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

Members present:
Mr AD Harper MP (Chair)
Mr MC Berkman MP
Ms NA Boyd MP
Mr MA Hunt MP
Mr MF McArdle MP
Ms JE Pease MP

Staff present:
Mr R Hansen (Committee Secretary)
Mr J Gilchrist (Assistant Committee Secretary)

PUBLIC BRIEFING—INQUIRY INTO THE TERMINATION OF PREGNANCY BILL 2018

TRANSCRIPT OF PROCEEDINGS

MONDAY, 17 SEPTEMBER 2018

Brisbane

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The committee met at 10.02 am.

CHAIR: Good morning, ladies and gentlemen. Before we start, I request that mobile phones are switched off or turned to silent. I declare open this public briefing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee. I would like to start by acknowledging the traditional owners of the land on which we are meeting today. I am Aaron Harper, the chair of the committee, and the member for Thuringowa. The other members of the committee are Mark McArdle, the member for Caloundra and our deputy chair; Michael Berkman, the member for Maiwar; Marty Hunt, the member for Nicklin; Joan Pease, the member for Lytton; and in attendance is Nikki Boyd, the member for Pine Rivers, who has been appointed to the committee replacing Barry O'Rourke, the member for Rockhampton.

Today's briefing is part of the committee's inquiry into the Termination of Pregnancy Bill 2018. The inquiry was referred to the committee on 22 August 2018 and we are required to report back to the Legislative Assembly by 5 October 2018. Well over 6,200 groups and individuals have shared their views with us on the bill. We will get you to unpack some of your observations of that. We have some questions as we go along.

I have a couple of procedural matters before we start. As you know, the committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee that takes a nonpartisan approach to inquiries. The briefing 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 all witnesses that intentionally misleading the committee is a serious offence. Hansard will record the proceedings and a copy of the transcript will be available from our website.

I remind all of those in attendance today that these proceedings are similar to the parliament to the extent that the public cannot participate. I remind members of the public that they may be admitted to or excluded from the briefing at the committee's discretion. Please note that this is a public briefing and you may be filmed or photographed. To everyone here today, whatever the views are of the legislation before us, I ask that we give everyone today the courtesy and respect on what is a sensitive issue in Queensland.

LAW, Ms Kirsten, Director, Legislative Policy Unit, Strategy, Policy and Planning Division, Queensland Health

ROBERTSON, Ms Leanne, Assistant Director-General, Strategic Policy and Legal Services, Department of Justice and Attorney-General

RYLKO, Ms Julie, Director, Strategic Policy and Legal Services, Department of Justice and Attorney-General

WAKEFIELD, Dr John, Deputy Director-General, Clinical Excellence Division, Queensland Health

CHAIR: Thank you all for being here this morning to provide this briefing. Before you start, I inform you that responses to any questions taken on notice are to be provided to the committee by 5 pm on Friday, 21 September. I invite you to give us a briefing to the committee on the bill before us before we turn to members asking the questions. Thank you very much for being here.

Dr Wakefield: Thank you, chair. Thank you for the opportunity to further brief the committee about the Termination of Pregnancy Bill 2018 and also to respond to issues raised in submissions and at last week's public hearings. The department acknowledges that termination is a sensitive topic that elicits a range of views within the community. We have heard from stakeholders throughout the committee process who support the bill and from those who oppose the framework or termination of pregnancy more generally. I note that some of the issues that have been raised in submissions and at the hearings are outside the scope of the bill. I would like to re-emphasise that, as departmental

officers, we can answer technical and factual questions about the bill and how it will operate if passed by the Legislative Assembly. However, we will not be able to answer questions about the merits of the policy in the bill, or issues unrelated to the bill.

I turn to the issues raised in submissions and at the hearings. I would also like to address a number of these issues before taking questions, if I can. Firstly, in relation to late-term termination, we have heard from a number of witnesses at the hearings who were concerned that the bill would allow for late-term terminations up until birth, or result in an increase number of late-term terminations. Late-term terminations after 22 weeks are rare and constitute less than one per cent of the total terminations in Queensland. In 2016, of the 10,421 patient admissions for terminations, 76 occurred at 22 weeks gestation or later.

Terminations after 22 weeks gestation generally involve complex medical circumstances, such as delayed diagnosis of serious foetal abnormalities, or complex medical or personal circumstances. After 22 weeks, the bill requires medical practitioners to take a broad range of factors into consideration and consult with a second medical practitioner before deciding if the termination should be performed. Decisions will be guided by ethical considerations and best practice requirements outlined in clinical standards and guidelines.

A medical practitioner may decide, having considered all the circumstances, that the termination should not be performed. Cherish Life's submission stated that late-term terminations are increasing in Victoria. The department cannot comment on the veracity of this data. However, I note that the QLRC considered this issue. The report referred to a recent qualitative study that found that Victoria's abortion law reforms did not result in an increase in access to termination services, including late-term terminations.

I turn to the second medical practitioner to consult. A number of witnesses raised the requirement for a second medical practitioner to be consulted after 22 weeks. The AMAQ suggested that the bill be amended to require the second medical practitioner to consult the patient. The QLRC considered that the requirement for consultation should not be unduly onerous or burdensome. It said that it should reflect the minimum that is required whilst leaving flexibility for service providers to adopt further measures in practice if deemed appropriate.

The QLRC concluded that the legislation should not require the second medical practitioner to examine the woman or require that the consultation occur in person. The QLRC recognised that it may be good medical practice for the second medical practitioner to examine the woman, or for the consultation to occur in person, and that this would not be precluded by the bill. However, the QLRC considered that, in some areas of the state, such steps would be impractical and could significantly delay or restrict access. In some case, the QLRC considered that it might be appropriate for the consultation to occur by telephone or videoconference to facilitate access in regional areas.

