

REPORT ON PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

REPRODUCTIVE HEALTH CARE REFORM BILL 2019

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At Macquarie Room, Parliament House, Sydney on Thursday, 15 August 2019

The Committee met at 8:55 am

PRESENT

The Hon. Shayne Mallard (Chair)

The Hon. Niall Blair

The Hon. Abigail Boyd

The Hon. Greg Donnelly

The Hon. Rose Jackson

The Hon. Trevor Khan

The Hon. Natasha Maclaren-Jones

Reverend the Hon. Fred Nile

The CHAIR: Good morning and welcome to the New South Wales Parliament and the second hearing of the Standing Committee on Social Issues inquiry into the provisions of the Reproductive Health Care Reform Bill 2019. I will go through some very important housekeeping matters, which we do at the beginning of inquiries. Bear with me and then we will start the evidence. First of all, of course, on behalf of the Committee I acknowledge the Gadigal people, who are the traditional custodians of this land. I also pay respects to the elders, past and present, of the Eora Nation and extend our respects to other Aboriginal people present or viewing.

Today we will hear from panels of witnesses representing pro-choice groups, medical groups and others representing organisations' individual perspectives. I thank all the witnesses for their flexibility in making time available at such short notice. The purpose of this inquiry is to assist the members of the Legislative Council with more information both from experts and the general community on the implications of the Reproductive Health Care Reform Bill 2019. This Committee has held similar short inquiries on bills prior to considering them in the House and we have adopted the same approach to this bill as for previous inquiries into bills. On Tuesday 20 August, which is next week, the members of the Legislative Council will begin debating the bill. In doing so, they will be assisted by the evidence gathered at these hearings and the report that will be tabled next week.

I thank the thousands of people who have made submissions to this Committee since Friday. All members of this Committee acknowledge that there are very strong views in the community about this bill. As with other inquiries into bills that this and other Committees have conducted, it will not be possible to acknowledge all of the submissions that have been made. We hope to make available on Parliament's website certain submissions prior to debate on the bill in the Legislative Council next week.

Before we commence I will make some brief comments about the procedures for today's hearing. In relation to webcasting, today's hearing is open to the public and is being broadcast live through the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In relation to broadcasting guidelines, in accordance with the broadcasting guidelines while members of the media may film or record Committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I also remind media representatives that you must take responsibility for what you publish about the Committee's proceedings. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of their evidence at the hearing. I urge witnesses to be careful about any comments you may make to the media or to others after you complete giving your evidence as such comments would not be protected by parliamentary privilege if another person decided to take an action for defamation. The *Guidelines for the Broadcast of Proceedings* are available from the secretariat.

Regarding questions taken on notice, due to the short time frame for this inquiry, there will be no questions taken on notice today. In relation to adverse mention, I remind everyone here today that Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. I therefore request that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily. In relation to the delivery of messages and documents to the Committee, witnesses are advised that any messages or documents should be delivered to the Committee through a Committee staff member. In relation to audibility, to aid the audibility of the hearing may I remind both Committee members and witnesses to speak into the microphones. The room is fitted with induction loops compatible with hearing aid systems that have Telecoil receivers. In addition, several seats have been reserved near the loudspeakers for persons in the public gallery who have hearing difficulties. I ask those with mobile phones to turn them to silent.

In relation to order in the Committee room, before swearing in our first panel of witnesses I will say a few words to the many of you in the public gallery—fewer today than yesterday—who have come today to watch proceedings. I welcome you and hope that you find today's hearing informative. I note this bill and the issues it deals with are extremely important to all of us here today. You may have very strong feelings about statements which either witnesses or Committee members make during this hearing. Whatever you think about what is said though you need to watch the hearing quietly. Absolutely no applause or any other gestures will be permitted. I make the comment that yesterday's public gallery was extremely well behaved. I am sure that will continue today.

