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 MF McArdle MP
Mr ST O'Connor MP
Ms JE Pease MP

Staff present:

Mr R Hansen (Committee Secretary)
Mr J Gilchrist (Assistant Committee Secretary)
Ms R Stacey (Assistant Committee Secretary)

PUBLIC BRIEFING—INQUIRY INTO THE TERMINATION OF PREGNANCY BILL 2018

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 24 AUGUST 2018

Brisbane

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The committee met at 11.34 am.

CHAIR: Good morning and welcome, ladies and gentlemen. I declare open this meeting 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 meet today. I am Aaron Harper, the chair of the committee and the member for Thuringowa. With me today are: Mark McArdle, the deputy chair and member for Caloundra; Michael Berkman, the member for Maiwar; Barry O'Rourke, the member for Rockhampton; Nikki Boyd, the member for Pine Rivers, who is standing in for Joan Pease who may join us shortly; and Sam O'Connor, the member for Bonney. We have an apology from the member for Nicklin, Marty Hunt.

The purpose of the meeting today is to receive a briefing from officers of Queensland Health and the Department of Justice and Attorney-General to assist us in our examination of the Termination of Pregnancy Bill 2018. The bill was referred to the committee on 22 August for examination. I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing rules and orders. In this regard I remind members of the public that under standing orders the public may not participate in proceedings and may be admitted to, or excluded from, the briefing at the discretion of the committee. This briefing is being broadcast live on the parliamentary website and being transcribed by Hansard. We will make the transcript available at the end of the hearing in due course. Those here today should note that media may be present, so you may be filmed or photographed.

I would like to acknowledge those who are observing the proceedings possibly downstairs in the Dandiir Room. As there is limited seating in the committee room, we have booked the additional room for anyone who is interested in this particular bill. I welcome officers from Queensland Health and the Department of Justice and Attorney-General.

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 for being here this morning to provide the briefing. Any responses to questions that are taken on notice must be provided by Friday, 31 August. I invite you to make an opening statement to the committee before we move to questions.

Dr Wakefield: Thank you for the opportunity to brief the committee today on the Termination of Pregnancy Bill 2018, otherwise referred to as the bill. As departmental officers we are here today to answer 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. With the chair's permission, I propose to provide the committee with a brief summary of the key changes contained in the bill before questions.

This bill implements the government's commitment to introduce a bill based on the recommendations of the Queensland Law Reform Commission. The QLRC report contains 28 recommendations for legislative changes to reform the law and decriminalise safe termination practices in certain circumstances. It also introduced draft legislation based on its recommendations. The bill incorporates the QLRC's draft legislation with some additional provisions to support its effective implementation.

Sections 224 and 225 of the Criminal Code currently make it a crime to unlawfully terminate a woman's pregnancy. Under section 226, it is also a crime for anyone to supply or procure anything which that person knows is intended to be used unlawfully to procure a miscarriage. Current case law provides that a termination will be lawful where it is necessary to prevent serious danger to a woman's life, physical or mental health, and is not out of proportion to the danger intended to be averted.

The purpose of the bill is to enable reasonable and safe access by women to terminations of pregnancy and to regulate the conduct of registered health practitioners in relation to such terminations. The bill achieves this by amending the Criminal Code and creating a new legislative scheme for the conduct of terminations in Queensland.

The key aspects of the bill include a repeal of the current offences relating to termination in the Criminal Code and the insertion of new offences in new section 319A for an unqualified person to perform or assist in a termination. A medical practitioner may perform a lawful termination on a woman upon request up to a gestational limit of 22 weeks. After 22 weeks a lawful termination can be performed if at least two medical practitioners agree that the termination is appropriate in all the circumstances. A medical practitioner, nurse, midwife, pharmacist, Aboriginal and Torres Strait Islander health practitioner or other registered health practitioner prescribed by regulation may assist a medical practitioner to perform such a termination.