Consistent with the QLRC's recommendation, the bill reflects the minimum requirements necessary to provide oversight for terminations after 22 weeks without imposing additional barriers. Medical practitioners would still be required to consider all the circumstances in reaching their view on whether a termination should be performed. Indeed, the bill does not prevent a second medical practitioner from examining the woman in person if he or she wishes to do so. If a medical practitioner considers that there is a need to examine the patient to form a clinical judgement on whether the termination should be performed, they can insist on doing so before giving their approval to the termination. However, I also note that the committee heard testimony from some witnesses that the process of having to be seen by multiple doctors can be distressing for women facing the very difficult decision to terminate a pregnancy due to severe foetal abnormalities.

I turn to conscientious objection. I would like to clarify a number of points in relation to the conscientious objection provision. The AMAQ raised concerns that the bill places a duty on registered medical practitioners to perform a termination in an emergency regardless of whether they have the skills and training to safely do so. The AMAQ recommended that clause 8(4) be amended to clarify that it applies only to a registered health practitioner who is qualified to provide a termination of pregnancy. The bill does not require a medical practitioner to perform a termination of pregnancy in an emergency. Clause 8(4) simply states that the conscientious objection provision does not limit any existing duty owed to a patient.

Good medical practice: a code of conduct for doctors in Australia states that good medical practice involves offering assistance in an emergency that takes into account the practitioner's own safety, their skills, the availability of other options and the impact on other patients under their care. It involves continuing to provide assistance until the practitioner's services are no longer required.

Practitioners faced with an emergency of any kind will need to consider what assistance they can provide based on an assessment of these factors. The bill simply notes that the conscientious objection provisions do not change this duty.

Regarding the obligation on the objecting health practitioner to refer the woman, questions have arisen about whether the practitioner has discharged their duty by referring the woman to a counsellor only. The bill provides that, if a woman requests a registered health practitioner to perform or advise her on a termination and the practitioner has a conscientious objection, then they must disclose the obligation. The practitioner must also refer the woman or transfer her care to another registered health practitioner or health service provider who, in the first practitioner's belief, can provide the requested service and does not have a conscientious objection. Unless the practitioner has done this, they have not discharged their obligations under clause 8 of the bill. Referring the woman to a counsellor is not sufficient. The requirement to inform and refer or transfer care is in line with the codes of conduct and guidelines for health practitioners and with the Queensland clinical guidelines.

Some stakeholders raised concerns that the bill may compel private hospitals, entities or other practitioners to provide termination services. This is not the case. Practitioners have the ability to conscientiously object. The conscientious objection requirements do not apply to hospitals, institutions or health services. However, the bill also does not compel private hospitals to provide termination services. The services that private facilities provide is a matter for them.

A number of witnesses raised the issue of counselling and whether it should be mandated under the bill. The QLRC considered this and recommended against including the legal requirement for women to have counselling prior to termination. The clinical guidelines and the current clinical practice deal with this. The choice to access counselling is a matter for the woman in consultation with her health practitioner. There is nothing in the bill that prevents a woman from seeking counselling or being offered counselling either before or after a termination. The QLRC noted that a legislative requirement to seek counselling could present an additional barrier to accessing services for some women.

The committee has heard differing views from stakeholders about the threshold for conduct to be an offence in a safe access zone. Concerns were also raised about the constitutional validity of these provisions. The QLRC carefully considered the issue of safe access zones in chapter 5 of its report, and the provision in the bill reflects the QLRC's recommendations.

The rights of people with a disability was raised at the public hearing in Brisbane, including the need to consider supported decision-making to ensure that the wishes of women with a disability are respected. The QLRC considered international instruments relevant to the reform of termination of pregnancy laws as part of its review, including the United Nations Convention on the Right of Persons with Disabilities. In Queensland there is a statutory framework for the appointment of a substitute decision-maker for an adult who does not have the capacity to make their own decisions, including giving consent to medical treatment. Health practitioners treat people with disabilities and must address these issues currently in a range of different contexts.

Finally, the committee has heard data and studies cited from many submitters. In some cases these studies reach different findings. This is a contested area, and evidence needs to be carefully considered to ensure that the methodology was appropriate and that findings have not been taken out of context. For this reason the department is not in a position to comment on the veracity of the studies cited by submitters or to draw conclusions from their findings. The QLRC consulted widely as part of its review and considered a range of studies and evidence in formulating recommendations which are reflected in the bill.

Chair, thank you for the opportunity to address the committee on some of the key issues raised during the inquiry. We are now happy to take questions on the bill.

CHAIR: Thank you very much, Dr Wakefield. You have just answered my first question: you cannot really comment on those studies. We did hear from various submitters that there are a range of outcomes in the studies. Are you aware whether other states like South Australia, ACT or Victoria have evidence to demonstrate that the rate of termination of pregnancy has decreased since legislation has come in in those particular states? Are you aware of any data there?

Dr Wakefield: Turning to the QLRC report referencing a study from Victoria, they drew the conclusion that the legislation did not have a significant impact on the number of terminations in the state.

Ms BOYD: The Australian Christian Lobby quoted a La Trobe University study that they claim substantiates gender discrimination in women and skewed gender outcomes due to gender-selective terminations in the jurisdiction of Victoria. Are you aware of such a study?

Dr Wakefield: I am aware of the study. As I indicated previously, I am not really able to comment on the detail in the study's findings. I have read the study. It is certainly the case that the study did not specifically consider the effect of the legislation in Victoria. It spans a considerable amount of time prior to and after the changes in legislation. If there are any specific questions about that study, I would like to take that on notice.

Ms BOYD: Are you able to provide us with an analysis of the veracity of these claims based on available evidence? Are you able to take that on notice and go away and do that work?

Dr Wakefield: Can I clarify that question? About this study in particular?

Ms BOYD: Yes.

Dr Wakefield: I am happy to do so.

Ms BOYD: We heard from many submitters that they were fearful that the implementation of this bill would result in gender-selective abortions. Are you able to provide the committee with some remarks around those concerns?