Members of the public also are not able to display signs or banners in the hearing. As each witness leaves the hearing, you need to let them leave the room and the building without any interference. Also you should note that no photographs or filming are permitted from the public gallery apart from the media photographers, who are authorised to do so. As Chair of this inquiry, I emphasise that if there is disregard of these hearing rules, I will not hesitate to ask people to leave the gallery or even temporarily adjourn the hearings. Throughout this hearing please follow any instructions from officers of the Committee. Thank you all for your cooperation so we can all

respectfully hear the evidence given today. I will proceed with our first panel for today of the 21 witnesses we have today. I thank you for coming in.

SINEAD CANNING, Campaign Manager, NSW Pro-choice Alliance, affirmed and examined

WENDY McCARTHY, Chair, NSW Pro-choice Alliance, affirmed and examined

EDWINA MacDONALD, Legal Director, Human Rights Law Centre, affirmed and examined

CLAIRE PULLEN, Chair, Our Bodies, Our Choice, affirmed and examined

MELANIE FERNANDEZ, Co-Founder, NSW Pro-choice Alliance, affirmed and examined

The CHAIR: Hello Wendy.

Ms McCARTHY: Hello Shayne.

The CHAIR: Welcome along.

Ms McCARTHY: It is some time since I have seen you.

The CHAIR: Yes indeed. We have submissions from each of your organisations numbered 26, 25, 28 and 30. There are two representatives from the NSW Pro-choice Alliance but only one can do an opening statement of up to five minutes.

Ms McCARTHY: Don't encourage me: I thought it was two.

The CHAIR: The secretariat says two, but we are more than happy to extend that to five.

The Hon. NIALL BLAIR: There will be more time for questions if you get through it.

The CHAIR: That is correct.

Ms McCARTHY: May I proceed?

The CHAIR: Yes.

Ms McCARTHY: My name is Wendy McCarthy and I am extremely proud to chair the NSW Pro-choice Alliance, which collectively covers an extraordinary number of organisations and people who are front-line providers in all aspects of reproductive health and education. Most of these organisations have been campaigning on these matters since the seventies when incremental gains were made in access to abortion services under common law. These groups are made up of the people who educate, advocate and care for the sexual and reproductive health and education of women and girls in our community. They collectively hold the trust and confidence of thousands of women and girls and many men. We feel confident of majority community support for our assertion it is time to remove abortion from the New South Wales Crimes Act and regulate it as a health procedure. Access under common law ruling does not remove the criminal risk.

Let us reflect. The New South Wales abortion laws have been in place for 119 years. While they may have been intended to protect women from backyard abortion providers they were also designed to punish women who dared to stray outside the nineteenth century boundaries of female sexuality when women were supposed to engage in sex only within marriage. These laws have not matured with our times. They have contributed to the shame, stigma and secrecy surrounding abortion in New South Wales and to the deaths of many women—well over the hundreds—as well as to the chronic ill health and infertility of many others. Many women of my age will remember visiting an underground abortion clinic, making furtive phone calls from public telephones to arrange the visit, driving to distant suburbs, passing through double doors after prepaying cash for the operation—67 guineas in 1964. It was humiliating, shameful and degrading—an experience to bury in the deep recesses of consciousness.

Many of us did bury those. Many of us did not speak out or find our voices for many years subsequently because by then we were educated and knew that it was time to speak out. I speak of a time before the Levine ruling, a time when contraception was still hard to access despite the availability of the pill in Australia since 1961. However, in those times many doctors would prescribe only to married women.

The contemporary equivalent of this situation, unbelievably, is the lack of timely access for women in remote and rural areas, who are often forced to cross State borders to obtain the health services they require. I

have this lived experience. I know what it feels like. Growing up in rural and regional Australia, I know how very difficult it was and how many young women at my university in New England disappeared. They disappeared because of unplanned pregnancies. Creating public debate about abortion, contraception and childbirth choices has been a major part of my professional life for over 50 years. This is not a new discussion. Since the Royal Commission on Human Relationships was established in 1974 and reported in 1976, the Australian community has been debating these matters. It is one of the reasons the royal commission was established.