Registered health practitioners are required to inform a person in certain circumstances of their conscientious objection to termination of pregnancy and to refer or transfer the care of a woman who seeks advice or treatment about a termination. In considering a matter under another act about a registered health practitioner's professional conduct or performance, regard may be had to whether that practitioner complies with this bill. Safe access zones will be established around premises where terminations are performed to prevent the harassment and intimidation of people as they enter, that is staff or women.

Clauses 5 and 6 of the bill provide that a medical practitioner may perform a lawful termination on request up to the gestational limit of 22 weeks and after 22 weeks gestation if the medical practitioner considers that in all of the circumstances a termination should be performed and that another medical practitioner has been consulted who concurs. In forming that opinion the medical practitioner must have regard to: all relevant medical circumstances; the woman's current and future physical, psychological and social circumstances; and the relevant professional standards and guidelines that apply. The bill makes it clear that these provisions do not need to be complied with in an emergency.

This broad test gives discretion to address the range of individual circumstances that may arise in practice, and this approach leaves the assessment of the individual circumstances to the medical practitioner or practitioners and the woman. The provision does not impose additional requirements about the qualifications, expertise or experience of the second medical practitioner, as these are matters to be determined on a case-by-case basis in accordance with good medical practice. The bill does not include any express requirements about obtaining consent, and the usual requirements under the general law about consent for surgical and medical treatment apply to terminations performed under the bill.

The term 'medical practitioner' is not defined in the bill, as its definition is already contained in schedule 1 of the Acts Interpretation Act 1954 to mean a person registered under the Health Practitioner Regulation National Law to practise in the medical profession other than a student. Other relevant terms are defined in the dictionary in schedule 1 of the bill. 'Termination' is defined to mean an intentional termination of pregnancy in any way, including by administering a drug or using an instrument or other thing. This makes it clear that a termination can be a surgical or medical procedure.

As mentioned earlier, the bill includes some additional provisions to the QLRC draft legislation to support effective implementation. Most of these changes are minor and technical amendments that are included to clarify the intent of the QLRC; for example, the use of examples, inserting notes, better alignment with the language of the relevant health or legislation or as necessary and consequential to the repeal and insertion of new Criminal Code provisions.

I draw the committee's attention to key variations from the QLRC's draft legislation. Firstly, the bill provides that an Aboriginal and Torres Strait Islander health practitioner or other registered health practitioner prescribed by regulation may, in the practice of their health profession, assist a medical practitioner to perform a termination. The addition of assistance for ATSI health practitioners will actually contribute to providing culturally safe and appropriate advice and support for women in rural

and remote areas in particular. This is actually consistent with the Northern Territory legislation. The ability to add registered health practitioners by regulation future proofs this legislation by ensuring that other appropriately qualified health practitioners or emerging health professionals may assist.

The bill expressly provides that the part relating to safe access zones overrides the operation of the Peaceful Assembly Act 1992. This is a variation from the QLRC draft, but is consistent with its stated intention in the report. It would undermine the purpose of these provisions if, for example, an organiser of a protest in relation to terminations could hold an authorised public assembly within a safe access zone. To ensure police have adequate enforcement powers for the safe access zone offences, an amendment is also made to section 32 of the Police Powers and Responsibilities Act 2000 to allow the police to search a vehicle without warrant. Provisions are also included to facilitate the giving of evidence of certain matters relating to safe access zones. An amendment to the definition of 'perform' in new section 319A of the Criminal Code is made to clarify that that includes an attempt.

Going to consultation, as detailed in the explanatory notes, no specific consultation has occurred in relation to the bill. However, the bill is based on the QLRC report and its specific consultation and the consideration of former parliamentary committee inquiries where some thousands of submissions were made.

Chair and committee, thank you for the opportunity to address you on the significant reform contained in the bill. We are now happy to take questions.

