is a given. You made the comment that this would be down to the choices the woman made. Could it not be a procedural error that would have occurred or not occurred to allow these live births? Would it always be the woman's choice to just say, 'No, I don't want foeticide. I don't want a procedure to terminate the baby'? My lay understanding is that they were from incomplete or failed abortions. If it is a failed abortion, my expectation is that the doctor would have performed some sort of procedure to terminate the foetus before coming out. Would that not be correct? Could it be a procedural error?

Prof. Ellwood: No, I do not believe so. Again, I need to emphasise that the legislation in Queensland requires a birth to be registered as a neonatal death if anybody present at the birth believes they saw signs of life. It might be a heartbeat. It might be a gasp. It might be a reflex muscle movement. Babies who are born following whether it is a termination of pregnancy or, indeed, a miscarriage at 17 or 18 weeks in Queensland can be classified as having been born alive even though they are less than 20 weeks gestation. Again, I do not have the details of those 27 cases.

Mr CRAMP: I believe they were 20 weeks plus from my understanding from some of the documentation.

Prof. Ellwood: I know the source of the data. I chair the Queensland Maternal and Perinatal Quality Council and I have oversight of the perinatal data collection. I know that all cases that are registered within the perinatal data collection as perinatal deaths include sub-20 week cases. Queensland is different. It is a unique jurisdiction compared to the rest of Australia in that we do classify as perinatal deaths babies of those much earlier gestations. Without having the data in front of me of those 27 cases, I do not believe that they are failed terminations of pregnancy. They may well be terminations of pregnancy where foeticide was not performed either because they were less than 22 weeks gestation, which is the policy statement through Queensland Health, or because they were above 22 weeks and the woman chose not to have a foeticide procedure performed.

Mr CRAMP: My argument is not around the data. Be assured that I was not trying to drill down to ascertain what you knew about the data itself. The fact is that there are procedural errors in operations from time to time. We do require some form of regulatory framework in most cases to ensure that, whether it is done through negligence or otherwise, at least it can be investigated to ensure that all that could be done was done.

My concern in this case is that we are removing three sections of the Criminal Code to remove any form of illegality in this process. However, on the other side of it, and as my colleagues have previously questioned around this, there is a great concern that there does not seem to be anything on the other side. There is no regulation being put in to ensure the safety of the patients, to ensure doctors are performing the correct procedures.

We talk about community expectations. The community expectation that I have received individually as a member both from local constituents and from other people at these hearings is that there is a community expectation that we would ensure that there are some regulations and some safeguards placed around that and, no offence, not just left up to doctors and their professional bodies.

Prof. Ellwood: Again, just to respond to that, all terminations of pregnancy in Queensland above 20 weeks gestation are performed by induction of labour. It is not a failed procedure. An induction of labour occurs and a birth happens. Sometimes there is an intent for the baby not to be born alive, in which case a foeticide procedure is performed. Sometimes that intent is not there whether it is because the woman is earlier in gestation or whether she has chosen not to have that procedure. In the same way that many babies born between 20 and 24 weeks gestation following spontaneous labour will be born alive, it will happen following termination of pregnancy.

Mr CRAMP: When you are talking about foeticide, can you tell me what is involved in foeticide exactly from a medical procedure point of view for both the child and the mother?

Prof. Ellwood: It is a procedure where, under ultrasound guidance, a needle is inserted into the foetal heart and an injection of potassium chloride is given which stops the heart. It is possible for that procedure to fail. Best practice is to observe the heart over a period of time, usually up to an hour, to ensure the procedure has been successful.

Mr CRAMP: Are there any other late-term abortion techniques used in Queensland currently?

Prof. Ellwood: Not that I am aware of, not beyond 20 weeks gestation, no.

Mr CRAMP: That was a general question. I just wanted to know whether that is the only procedure.

Prof. Ellwood: Certainly at my own hospital—and Dr Portmann talked about surgical procedures—we would only offer surgical procedures up to about 16 weeks gestation. I believe the same is true at Royal Brisbane and at Townsville.

Mr CRAMP: Dr Portmann had a very interesting answer to some late commentary from the chair. The chair stated that there is emotive commentary around pain involved for the foetus. With all due respect to the chair, I disagree with the use of the word 'emotive'. I think everyone's concerns are valid from all sides. I would not like to imply that they were coming from an emotive sense. The doctor ruled out any form of pain. Are there any studies that are relevant or valid that would prove beyond a doubt that this foetus or this unborn child is not feeling any pain whatsoever? I can tell you again that this is based on concerns—I have literally had local constituents come to my office and discuss this matter and I have had no answer for it.

Prof. Ellwood: I am not an expert in this field by any means, but I am aware that research has been done. It is an incredibly difficult area to research.

Mr CRAMP: Yes.

Prof. Ellwood: Glenn might want to comment as well. Again, I would reiterate that termination of pregnancy in Queensland beyond 20 weeks is through induction of labour. I think a lot of the concerns that have been expressed—I am aware of these; I read the literature myself—is around late-term surgical procedures. I think the honest answer is that we do not really know the answer to the question about at what point in gestation does the foetus begin to feel pain.

Dr Gardener: I agree with David. I do not think we really know. Given that we operate on the foetus in the womb, we take a view that if there is a possibility of the foetus feeling pain we provide pain relief for that procedure prior to the procedure.

Mr CRAMP: For the foetus and the mother.

Dr Gardener: For the foetus. The mother clearly has whatever she needs. In addition, we provide intramuscular pain relief to the foetus. Whether that is absolutely necessary, maybe in time with more research we will know, but we take the view that we would rather be safe and make sure that the foetus is not distressed and provide that.

Mr CRAMP: I can assure you that that would be a reassuring view for the people I speak to.

Dr Gardener: I think it is a very valid concern.

Mr CRAMP: You spoke about a medical procedure with a needle to the heart of the unborn child. Would an adult person feel pain if that procedure were performed on them?

Prof. Ellwood: I am sure that an adult feels pain with the insertion of a needle anywhere. We do use needles for various foetal procedures, for various types of foetal therapy and for foetal transfusion we sometimes give intramuscular injections to the foetus to paralyse the foetus before the transfusion. Again, I would give you the same response: I do not think we know at what point foetal pain is appreciated.

Mr CRAMP: I appreciate that. Thank you, doctors.

CHAIR: In reference to your referencing my comments, member for Gaven, a commonly accepted definition of the word 'emotive' is emotional. You and I were making the same point and raising the same question. Professor Ellwood and Dr Gardener, thank you so much for coming today and thank you for being so gracious to stay well past time. You have expertise that was very beneficial to this committee and expertise that we have not had in your specific area with three practitioners as we have this morning. On behalf of the committee, thank you for the support you provide in a very complex and often painful area of medicine for women in our community. I thank today's witnesses for their contribution. The committee appreciates everyone's assistance. The proof transcript of today's hearing will be published on the committee's web page as soon as possible. Witnesses will be sent the proof transcript and invited to make any necessary corrections. I thank Hansard and secretariat staff in support of the hearings today and throughout the last six days. I declare this hearing closed.

Committee adjourned at 11.17 am