Dr Wakefield: Yes. The QLRC considered carefully the issue of termination for the purpose of sex selection. They also took into account the WHO's interagency statement on the prevention of gender biased sex selection. The QLRC has specifically elected not to include provisions regarding sex selection in the bill. If a woman does disclose that she is seeking termination based on sex selection before 22 weeks, the doctor may refuse on conscientious grounds. After 22 weeks, a lawful termination does require two medical practitioners to agree in all circumstances that the termination should be performed. If the doctor does follow the process in clause 6 and considers all relevant circumstances and concludes that the termination should not be performed, the doctor does not need to refer the patient to another practitioner or provider under the conscientious objection provisions.

In my experience as a doctor I would find it very difficult to imagine that doctors would agree to provide a termination purely on the grounds of sex selection. Practitioners—and this is covered in the bill—must be guided by relevant ethical considerations and clinical guidelines. Again as a practitioner I would find it highly unlikely that two practitioners would agree to a termination of pregnancy post 22 weeks solely based on the sex of the baby. The key issue is whether a woman actually discloses that is the reason. It is not possible to address that through legislation. Before 22 weeks the woman is not required to provide a reason, so at that stage that is the case now.

Ms BOYD: Cherish Life Queensland has claimed that a woman can get an abortion on the basis of a foetal abnormality right now under the current legislation. Can you please clarify that statement for the committee?

Ms Rylko: The QLRC considered the current provisions—which are sections 224, 225 and 226 of the Criminal Code—that make it a crime to unlawfully terminate a woman's pregnancy except in limited circumstances. The Queensland courts, in interpreting these sections, have adopted a ruling based on decisions in other jurisdictions that a termination by a medical practitioner, with the consent of a woman, is lawful if it is necessary to preserve the woman from a serious danger to her life or her physical or mental health, not merely the normal dangers of pregnancy and childhood which the continuance of the pregnancy would entail, and in the circumstances is not out of proportion to the danger to be averted. This became known as the Menhennitt ruling. In terms of the medical circumstances, I would need to refer to our colleagues in terms of health.

Ms BOYD: Do you have anything to add to that, Dr Wakefield?

Dr Wakefield: Not from a technical legal perspective. Obviously those late terminations are rare, as I have pointed out, and they are based upon usually serious foetal abnormality and/or maternal illness.

Mr HUNT: I want to address the conscientious objection framework, particularly around where we talk about pre-22 weeks. Previously you said that if a doctor becomes aware of somebody seeking a termination for sex selection then that doctor may object on the grounds of conscientious objection, but the law requires that doctor to refer the patient to somebody that he or she believes will provide that service; is that correct?

Dr Wakefield: Yes. If the doctor objects under the conscientious objection provisions they are required to refer that person to an individual or a service.

Mr HUNT: Ethically or legally is that doctor able or required to pass on the information to the doctor they are referring to that it is a sex selection abortion?

Dr Wakefield: That would be a matter for the clinician and the patient. As for any referral, the information provided in that referral between two practitioners would cover the relevant clinical information, including the reason for termination if they so choose to do so.

Mr HUNT: Is a doctor ethically obliged to refuse a termination based on sex selection if they become aware that that is the case under 22 weeks? Are they ethically obliged to refuse?

Dr Wakefield: The basis upon which they can refuse to offer a termination under 22 weeks is based on the conscientious objection provisions, and that would be the basis upon which they would object.

Mr HUNT: As technology around the genomic space improves, obviously we are getting more and more information in relation to genetic conditions. If a doctor becomes aware that a termination under 22 weeks is based on a genetic condition and they conscientiously object, does the same thing apply and they must refer to somebody else who they believe will perform a termination?

Dr Wakefield: Correct. In the bill, under 22 weeks it is abortion on request. There is no need for a reason to be provided. A doctor can refuse, as can other clinical practitioners who are asked to assist, on conscientious objection grounds. As a doctor, I would envisage there would be people who would hold a conscientious objection period for all matters of termination, and there would be those who I would proffer would hold a conscientious objection in certain circumstances for certain reasons. Simply put, if the doctor does not agree to perform a termination, they do so on conscientious objection grounds and must refer the person on to a service who can consider the patient's needs. That is a fact in the bill, and that is how it would operate in practice.

Mr HUNT: If a doctor becomes aware of a reason for the termination they are not required to give but becomes aware of a reason that other doctors may find objectionable, are they legally able to tell that doctor if the patient does not wish them to? If they become aware, for example, that it is a sex selection abortion and they object to that conscientiously, they are therefore required to refer to another medical practitioner. But if the patient says to them, 'Do not tell them because I do not want them objecting on the same grounds,' is that doctor legally able to pass on that information?

Dr Wakefield: I will take that as a legal technical question and I might have to ask my Justice colleagues to answer.

Ms Robertson: I think we are going to have to take that question on notice, Chair.

CHAIR: Fine; thank you.

Mr HUNT: Thank you.

Mr BERKMAN: Thank you very much for the comprehensive report back, too. That covered a lot of the ground that I might have wanted to go to. You have referred in your response to issues around mandatory counselling and that counselling is otherwise dealt with by the *Therapeutic termination of pregnancy* guidelines and potentially others. Can you shed any more light on the scope of those? What is the source of any of those practice guidelines around counselling and what any patient might expect to receive in terms of guidance in that respect?

Dr Wakefield: Access to counselling is a decision for the woman in conjunction with her health practitioner, and the QLRC did look very carefully at the issue of whether counselling should be required prior to a termination and made the recommendation that it not be required. In practice, counselling would be a matter that would be considered between the practitioner and the patient and if the practitioner felt that the patient needed counselling then they will offer it. In fact, if the practitioner believed that every patient needed to have counselling, there is nothing in the bill to stop them from offering that counselling. Our clinical guidelines, which again distil the evidence around practice, are clear on counselling as being important. Your question went to how that happens or what the requirements are. Sorry, but can you just clarify?

Mr BERKMAN: I suppose I am just hoping you could advise the committee as to how accessible that is. Given that it is not proposed to be a requirement of the bill, I guess I am just looking to shed some light on what potential barriers to counselling might there be where that is part of the discussion between the patient and the medical practitioner. Additionally—I guess you have already really responded to this—how will that question be dealt with?