CHAIR: Thank you very much, Dr Wakefield. Firstly, I welcome the member for Lytton, Joan Pease.

Ms PEASE: My apologies for my lateness.

CHAIR: Just to clarify, the member for Pine Rivers, Nikki Boyd, is substituting for the member for Rockhampton, Barry O'Rourke. Dr Wakefield, thank you for your opening statement. You are entirely correct: this is a significant bill that will affect women in Queensland. As the QLRC report mentions on its first page, this is a health related issue. The bill has been drafted to address some specific areas of decriminalisation and to make termination in Queensland a health issue, of course drawing on the 22-weeks gestational period, conscientious objection and safe zones.

I was a member of the former committee, as was the deputy chair. You talked about consultation. I think over 3,000 submissions were made to that committee. The QLRC had a further 1,200. There has been significant consultation in Queensland over the past couple of years on this particular issue, which did bring some divergent views from across the state. However, as chair of this committee, it is my intention to guide committee members to stick within the confines of the QLRC report, that is, 22 weeks gestation, conscientious objection and safe zones. I say that because I do not want to go outside the scope of the bill. We have a short reporting period. We will be going out to consult with the public and drafting a report to the parliament.

Obviously, you looked to other jurisdictions. Victoria would probably be the closest with 24 weeks. They introduced their legislation some years ago. From memory of their briefings, they have seen a decrease since decriminalisation. Can you talk to the Victorian experience a little before we move to other questions?

Dr Wakefield: The QLRC referred to this in its report and to relevant research. Certainly, the experience in Victoria and, as I understand it, internationally has been that the decriminalisation of termination of pregnancy in jurisdictions has not led to a significant increase in the numbers of terminations of pregnancy. Obviously, there would be a significant body of research around that. I draw on the conclusions made by the QLRC that that is the case.

CHAIR: I will open up questioning to other members.

Mr BERKMAN: Conscientious objection is a key component of the bill. Obviously, the right for conscientious objection and the requirement for referral is intended to strike a balance there. The outcomes of that, though, are going to differ quite dramatically for people in regional communities as compared to those who have generally better access to termination services. Obviously it will lower barriers for women in regional and remote areas. What consideration has been given to the way that conscientious objection is dealt with in those areas to, I guess, deal with the greater barrier faced in those areas?

Dr Wakefield: In respect to conscientious objection, the bill is clear on the fact that it is a right of a registered health practitioner and doctor to be a conscientious objector and to not engage in performing terminations of pregnancy. But there are some specific obligations upon conscientious objectors in the legislation. Any conscientious objector is required to inform a patient about their conscientious objection. They are also required to make a referral, either to a person who they believe

to be a provider who does not have a conscientious objection or to a service such as a termination of pregnancy service provider organisation that they have a reasonable belief would provide those services. From a technical perspective, in the bill that is very clear.

Going to your question more specifically about rural and remote areas, the question perhaps is: will the conscientious objection provisions change access? I am not sure I can realistically comment on that or hypothesise on it. I can say that, certainly from a policy position—and the minister has made public announcements about this—Queensland Health will be undertaking a process, which we have commenced, to work with health services and their own local service providers to understand where there are significant barriers to access for services for women.

We know that some women have significant geographic and economic disadvantage, particularly in remote areas—and we know this is the case particularly in Far North Queensland, on the cape and in the Torres Strait—and we will be seeking to close that gap. That is not specifically around conscientious objection, but I understand you are saying that, in rural areas where there are not a lot of providers, the conscientious objection provisions can impact access. We will be seeking to identify particular groups of women that are disadvantaged. If necessary, the Queensland public health system will be taking steps to try to address that.

Mr BERKMAN: Fundamentally, the question is to whom might those women be referred in the case of conscientious objection when they are in remote and very remote areas? From your response, it sounds as though Queensland Health is trying to look at that in some kind of systemic way.