All other States have come to an understanding that abortion is a health issue, not a criminal matter. Our gift to our daughters and granddaughters must be the reproductive choices we did not have, and safety and protection from criminal prosecution. It is time for change. I support the amended bill and commend our submission to members, but I want to leave you with one thought. In 1911 a group of women took the suffrage banner to the House of Commons in London. They were led by the wife of the Premier of New South Wales and various other dignitaries. The banner said:

Trust the women mother as I have done.

I commend that idea to you. Thank you.

Ms MacDONALD: I am Edwina MacDonald, the Sydney legal director of the Human Rights Law Centre. The Human Rights Law Centre welcomes this bill, which would finally bring New South Wales' archaic abortion laws into the twenty-first century and promote the right of women to control what happens to our bodies and our lives. I thank Ms McCarthy for her work and the work of so many other women for over a century to reform these hopelessly out-of-date laws. We urge the Committee to support passing the bill in its current form without any further delay or amendment. This bill is critical to improving reproductive health outcomes and will see abortion treated as a health matter to be determined between the patient and their doctor.

No other health procedure is regulated in law like abortion. It is beyond time to start treating abortion like a healthcare matter. As it stands, New South Wales' current abortion laws are hopelessly out of step with community standards, modern medical practice and human rights. The international human rights framework is clear: New South Wales has a duty to guarantee safe access to abortion services and post-abortion care, including by decriminalising abortion. Forcing women to carry pregnancies to term against their will causes serious physical and psychological harm, and has been recognised as violating the right to freedom from torture and cruel and inhuman or degrading treatment.

Laws that criminalise or restrict medical procedures needed by women discriminate against women and threaten basic rights to life, health and bodily autonomy. They perpetuate wrongful stereotypes of women as reproductive instruments and as being incapable of making decisions about their own bodies. Passing the bill would demonstrate that this Parliament respects women as competent decision-makers over their bodies and is committed to promoting women's health, safety and equality.

Ms PULLEN: We asked our community what we should say to this Committee today about why abortion should be decriminalised. I am going to read some of their stories to you. "Women had little rights under law and within society when this law was written. They could not vote, they could not inherit property in some cases, and general society expected that they would bear as many children as their reproductive and sexual lives demanded. This was seen as the only role for most women. Women need to be able to make decisions about their own lives. My mother was much more than a uterus for us seven children but was not able to be her complete person. While I absolutely believe abortion would never be the first option, for some it becomes their best option in their personal circumstances."

Our community told us stories of helping daughters, God daughters, sisters and friends to access abortion in New South Wales. Another story says, "I had an illegal abortion. When I woke up after the procedure I got medical instructions for the next few days and severe instructions on how to leave the clinic—to look casual, to make sure I was not followed, to speak to no one and, if approached by police, deny everything and never reveal the doctor's name". Another testimony said, "I have luckily never had to consider an abortion. I am educated, privileged and lead a wonderfully busy life compared to many others. My situation gives me a whole level of empathy for any woman that finds themselves in a situation in which they are classed as criminals for wanting to make a choice about their own destiny. I shudder to think that I could sit comfortably in my life knowing I have not spoken up for a woman in that spot."

Another wrote to us, "I am here to say and to comfort women who feel ashamed of having an abortion that you are not a disgrace or a murderer. You made the choice for you and no one has the right to tell you what to do with your body." One woman wrote to us and said, "I sat in an abortion clinic on Macquarie Street and signed a document that ensured I understood that I was a criminal. I felt so much shame. I was convinced I had to

make the toxic relationship I was in work. The relationship finally ended four years later with police intervention and a court-ordered AVO. Last week I was back in Macquarie Street, this time outside New South Wales Parliament rallying in support of a bill to decriminalise abortion. No person should ever feel ashamed of exercising their reproductive rights."