Dr Wakefield: With regard to access to counselling, which is at the heart of your question I think, given that 95 per cent of terminations currently are performed in the NGO sector—in the private sector—I know for a fact, for example, Marie Stopes and other providers have their own counsellors available and also have referral mechanisms in place. I cannot comment on any financial barriers to those in terms of cost, but certainly termination service providers have counselling resources available because that is part of the business that they are in.

If we turn to the public hospital system—and, again, our role is very small and it tends to be in that sort of later phase—we obviously have resources internally, including psychology and social work, so we are also able to provide counselling that is required if a woman or the practitioner agree that that would be a good thing, both before and after a termination of pregnancy.

I cannot comment any further really on geographical access. Again, I think part of the issue with our state is that we have a distributed population and certainly in some regional and rural areas access to services generally can be challenging. That is part of the commitment that the minister has given and that Queensland Health is undertaking as part of implementing this bill—that is, to particularly focus on areas of the state where access to services is problematic for women, for women's health generally and for pregnancy and termination services and take action to improve that access. Does that answer your question?

Mr BERKMAN: Yes; thank you.

Dr Wakefield: If women want counselling and need counselling, it is generally available.

Mr BERKMAN: Thank you. I did want to touch briefly on safe access zones as well. You understandably made fairly limited comments in your introduction. None of us can second-guess how the court might deal with existing challenges on foot, but there is a pretty clear relationship between constitutionality and the threshold for conduct as it is drafted in the bill at the moment. Is there any more you can say to us on that issue? We have had a number of fairly detailed submissions and suggestions about how the wording of the bill or how that threshold of conduct might be changed. Do you have any thoughts in particular about those recommendations at all?

Dr Wakefield: I will refer that matter to my Justice colleagues.

Ms Robertson: It is obviously not appropriate to comment on a matter before the High Court at the moment as you know, but I guess there are a couple of points to note. The QLRC was obviously very much aware of those current challenges and had regard to that in framing the framework upon which this bill is based. I do not think I can take it any further except to note that the QLRC itself in considering and making the recommendations did have regard to the provisions in other jurisdictions and also was obviously cognisant of the challenge itself.

Mr BERKMAN: Okay; understood. Thank you.

Dr Wakefield: Just if I may, again, at a practical level, obviously the Department of Health is working through implementation issues. The 150-metre note in the bill or reference in the bill to the premises where the termination will be taking place is a matter of fact. It is particularly for those facilities that are established for provision of termination services. That is a fairly clear definition for them.

It is actually less clear for hospitals that conduct a range of business where that threshold is. Is it in a particular building? Is it on the perimeter of the site and so on? That is part of the implementation of the bill in terms of determining that and my understanding is that in practice each provider will make that determination and for any issues arising from that—complaints or issues that are raised—there will be a relationship with the QPS in terms of dealing with any complaints or issues that arise as a consequence of any potential breach of that.

Mr BERKMAN: Thanks. I will leave it there.

CHAIR: Just before we go to the member for Lytton, just picking up on the point from the member for Maiwar with regard to counselling, that is something we heard directly from providers in our movements around Queensland—that is, counselling is provided in a very high percentage of cases and of course post 22 weeks these decisions are not taken lightly. They were very tragic cases that we heard and of course Queensland Health is very well resourced, but it was an observation that we certainly picked up on in our travels.

Ms PEASE: Thanks very much for coming in. I just want to pick up again on what the member for Maiwar was talking about with regard to safe access zones. The Queensland Law Society submission raised some concerns about inconsistencies between the bill and the explanatory notes around exclusion zones. I ask the panel to perhaps elaborate on that please.

Ms Rylko: Thank you for your question. The explanatory notes and the bill are consistent with each other and in this respect I draw the committee's attention in particular to subclause 15(2) which relates to the QLS comments and states—

A person's conduct may be prohibited conduct whether or not another person sees or hears the conduct or is deterred from taking an action mentioned in subsection (1) ...

That clause relates to the comments in the explanatory notes and is consistent with the QLRC's recommendations in relation to the definition of 'prohibited conduct'. The bill is reflective of the QLRC's recommendations and also the QLRC's draft legislation in relation to the definition of 'prohibited conduct'. Particularly at paragraph 5.140 of the QLRC report it outlines what should be defined as prohibited conduct and says specifically at the end of that paragraph—

However, the draft legislation should make it clear that, in proving the offence, it is immaterial whether a person saw or heard, or was deterred by, the conduct.

My understanding is that is the issue that has been raised by the QLRC in its submission.

Ms PEASE: Okay; thank you. Dr Wakefield, in your opening statement you talked about providing access to people with a disability to a termination. Can you just revisit that for me please and what sorts of supports are around that? Does that also apply to younger people in the community?

Dr Wakefield: In relation to consent for procedures, under the bill termination will be deemed a health matter. There are two statutory approaches to that depending on whether you are an adult or whether you are a minor. Dealing with minors first, you talk about disability but the test comes down to whether someone is able to understand—is cognitively impaired in some way—so in terms of the test for a minor there is something in common law called Gillick competency. Generally speaking, around the age of 14 and above most minors are able to consider the implications and consequences of health decisions. This is covered in our current clinical guideline. If a 14-year-old is assessed as Gillick competent by the clinician, then they are able to give their own consent. That does not mean to say we do not involve parents, but there are circumstances where that is not applicable or the person does not want that.

In the case of disability, if that minor is not deemed to be competent in terms of providing consent, termination of pregnancy is deemed a special procedure, so it is not something that a parent can make a decision about on behalf of that child—14 or otherwise—and that decision has to go to the Supreme Court and the court has something called a parens patriae responsibility which essentially is a decision maker substituting for a parent in those matters given the significance of that decision. For children with disability in this setting, say a 14- or a 15-year-old intellectually impaired person who is pregnant, the parent cannot make that decision for the child. The court has to make that.