Dr Wakefield: This opportunity is being taken to really understand what the current state of access is for communities. Whether barriers exist as a consequence of conscientious objection or for other reasons, we will be seeking to identify significant barriers and work with local providers to help overcome those.

Ms PEASE: Thank you very much, everyone, for coming in to discuss this really important piece of legislation. My question sits around the 22-weeks gestational period. I know there is much discussion around that and it is outlined in the paperwork. Would you be able to explain why you have arrived at 22 weeks as the most appropriate time?

Dr Wakefield: The gestational limit of 22 weeks was a recommendation of the QLRC. It was based on their analysis. The things that they took into account were several and I will explain those. Firstly, 22 weeks generally fits with the time or the stage immediately before the threshold of viability of a foetus on current clinical practice. The accepted threshold of viability is between 23 weeks and 25 weeks and six days. Today's clinical practice and our abilities to support very premature life rest in that window. That was one reason they made that recommendation.

The second reason was that we have a clinical services capability framework in Queensland that applies to the public health system and also applies through regulation to the private health system. What does that mean? Essentially, it provides a definition of the level of service capability that is required in order to support termination of pregnancy, in this case, according to the complexity of what is involved and the risk to the mother. In our current services capability framework, terminations after 22 weeks require that they be done only in hospitals and not in day surgeries and community clinics, and that they be done at the highest level hospitals. These are the sorts of hospitals that have access to the highest level of specialisation, sub-specialisation and support services, including social work and other types of psychological support and assessment, as well as the expert clinical support.

The third reason that they quoted was that this aligns with current practice. At the Royal Brisbane and Women's Hospital, the premier women's hospital of the state, they have a facility level approval process that used a 22-week threshold. If you like, it already existed in practice.

Finally, and certainly the QLRC referenced this significantly, post-22 weeks it is significantly more complex and risky to the mother to undertake those procedures, so that required a specific threshold. After 22 weeks, the bill and the QLRC recommended that there be a very different threshold for the approval of a termination. As you would be aware, pre-22 weeks it is on request, so no particular reason is given; it is deemed to be health care. Post-22 weeks, the requirement is for there to be two doctors and it cannot proceed unless those two doctors sign off on it and, in doing so, consider all the relevant circumstances. That really is why they came up with 22 weeks.

The other comment I would make about that—and the QLRC made this very clear—is that in consideration of the rights of the foetus, they recognise this was an arbitrary threshold but post 22 weeks they recognise the issues around viability of the foetus change and the risk to the mother of procedures changes. Again, they provided that explanation for having a threshold and for that being 22 weeks.

Mr McARDLE: Thank you, Dr Wakefield. I too want to stay with the 22 week period but take the other perspective. States across Australia have different periods in relation to when a termination can occur—at 22, 14, 24 et cetera. Can you indicate how many babies were born before 22 weeks gestation and have been successfully resuscitated and compatible with life in 2015-16, 2016-17 and 2017-18? Can you get that data for us?

Dr Wakefield: Through the chair, I would certainly have to take that on notice.

Mr McARDLE: Absolutely, that will be fine.

CHAIR: I am just trying to draw how that might be relevant to what we are talking about here so I can make a determination.

Mr McARDLE: Certainly. We are saying to the parliament and the people of Queensland that up to 22 weeks a woman can have a termination. I am asking the department to substantiate why 22 weeks is the relevant time period, as opposed to 14, 15 or 16 weeks et cetera.

CHAIR: Deputy Chair, Dr Wakefield has just given us extensive details of why they chose 22 weeks. It has been reported in the QLRC. I do not see the relevance of your question.

Mr McARDLE: Chair, with all due respect, the government has put this bill up putting in 22 weeks. If there is evidence out there that children actually were born before that period successfully, that is an important criteria for the parliament to understand. It is all well and good for the Queensland Law Reform Commission to come to a conclusion, but it is still up to us and the parliament to come to a conclusion whether or not that is a fit and proper time period.