I sit here today to bear witness and give testimony in Macquarie Street on behalf of our community who want to see abortion decriminalised. Thank you.

Ms FERNANDEZ: Pro-Choice NSW thanks the Committee for the opportunity to appear today. Abortion is a health care issue, not a crime. Abortion must be removed from the Crimes Act in New South Wales to bring New South Wales in line with every other State and Territory across Australia. We support the bill in its current form and have grave concerns regarding some proposed amendments that would compromise access to health care when women need it most. In particular, we have grave concerns around amendments regarding gestational periods, sex-selective abortion and conscientious objections. With regard to gestational periods, the issues facing women seeking access to abortion services after 22 weeks are often distressing and include severe or fatal fetal conditions, a life-threatening illness to the woman and access issues, including rural conditions and experiences of domestic and family violence.

In 2018 the Queensland Law Reform Commission found that only 1 per cent to 3 per cent of abortions in Australia occur after 20 weeks. Some severe fetal conditions only present at the routine 18-to-20 week ultrasound, and often require further testing. For women in regional and remote areas, these tests can be delayed, which means they are pushed further into their time. For women in poverty, the ultrasound that happens at 20 weeks is the first opportunity they have to free access to a chromosomal abnormality scan. In particular, for these women experiencing intersecting disadvantage, earlier access could be prohibited. The one-to-two week buffer from the scan is essential so that women have time to make a decision in the most extreme circumstances, to not feel rushed in their decision-making and recognising that many will not receive the scan until 21 weeks.

With regard to sex-selective abortion, a 2013 Senate inquiry found no robust evidence that this practice is occurring in Australia. It also found that our sex ratio is within the expected range. Such an amendment is unnecessary and will also do harm, resulting in discrimination in healthcare provisions, particularly based on ethnicity and religion. The current public discourse around this issue has already resulted in unfounded generalisations and allegations being made against culturally and linguistically diverse communities. With regard to conscientious objection, any amendment that removes the obligation to refer would create barriers to needed health care, significantly impacting women in rural, regional and remote communities, and those facing domestic and violence, in particular.

Doctors have a duty of care to act in their best interests. The current bill balances our need for health care with religious freedoms, and any changes would disadvantage women. We strongly support the bill in its current form and have grave concerns about any amendments that have been proposed or discussed. Thank you.

The CHAIR: Thank you for your opening statements. They are very helpful. The Committee has agreed to five minutes per member to ask questions, generally in alphabetical order.

The Hon. NIALL BLAIR: Thank you for your submissions and for coming along this morning. I only have five minutes so we will crack on. I do not know if you saw the hearing yesterday, but there was some evidence from a number of witnesses that no women are being prosecuted under the current arrangements so therefore we should leave things as is. Some witnesses said that maybe we should put a little more investigation in and implement the current laws a bit more rigorously. What does it mean to decriminalise from your organisation's point of view and what do you say to those who say, "Just leave it as is because no women are being prosecuted"?

Ms MacDONALD: I think the starting point is that abortion should be treated absolutely as a health matter and not a criminal matter. With the current system it is not just about the prosecutions that are occurring, but also about the context of fear and uncertainty within which both doctors and women are operating and having to make personal decisions. What we are seeing is that it can deter health professionals from being involved in the service delivery for fear of committing a crime and it can also legitimise misinformation. We have heard of cases where doctors with conscientious objections have told women that abortion is illegal, so it can inhibit their access in that way. Ultimately, no other health procedure is treated like this and abortion should be treated like any other health procedure and be removed from the Crimes Act.

The Hon. NIALL BLAIR: Thank you. Does anyone have anything to add to that?

Ms CANNING: I have one thing to add to that. A woman was successfully prosecuted two years ago in 2017. It is patently untrue to say that women are not targeted under these laws.