For adults—again, once you reach 18 and above—the Guardianship and Administration Act takes over in that domain. As a clinician, to do any procedure or to provide health care of any description I am required to get informed consent from the person. I have to make a judgement about whether that person can understand the nature and consequences. If they cannot, whether they are 18 or 80, then the substitute decision-making legislation kicks in. In the case of termination of pregnancy for, for example, an intellectually disabled young adult over 18, that would again require discussion with the Adult Guardian and I believe that QCAT is capable of deliberating on that matter. Again, it is not simply that a parent of either an intellectually disabled child or an intellectually disabled adult is able to make that decision on behalf of that person. It is deemed to be a weighted decision that requires either the court or the tribunal to undertake.

Ms PEASE: Further to that, within your clinical guidelines, is there a requirement on the clinician to report if they suspect rape or sexual abuse?

Dr Wakefield: There is a legal obligation on all registered health practitioners to report suspected child abuse, a child being defined as under 18. I would have to take some advice on the specifics of this, but I am aware that there is certainly also an obligation on registered health practitioners to report a crime or a suspected crime to the police.

Ms PEASE: Finally, what would happen in terms of reproductive coercion, where a woman presents who is possibly being forced into having an abortion? What protections are in place?

Dr Wakefield: Clearly there are circumstances, particularly with domestic and family violence, where women are in very difficult situations and may feel or may actually be deemed to be coerced by a partner, for example, to either keep a pregnancy or terminate a pregnancy. That is a much broader issue than this bill, in fact. It goes beyond the scope of the bill.

In our current clinical guidelines, we do provide some guidance to practitioners on this issue. This is an environment where counselling is very important—independent and objective counselling for the person, away from partners, et cetera. Usually our job as clinicians is to, first of all, pick up on this in our engagement with a patient and take the necessary steps to give support to that person, without having an overbearing partner with them, for example. Usually that involves trying to separate, for example, a male partner who refuses to leave the person's side. Again, I think that is beyond the scope of this bill. It goes very much into a broader context of domestic violence and so on.

Mr McARDLE: Thank you for being here today. I certainly take on board the advice you have given us based upon earlier evidence. Dr Wakefield, I think you mentioned in 2016 some 10,400 terminations and, of those, 76 were at 22 weeks or post 22 weeks for complex medical circumstances. Could you clarify for me the gestation period at which those circumstances can be picked up in an examination of the mother and the foetus?

Dr Wakefield: Can I clarify that you are talking about congenital abnormalities?

Mr McARDLE: Exactly, spina bifida and things of that nature.

Dr Wakefield: The key point in time when those significant structural and anatomical defects are usually picked up is at the 20-week scan or the so-called morphology scan. It is called that because it looks in detail at all the organs that make up the baby. Really, it is looking for those sorts of issues of the brain, the heart, the lungs, the spine, the limbs and so on. That usually is the time when, in detail, there is good evidence if there is a problem.

There are some blood tests that can be done earlier that provide genetic analysis and other types of analysis and that can give fairly high-level confirmation of certain problems such as Down syndrome and so on. Not all of those are visible on a morphology scan. Certainly, some genetic disorders, particularly the metabolic ones or with the structure of the brain, might not be visible on a morphology scan. By and large, when it comes down to significant foetal abnormality, the 20-week scan is the point at which those things come to light. Bear in mind that the 20-week scan is generally conducted somewhere between 18 and 21 or 22 weeks, so it is around that time.

Mr McARDLE: Could we take on board that between 18 to 21 weeks is roughly when that would show in examination as a potential issue or a clarified issue?

Dr Wakefield: Yes.

Mr McARDLE: I want to explore that a little further. In those circumstances, the medical practitioner would refer the mother to a specialist, although maybe not Queensland Health as it is not post-24 weeks at this point in time. Clinical practice and guidelines would require what takes place when mum goes to see a specialist. What is required to occur by the guidelines and ethical standards at that point?

Dr Wakefield: In terms of what is required, the clinical guidance at that point in time would be, first of all, to sit down with the woman and her partner, if she has a partner, and discuss what is being found. In terms of referral, really it comes down to an individual case. It depends on what the issue is. It depends on the wishes of the mother and the parents. Certainly if they want more specific information about the issues, and there may be some more tests to be done and maybe more information to be gleaned, usually that would lead them to a referral to a subspecialist, such as a foetal medical specialist who really looks at the unborn child in terms of what those issues are. They tend to be people only in major centres. That referral would generally be to that service. It depends on the circumstances. If there is a diagnosis of Down syndrome and the parents, in conjunction with their own local obstetrician, decide they want to proceed with the pregnancy, there is nothing to stop that from happening.

Mr McARDLE: I suppose my point would be—and please comment upon this—that that initial diagnosis would be reviewed by a relevant person or body if the mother wanted it to happen that way?

Dr Wakefield: Correct.

Mr McARDLE: The doctor would simply say, 'These are your options. I can refer you to Dr So-and-so and Dr So-and-so, but then you need to make a call.' If the mother wanted further testing undertaken, that would be an opportunity for the doctor to refer to a relevant specialist.

Dr Wakefield: I am assuming you mean a referral for a termination?

Mr McARDLE: Yes.

Dr Wakefield: I think there is a bit between diagnosing or an issue determined on a morphology scan—there seems to be a problem with the bottom of the spine or whatever it is—and a decision to terminate the pregnancy. It depends on the circumstance, but between those two things there is a range of clarifications: what are we dealing with, what are the issues, what is the likely outcome, will the baby survive with this, what disabilities might they have?

All of those questions, dependent on what is found, are taken into account by the family, the treating clinicians and the extra specialists involved, for example. Maybe other tests are done. That is already at 20 or 22 weeks. There will come a point when, armed with the information and the questions of the doctors, the mother will make a decision. They may or may not wish to even discuss termination. They might not want to go there. If that is a question that they have, that will usually come after quite a bit of consideration of the likely outcome for the baby.

Mr McARDLE: Can I compare that discussion that takes place with what occurs at 24 weeks plus. I understand it is a different scenario, in that tertiary hospitals become involved by definition. What are the clinical guidelines in relation to a termination occurring or being offered to the mother? Are they different to pre-24 weeks or are they the same as at 24 weeks? I want to clarify this in my mind; I am not trying to be tricky. I want to understand this.