CHAIR: Deputy Chair, I have considered your question. I do not see it being relevant, particularly given Dr Wakefield's response of why 22 weeks has been suggested. Dr Wakefield has given a very detailed response, and I thank him for that. You referred to the QLRC report on the viability. I do not consider your question is relevant. I am going to rule that one out of order and ask you to consider moving to another question.

Mr McARDLE: Chair, that is a relevant question. Dr Wakefield can refer to the Law Reform Commission report. I am asking Dr Wakefield simply to explain whether there is evidence that runs contrary to that being a relevant time line. What about 15 weeks or 16 weeks or 17 weeks? That is a legitimate question.

Ms BOYD: I raise a point of order around the member being argumentative. Chair, you have just ruled on this matter. I ask you to direct him to move on.

CHAIR: Thank you for your point of order. I have made a ruling and I am asking that we move on to another question.

Mr McARDLE: I will put on record my disappointment in relation to this ruling. You have made a ruling and I will abide by it, but I can certainly state that this question should be investigated and investigated properly in this committee.

CHAIR: Will you move on to the next question please?

Mr McARDLE: Question on notice No. 779 which was asked on 11 May 2016 raised the point of terminations that resulted with a live birth outcome, and it covered the years 2005 to 2015. The answer provided the calendar year and the number of terminations that delivered a live birth outcome. What I am asking in relation to that question is what were the relevant gestation periods for each of those babies and what was the purpose of the termination?

Ms PEASE: Point of order, Chair. That is in line with the previous question which you have ruled out of order.

Mr McARDLE: No, it is not.

Ms BOYD: It is exactly the same question just rephrased.

Mr McARDLE: With respect, it is not. It is a completely separate question that requests further information on a question on notice answered by the relevant minister back in 2016 that relates directly to this matter.

Ms BOYD: You had an opportunity to ask further questions to the minister then.

Mr McARDLE: With all due respect, Dr Wakefield is here on behalf of the department.

CHAIR: Order, members. If we cannot progress to questions that are relevant, we may adjourn and step outside if you are dissenting the ruling. I have considered the point of order. It does relate to your previous question that has been rephrased. We have valuable time in front of us, with just 25 minutes left to get as much information as we can about this bill. I ask that we move to another question.

Mr McARDLE: Again, I put on record my disappointment—

CHAIR: I note—

Mr McARDLE: With respect, I will put on record my disappointment that these questions, in my opinion, are valid and this committee is not allowing them to be put or answered.

Ms BOYD: The chair has made a ruling.

CHAIR: I have made a ruling and I also made a statement at the beginning of this that we will stick to the scope of the bill. Let us please use the valuable time of the department in front of us.

Mr McARDLE: Chair, given your ruling and your comment, I will move on to the issue of conscientious objection in relation to clause 8 of the bill. This deals with the practitioner involved and it says that the practitioner can refuse to undertake the termination, but it then states that the obligation rests with that practitioner to refer to a practitioner who they believe will perform the termination. My concern is if I am a practitioner and I have an objection about a termination occurring based upon conscience, I am legally now being obliged to refer to a practitioner to undertake a practice that I am against. I do not understand the rationale of why you accept that I can have an objection based upon my conscience but then legally compel me to refer to a practitioner who will perform a service or termination that is contrary to my conscience. Can you explain that please?

Dr Wakefield: The provisions of the bill reflect the QLRC's deliberations on this matter and their recommendations. As referenced in their report, the QLRC considered the conscientious objection requirements in such a way to balance the rights of health practitioners with the rights of women in relation to their overarching objective which was around access to this as a health service. Going specifically to the report, 4.159 says—

Some health practitioners may consider that referring a woman elsewhere or transferring her care would make them 'complicit' in any subsequent termination. A referral does not necessarily mean that a termination will take place, but enables a woman to access a practitioner who can offer her a range of options, including termination.

Mr McARDLE: So the initial practitioner is to comfort themselves on the basis that it may not happen. I assume that is what you are saying.

Ms PEASE: I think that is out of order.

Mr McARDLE: The doctor can answer for himself.

Dr Wakefield: Again, I can only comment on the bill in terms of its technical nature and how that would occur in practice. I understand your question. I guess it is not my purview to comment on the merit of a particular aspect of the bill in terms of—

Mr McARDLE: Can I ask this question then. You have referred to the Law Reform Commission now on three or four occasions as being the basis for the content of the bill. At any time, did the department do an internal assessment as to the content of the bill before it was placed into the House, or does the department simply rely upon the Law Reform Commission as being the body of knowledge that generated the bill?

Ms BOYD: Point of order, Chair. In terms of the introductory statements we have had from the Attorney-General to this bill, this question has already been answered and addressed.

Mr McARDLE: This is the Department of Health. The Department of Health is taking conduct and carriage of this matter, as I understand it, even though it came through the Attorney-General's office. It is a health matter as outlined by Dr Wakefield, not a criminal law matter. Therefore, I simply pose the question of whether the department has undertaken an assessment itself of the terms of the bill.

Dr Wakefield: Through the chair, as a departmental officer, I can provide answers to the committee in relation to an explanation of the bill. It is not my role to provide an answer about the merits of the policy or how that policy came about. I would invite my Justice and Attorney-General colleagues to comment.

Ms Robertson: There are a couple of things that need to be reiterated. The bill that was presented to the House was a policy decision by government. The government was very clear that it was making a reference to the QLRC and that it intended to adopt the QLRC's recommendations. As Dr Wakefield indicated in his opening statement, departmental officers obviously had to examine the bill to make some of those changes that Dr Wakefield alluded to that were technical in nature. In relation to what I would say was a policy position in relation to the clause that the member has referred to, that is a matter for government and I really do not think the departmental officers can take it any further.

CHAIR: Thank you very much for that. I agree. Can you move to the next question?

Mr McARDLE: I will go to my final question before I move to other members. This is a matter where post 22 weeks—and, if I am wrong, please let me know, Dr Wakefield—termination would normally occur in a public health service.

Dr Wakefield: In a level 6, in a high-level facility, which is predominantly in the public health service.

Mr McARDLE: Exactly. At the last inquiry, we had some debate about exactly what takes place within a public health service hospital to ensure that a termination could take place. I want to dispel rumours that float around that you can, in my words, literally walk in and have a termination. There was a very strong clinical framework around how that takes place. You referred to that yourself in a question. Are you able to table or take on notice certain requests for documentation that explain the process that occurs in a public health hospital in relation to consultation and requirements, so that all the boxes are ticked properly before the termination takes place?

Ms BOYD: I raise a point of order, Chair, in relation to relevance. The question relates to the clinical framework that exists in a hospital or a health facility. It is not within the remit of this bill that is before us. I ask you to rule on relevance.

Mr McARDLE: I refer you to clause 6(2)(c).

Ms BOYD: The chair has the call.

Mr McARDLE: In considering whether a termination should be performed post 22 weeks, it states 'the professional standards and guidelines that apply to the medical practitioner in relation to the performance of the termination'. It goes to the very core; it is one of the reasons.

Ms BOYD: It is a departmental issue.

Mr McARDLE: It is a HHS issue.

Ms BOYD: Absolutely. It is not part of this bill.

Mr McARDLE: Yes, it is, because clause 6(2)(c) says that is one of the conditions. You have to comply with the standards and guidelines in relation to the practitioner in relation to the performance of the termination.

Ms BOYD: It is an operational matter.

Mr McARDLE: Dr Wakefield did say that predominantly it occurs in public hospitals so clause 6(2) (c) would apply here. It is not rocket science. I am not trying to do anything smart. I am trying to get the detail.