Dr Wakefield: Do you mean now or post the bill?

Mr McARDLE: Yes, now and then we will talk about post the bill.

Dr Wakefield: Our current statewide clinical guidelines certainly operate within the Queensland public health system. As we have said, for the most part late terminations tend to be done in the public system, because they need a higher level of care and treatment. Right now, that is done in conjunction with the mother and partner, and all the treating specialists. That is done now, with counsellors and so on. The guidelines give guidance to how that occurs. As I said before, in that period between 'there seems to be a problem' and 'we are making a decision about termination or proceeding with the pregnancy' is where those interventions take place.

Mr McARDLE: Is there a review panel established in the hospital to look at this? It does not appear to exist pre-24 weeks, from what you have said to me. Is there a formal structure within Queensland Health, the HHSs or the RBWH to look at this matter? That is what I want to understand.

Dr Wakefield: Sorry: I did not answer that. The current clinical guidelines, since they were created, have a second-doctor sign off. How hospitals do that is actually their own business. You commented on the Royal Brisbane and Women's Hospital. I think they do have a panel arrangement, if you like. Essentially, what we have said in the guidelines is that, given the weight of this decision, we recommend that there is another doctor involved beyond the treating doctor, if you like. How you achieve that, whether you have a single doctor that provides a second objective view and support to the family or whether you utilise a panel of two or three people in a hospital, that is a matter for the hospital. Basically, our guidance to date—right now, prior to this bill—has been that there is a second-step sign off.

Mr McARDLE: Under the terms of this bill, if it becomes law, how will that alter?

Dr Wakefield: In the public system I do not believe it will alter a great deal. Clearly we will have to amend the guidelines with whatever the date is; so if it is 22 weeks, if that is the way it remains. There will be some specific issues of implementation around conscientious objection and some of the other issues that we will have to take into account. As far as having a second practitioner consider all the circumstances involved in the sign off, that will still have to happen. Two doctors will still have to sign off on it.

In terms of the specifics of the bill, there is a change, which is the things that those doctors have to consider before signing off. The legislation is pretty clear that they have to consider all the circumstances; they have to consider the psychological, social and physical consequences, both now and into the future; they have to consider the medical circumstances; and they have to consider the ethical and clinical professional guidance that exists. We will be providing advice to our clinicians about what that means in practice. Essentially, as far as two doctors signing off independently, we already have that.

Mr McARDLE: In the guidelines, is that a doctor of similar knowledge, not just in regard to the patient but in the area of medical concern?

Dr Wakefield: Again, is that a question about what happens currently?

Mr McARDLE: Yes, now, and I am thinking it will be the same post the event.

Dr Wakefield: We do not prescribe that. There is no prescription about that second doctor being a specialist obstetrician, for example. Again, panel arrangements allow other considerations—psychiatrists, psychological input and so on. At the moment there is no prescription about the qualifications of that second doctor. I think in practice it will be people who are familiar with the clinical practice of obstetrics.

Mr McARDLE: You mentioned the consultation question and you made the comment that the report referred to the fact that it may be good practice to have the woman examined by a second doctor in person and also with her in the room discussing the question. Under 6(b) it says 'the practitioner has consulted with another medical practitioner'. Do the clinical standards and guidelines apply to that, and what do they state in relation to that consultation now and into the future?

Dr Wakefield: Can I ask you please to repeat that question?

Mr McARDLE: Proposed section 6(b) states, 'the practitioner has to consult with a second medical practitioner'. What do the clinical standards and guidelines say in relation to that consultation at this point in time? What will it be post the bill becoming law if it does?

Dr Wakefield: We will just have to refer to the guideline. Perhaps if I can move to the bill and the requirements post the introduction of the bill. Proposed section 6(b) states—

the medical practitioner has consulted with another medical practitioner who also considers that, in all the circumstances, the termination should be performed. That is the legal requirement—the text in the bill. In practice, the QLRC considered whether there should be a requirement for that to be in person. They made a recommendation that that not be a requirement in the bill because of concerns about access, particularly in a state like Queensland where we have significant geographical disadvantage.

In practice, in terms of implementing the bill, I have a couple of things to say. First of all, this is post 22 weeks; this is very much the domain of larger services. They will have the ability to provide video and teleconference facilities so that we can reduce and diminish some of those access issues.

It is important to realise that whilst the bill does not compel the second doctor to physically see or examine a patient, the bill does require the sign-off of those two doctors for a termination to occur and that doctor has to satisfy themselves. If the second doctor so chose that it was clinically necessary for him or her to see that person either on a videoconference or in person, they can require that. Whilst the bill does not obligate them to do so, they can make that a condition of their involvement on clinical grounds. Again, prescribing that is quite problematic because of all the different scenarios that occur.

I realise the AMAQ were concerned about that. Again, it is a sensible decision to have two doctors sign off on proceeding with that termination post 22 weeks. If that second doctor believes that they will not be happy, that they cannot consider all those circumstances without examining the patient or seeing the patient, they can require that. That is post the bill presently—I might have to take that on notice in terms of what the guidelines say. We cannot specifically find that right now. I will see if we can provide that by the end of the session perhaps.

Mr McARDLE: I recall back in the earlier inquiries Marie Stopes indicated in evidence that they provided reports to Queensland Health on a regular basis—or on a basis anyway—regarding the number of terminations that body performed in Queensland. Is that still the case, or not? There was some debate about whether they could be released or not for certain reasons. My recollection is that they provided to Queensland Health such data they had. Do you know if that is the case?

Dr Wakefield: I would have to take that on notice. In terms of the data for terminations of pregnancy, we have two sources. We have the in-hospital data. From private hospitals and public hospitals we collect all inpatient data. That is where the reporting came from in terms of admissions for surgical termination of pregnancy. That includes Marie Stopes admitting patients to a private day surgery for surgical termination of pregnancy. Marie Stopes do provide that data to us as a requirement of all inpatient activity. That is the surgical ones.