CHAIR: I take your point of order, member for Pine Rivers. I do think in listening to the response that it sits outside the remit of the bill that is before us.

Mr McARDLE: I think Dr Wakefield would like to give an answer but he cannot.

Ms BOYD: Are you a mind reader now?

Mr McARDLE: I know that he cannot, I accept that point.

CHAIR: Order, members. We are in a public hearing. Let us keep some decorum.

Mr McARDLE: It is going to clarify an issue that is burning out there in the public arena and that has been one of the bases for rejecting the bill.

CHAIR: I have made a decision based on the point of order raised by the member for Pine Rivers.

Mr McARDLE: I have no further questions.

Ms BOYD: My question goes to safe access zones within the bill of 150 metres which are intended to prevent harassment, intimidation and obstruction of women trying to access health services. I understand there has been a recent prosecution in Victoria in relation to their framework. Would you be able to inform the committee about what that is and how it may impact in Queensland? This may be a question for Ms Robertson.

Dr Wakefield: I might ask my colleagues to consider that question.

Ms Robertson: We are not aware of the details of that prosecution. We are happy to take that question on notice and make some inquiries.

Ms BOYD: Thank you.

Ms Robertson: Just to clarify, I do not know whether the member is alluding to the High Court challenge.

Ms BOYD: Yes.

Ms Robertson: I understand you are, apologies. We are aware of the High Court challenge. My understanding is that it is still at the very preliminary stage. I cannot actually give you the factual details around that, but I am happy to arrange for that to be provided.

Ms BOYD: Lovely.

Ms Robertson: It is a matter before the court so all we can give is the factual stuff that is on the public record.

CHAIR: What planning and training will the department offer staff if the bill passes?

Dr Wakefield: At present I think it is worth noting that around 95 per cent of terminations of pregnancy occur in the private and non-government sector in the community. We have turned our minds to how best to provide information on the bill that is suitable for clinicians in both the public and the private sector as well as to obviously consumers and women. I will cover that off in a couple of areas.

First and foremost, concurrent with the bill being passed into law should that occur, we will provide specific information to practitioners, targeted to practitioners, so they are very clear about their obligations under the law, and they will be published. We also have an implementation steering committee that has been established. That will work with stakeholders to make sure that their needs are met in terms of communication. You used the word 'training', but we will certainly be updating them on their obligations under the bill and to the extent that that requires them to put in place additional systems and processes. In addition to individual practitioners, of course, we will be providing information to service providers—public, private and non-government—so they are aware of their obligations including, for example, as was mentioned, how to set up a safe access zone and how to comply with the law in relation to pre- and post-22-week decision-making.

We already have in place a therapeutic guideline for termination of pregnancy, which exists within the current legal framework. It does not specifically apply to the private sector, although it is public and it is highly relevant to the current practice of termination of pregnancy. It is not specifically a legal document about the law, although the current law is explained in that document. It provides guidance to clinicians—and it is created—by clinicians in terms of the sorts of details of what the current evidence is in relation to providing the best clinical care at the different stages of pregnancy and the best care for women.

With a clinician led process we will be adapting that to obviously reference any new legislation. We will assist providers by, for example, providing the sorts of guidance documents that people can use that will help them comply with the law. Private providers will not be obliged to use a particular template, for example the two-doctor sign-off, but they are free to create their own. I guess our duty as the public health system is to create those resources so that anyone can use them. Because of the process, the clinical guidelines do take longer—they are more complex—but they will be done swiftly and make sure that the clinical context for termination of pregnancy reflects any new legislative framework. I hope that answers the question.

CHAIR: I think it does. Thank you very much, Dr Wakefield.

Mr O'CONNOR: Just going back to the conscientious objections, has any consideration been given to having a database of practitioners who will perform termination services? If so, how would you manage disclosing their views compared to ensuring that their views are known and making sure they are protected for having those views?

Dr Wakefield: In relation to the requirements of the conscientious objection provisions, we have turned our mind to how that would be administered. At this stage, given our early considerations we have no intention of creating any sort of register of persons with a conscientious objection. Why is that the case? It would be incredibly difficult to do. It may be prejudicial. Certainly this was referenced and considered in the QLRC report. I will quote 4.166 in that report. It states—

> Whether to publicly identify as having a conscientious objection to termination (for example, by placing a sign at their premises or on their website), and how to locate a practitioner or service to which a woman can be referred or transferred, are matters for individual health practitioners.

At that level the QLRC has deemed that that is an appropriate matter for consideration by providers.

Mr O'CONNOR: So it is between them and the patient, essentially?

Dr Wakefield: Yes.

Mr O'CONNOR: In terms of counselling, has there been any thought given to the provision for additional counselling services for women wishing to access a termination?

Dr Wakefield: Sorry, is that a question of clarification of an issue in the bill or an implementation question?

Mr O'CONNOR: Implementation.

Dr Wakefield: Again, the bill itself does not require women to have counselling or for that to be a prerequisite for access to termination of pregnancy. In the pre-22 week scenario, again that is a matter of abortion or termination on request. Service providers, generally speaking, would have access to referrals and support services, but they are not required to provide them and women are not required to have them.

Mr O'CONNOR: But the access is available?

Dr Wakefield: The access is available. Again, I cannot comment on every single provider, but I know as a matter of practice that that is certainly a consideration for providers of termination services. Post 22 weeks—we have already discussed that in practical terms they are relatively rare. I think there were 76 in 2016 out of an approximate 14½ thousand terminations of pregnancy, so these are not common; they are complex and every scenario is different. Because they have to occur in a high-level facility, it would be difficult to think of a situation where those wraparound services are not provided to women unless in an individual circumstance they refuse that. That includes social work, psychology support, potential for ethical care and so on. The short answer is that those services already exist and obviously they will be considered in any further development of services, but they already exist.

Mr O'CONNOR: In terms of the post-22-week situation we mentioned before, will any guidance be provided to practitioners in determining that, particularly with one of the provisions mentioning social circumstances?

Dr Wakefield: Again, from the technical legal perspective, I might just absolutely clarify the obligations for a doctor. The obligations in this new bill will be obviously that two doctors have to independently consider all the circumstances and sign off on this. That is not a matter of conscience; that is a matter of considering whether they should agree to termination. What does 'all relevant circumstances' mean? It means the woman's current and future physical, psychological and social circumstances and the professional standards and guidelines that operate within the medical practice and professional regulation.

What does that mean in practice? That is provided now certainly through the excellent work of the clinical guidelines program in that clinical guideline that I mentioned. We will provide significant guidance under a revised guideline to make sure that people know not only what the law is but, as I said before, how to give them confidence that they can comply with it. The tools, the templates, the scenarios, the necessary training support, if you like—so, 'Here are some scenarios. This is how that might work.' We will certainly be doing that. The ultimate responsibility, though, for compliance with the act obviously rests with, in that case, those two doctors.

Mr O'CONNOR: You would be updating the professional standards and guidelines? You cannot provide a definition of what they are at the moment; it would have to be updated with the act?

Dr Wakefield: There are quite a few different guidelines. There are the national guidelines that operate for registered practitioners, which are the professional regulatory guidelines. They are not our jurisdiction but they operate. They have to consider those when they make those decisions. I am saying that we will provide additional guidance for practitioners in making their decisions.

CHAIR: The allocated time for this briefing has expired. Thank you very much to each of you for appearing before the committee today. Please provide answers to the questions taken on notice by 12 pm, Friday, 31 August. The proof transcript of the briefing will be available as soon as possible. This brings our proceedings today to a close. Thank you, members, and thank you, witnesses from the department.

Dr Wakefield: Thank you, Chair, and thank you, committee.

The committee adjourned at 12.28 pm.