For the medical terminations—including medication that is prescribed by general practice but also Marie Stopes' so-called medical termination pregnancy—we do not have that data. That data is actually through the Pharmaceutical Benefits Scheme, through prescriptions of the medication, the MS-2 Step. We have accessed that data. The concern with that is that because of the use of telehealth by Mary Stopes and some other providers, just because a prescription is essentially filled in Queensland—the woman can be in another state, so we have to be a little careful about interpreting the numbers. That is where the data comes from. It is not Marie Stopes specific; it is based on the requirement of all surgical terminations to be reported as part of all hospital activity and the medication component which is captured essentially through prescriptions under the Commonwealth Pharmaceutical Benefits Scheme.

Mr McARDLE: How is that data utilised by Queensland Health? To what purpose is it put?

Dr Wakefield: The data that we collect is prescribed by a relationship with all hospitals in the Commonwealth. There are a number of purposes to the data. One is in terms of reporting activity to the Commonwealth as part of our funding agreements with the Commonwealth. Another one is around payments to hospitals. They are paid on the basis of work they conduct. A significant use of that data is about understanding what activity is taking place and compensating that. Then there is its use in this circumstance, which is essentially to say what is happening, what services are being provided, what is the change over time, and that then feeds into planning—service planning, legislative change, policy changes and so on.

Ms BOYD: A galaxy poll was conducted by Cherish Life and Australian Family Association in August this year. The committee has heard through the public hearings that this is a rigorous poll and has received a letter via Cherish Life of its veracity. Can the department provide an analysis of the veracity of the methodology used and the outcomes of this poll and provide us with a comparison to available research of the public view?

Dr Wakefield: I would certainly have to take that on notice. What specific question does the committee have in relation to—I am just questioning whether that is within our remit, if you like, in terms of our ability to provide that advice?

Ms BOYD: In terms of the poll, how does that sit in comparison to research that is available to Queensland Health and research that the Queensland Law Society referred to in their report?

Dr Wakefield: The question I have is: is this a matter of us providing advice on the merits of the bill, which is not really—

CHAIR: I understand where the member is coming from. In the previous iteration of this bill we did get some academia to look at the studies, which showed some interesting results in terms of skewing the questions. Is it a matter for the department? We might have to seek some further advice on that. I think we can probably land on the previous results, so we do not need to put it to the department in this context.

Dr Wakefield: I would be concerned about our ability to provide objective advice.

CHAIR: I think we got enough of that on the last one, which I will share with the member. It might be beneficial.

Ms BOYD: Thank you. My next question goes to conscientious objection. During the hearing in Brisbane Dr Purcell appeared to answer questions of Cherish Life. We were talking through the AMA's position on conscientious objection and the right not to be involved yet to refer on. The doctor said that she had referred patients to counsellors. She said—

I have referred them to counsellors. I did not understand that my duty went beyond that according to what the AMA said, and generally counsellors will refer a woman back to you anyway.

My concern is that if presently a patient seeking a termination was to go and see a doctor who is a conscientious objector, perhaps they would be sent to a counsellor who held the same views as the doctor only to be referred back to that same doctor again. Can you comment on that for the committee, please?

Dr Wakefield: I can comment on the bill, and it is pretty clear that if a woman presents to a doctor who is a conscientious objector, the doctor must disclose that to the woman; that is the first thing. If they are a conscientious objector and they have disclosed that, they must refer the woman to either a provider who they know would provide termination of pregnancy—an individual—or a service provider, for example, a clinic. Again, within that doctor-patient relationship they may have lots of discussions which may or may not lead to referrals to counsellors. That is all perfectly reasonable. Again, that is part of a doctor-patient relationship. Just because a doctor is a conscientious objector does not mean to say that that woman does not wish to maintain a relationship with that doctor; that is a choice for the woman.

The obligations on the practitioner are very clear: they must disclose to the woman and if she requests a termination, they must refer that woman to either an individual or a service provider that they know provides termination of pregnancy. I covered that in my opening statement. Again, the situation is quite clear: merely referring a person to a counsellor fails to discharge your legal duty under the bill.

Ms BOYD: Great. That was the bit that I wanted specifically clarified under the bill. Thank you.

Ms PEASE: I want to talk about the late-term terminations in relation to conditions for foetal abnormalities. Last week at our hearings we heard from a representative of Harrison's Little Wings, the organisation that Melanie set up. One of the things that I was very concerned about was that, under the current legislation, we can perform the termination and it is not considered illegal because it could impair a woman's mental ability. At any time would a woman be made aware that what she is doing is illegal under the current law?

Dr Wakefield: It would not be appropriate for me to make any sort of comment on any illegal practice. I think what is clear—and it is why we are here providing information to the committee—is that the current framework for termination being a criminal act with some defence, or exemptions, continues to create concern both for women who are seeking termination and practitioners. That is the reason we have worked with clinicians and consumers to create our statewide clinical guideline—because there was increasing concern by clinicians about their own risk in making what they believed to be appropriate clinical decisions.

It would not be appropriate for me to speak of individual circumstance. Practitioners are operating within the law as they see it. That is the only way they can do what they are doing. I think that is the purpose of the bill, that is the QLRC consideration—that the current environment of being under the Criminal Code creates problems for women and for practitioners.

Ms PEASE: Thank you. Basically, under the current law, women and practitioners potentially open themselves up to litigation because they are breaking the law but, with the bill that is before the House at the moment, it would become a health issue and not a legal issue?

Dr Wakefield: Correct. Again, just going back to your previous point in terms of breaking the law, they operate under the current law with the relevant exemptions and apply those accordingly. You are correct that this takes it away from the Criminal Code and the potential defences to a criminal act, if anyone were to claim that a crime had been committed, towards a more contemporary arrangement that this is health care, that this is a matter between the doctor and the patient and it is governed as a contemporary healthcare issue rather than under the Criminal Code.

Ms PEASE: Thank you.

Mr HUNT: You mentioned before that conscientious objection would be on a wide spectrum. You get the people who just object to it completely but then doctors, through circumstances, would conscientiously object. You also mentioned that coercive reproduction is outside the scope of the bill. However, it comes back to an ethical and legal dilemma for a practitioner. If somebody presents to them whom they believe is being coerced into an abortion, it is a legal requirement for them, is it not, if they conscientiously object, based on that reason, to refer them to another GP, or another practitioner who will perform the termination?

Dr Wakefield: Yes. If they are a conscientious objector, then they must refer that person to another service where they know that they are sympathetic to the termination of pregnancy. I will not use the technical words but, essentially, that is the obligation. There is nothing in the bill that requires a doctor to perform a termination of pregnancy at any stage. If, for example, a clinician—either a clinician with an conscientious objection, or any clinician—has deep concerns about whether a woman wants to go ahead with a termination of pregnancy, whether they express a view that they are being coerced, or there are concerning signs, for example, of domestic violence and so on, then the practitioners involved have an ethical responsibility to address that and deal with that as best they can with a woman and the family.

Mr HUNT: If they come to the conclusion that, based on that, they have an objection to performing it, they are legally required to refer to someone who might under the current bill.

Dr Wakefield: Yes, they are. Let me try to put a scenario around this in practice that might help to illustrate this. A woman goes to her general practitioner with a partner in tow who seems very overbearing and that GP is a conscientious objector. Merely referring that woman, for example, to Marie Stopes, which is their obligation to refer them to a provider, and particularly providing information as part of that referral, which is clinically necessary, may well lead to that woman getting the counselling and support that they need.

Mr HUNT: It may.

Dr Wakefield: It may.

Mr HUNT: My final question is, are there any circumstances, based on domestic violence, gender selection, genetic defects, where a doctor has a conscientious objection based on those ethical dilemmas—not just a general conscientious objection—that doctor can refer to anyone other than a medical practitioner who they believe will perform the termination for them? The law is quite clear, is it not? They must refer on.

Dr Wakefield: If the woman requests a termination, whatever the reason, if they are a conscientious objector they must tell the woman they are a conscientious objector and they must refer on.

Mr HUNT: Thank you.

CHAIR: Member for Maiwar, did you have a supplementary?

Mr BERKMAN: Yes. In the time remaining, I want to go to a couple of points that came up in evidence on Wednesday. You touched on this in your introductory statement, but I go back to the good medical practice guidelines and the existing requirement to not impede access to treatments that are legal on the basis of conscientious objection. Is it fair to say that what is proposed in the bill is essentially a codification of pre-existing obligations for medical practitioners as set out in that

guideline, or others? I am asking this in the context of some dispute about how that might be interpreted. I suggest that it was a non-expert dispute on both sides of the conversation. What is your view on that?

Dr Wakefield: From a technical perspective, conscientious objection is specifically prescribed in the bill under these circumstances that would have a greater weight than a code of practice where, essentially, that is professional guidance. I will not make the interpretation that they are the same in terms of the content. As you propose, they are the same, but I think it makes it unambiguous in the context of the bill that that is a requirement, which practitioners may or may not interpret, that is specifically in the good medical practice code. That is the best way I can answer that, I think. I would certainly refer to my Justice colleagues about that.

Ms Robertson: I think what Dr Wakefield said is correct. It provides clarity. It places those obligations, albeit hovering over that, from want of a better expression, still remains the issue around the normal disciplinary process in relation to medical practitioners generally. Because it is a specific legislative requirement set out there, it is clearer and very precise in relation to what has to happen in those circumstances. Again, it gives clarity to the medical practitioners. It also gives clarity for women in that particular situation about what they are entitled to be told in those scenarios, harking back to the underlying principle that this is a medical health issue.

Dr Wakefield: Essentially, this is a professional code of practice. Well outside termination of pregnancy, it is very clear that, under good medical practice, the professional obligations on doctors to not put their own value judgement on a particular procedure and to not stand in the way of patients accessing health care is really clear in the professional guide. The bill just makes that very explicit for the termination of pregnancy.

Mr McARDLE: Dr Wakefield, we have spoken about clinical standards and guidelines as they currently stand. Can you table that document for the committee's purpose, if you do not mind? There are myriad guidelines on the Queensland Health website and trying to extract the one that we are looking at is somewhat difficult. Would you mind doing that, or taking that on notice?

Dr Wakefield: I am very happy to provide that to the committee. I had better take that on notice so that we can provide you with the copies you need. In terms of the issue taken on notice previously about the current two-step process, I now have that information, if you want me to provide that?

Mr McARDLE: Yes, thank you.

Dr Wakefield: In terms of the facility-level approval—and this is for the current late-stage termination—under 3.2.1 of the clinical guideline titled 'All cases' it states—

Two medical specialists, one of whom must be a specialist obstetrician, consider the circumstances of each individual case—

- Ideally, one specialist should be the practitioner performing or overseeing the procedure—

The person to whom the patient has that therapeutic relationship—

- The speciality of the second medical practitioner should be relevant to the circumstances of the individual case
  - Consider local facility approval requirements—

and, again, often hospitals create their own governance of these decisions and—

This may include notification to/approval from the Executive Director of Medical Services or equivalent.

There are a few other components to that, including social work and counselling. Basically, that is what we have as our current guidance around those two doctors. One is the obstetrician and one may be, but it does not have to be.

Mr McARDLE: Thank you very much.

Dr Wakefield: That is in the guideline and we will tender that.

CHAIR: You have one final supplementary question?

Ms BOYD: Dr Wakefield, during the hearings we heard from the AFA that they still believe that abortions cause breast cancer. Can you please comment on that for the committee?

Dr Wakefield: I am not aware of any such evidence. That is probably all that I would have to say about it.

Ms BOYD: Thank you.

CHAIR: That brings our hearing to a close. I thank the department very much for your contribution in this particular inquiry. It has been very beneficial to have you here today. I declare this public briefing closed.

The committee adjourned at 11.28 am.