The Hon. NIALL BLAIR: Thank you. The other thing we were hearing yesterday is that this is being rushed. Some people are saying that this is something that popped up two weeks ago and that we have not been able to hear from everyone and hear from the women. I have been here for 8½ years and this is not the first time this has popped up. I am just wondering how many women you represent, how long this campaign has been going on for in your organisation and whether we in New South Wales are just building upon what has happened in the other States and the previous campaigns or whether this really only started two weeks ago.

Ms McCARTHY: I should probably answer this, having been around the longest. First of all I would say that in the early marches of second-wave feminism in Australia and New South in the late 1960s abortion was an issue that was brought to public attention. That was probably following on from the experience in the United States and the United Kingdom, both of which were places I had lived at the time. I think that in the early 1970s, with the increase in the value of the Women's Electoral Lobby—which I was a founder of in New South Wales—education and reproductive rights were always seen as the two gateways for women's autonomy. That conversation has never changed. At that time getting the Levine ruling was seen as a break through and therefore we thought people would be able to get the services they required.

But the world has changed around access to services and things that we thought were secure no longer seem to be secure. The shock of someone being prosecuted in Queensland a couple of years ago and someone being prosecuted in New South Wales, along with the rise of suggestions to patients by people who have a conscience objection that it is unwise to go this way because there is a criminal threat of prosecution, determined that the people who had been worried about this for some time decided it was time to be really formal about how we moved about the issue. I think it is just utterly ridiculous to say that this is a new story. This is a continuing story about women seeking autonomy and women being free from prosecution. We now have a much more educated cohort of women. How many thousands? We could talk about the thousands who have been on marches carrying placards; we could talk about the thousands of words that are written; and we could talk about the people, groups, clients and patients that our pro-choice group has seen. There are hundreds of thousands of women.

The Hon. NIALL BLAIR: I am probably being a little bit unfair when I say this popped up two weeks ago. The criticism is that the bill only was exposed two weeks ago. But that is not inconsistent with what we have seen debated in other States and passed in other States, is it?

Ms McCARTHY: No.

Ms CANNING: I worked on the bill in Queensland last year and I think there has been some confusion. People are talking about the fact that Queensland debated the decriminalisation of abortion for a number of years. In 2016 an independent member in Queensland introduced a bill to Parliament to decriminalise abortion. It was very similar to a bill that Mehreen Faruqi, who is a former MLC and now Senator, introduced in the same year in the Legislative Council. Last year in Queensland a bill was introduced in August and it was voted on in October. It was not a surprise to them because they had been debating since 2016. The Legislative Council has debated a bill to decriminalise abortion before. It is not a new thing and to pretend it is a new thing is an insult to the women who have been campaigning for this for 50 years.

Ms ABIGAIL BOYD: Thank you all for coming along today and providing your evidence and for your continued advocacy in this area. We have heard a lot about this idea that this is rushed and that there should be a delay where we take a step back and cool our heels before proceeding any further. I just wanted to hear from you on what it is like for women trying to access reproductive services during a campaign like this where there is heightened media attention and platforms for those who would further seek to shame and stigmatise. Could you comment on that?

Ms CANNING: I have been really privileged to work alongside women and their families who have terminations of pregnancy, particularly women who have had terminations of pregnancy at a later gestation. I am really awed by their courage, compassion and their determination to see laws criminalising abortion overturned. They are determined to ensure that no more families have to experience such a personal and heartbreaking decision that is further exacerbated by abortion remaining in the Crimes Act. These women have spent the past few weeks being called murderers, being called "flippant" in their decision making, being told they do not have the capacity to make their own decisions, and being disrespected time and again by opponents of this bill.

Last year when I was in Queensland I was really humbled to work with two women in particular, Ashley and Zena, who testified in front of the Queensland committee considering a very similar bill. Ashley wrote a letter to MPs last year right before they voted to tell her story. At 21 weeks gestation she and her partner were told that there were major and multiple devastating fetal diagnoses for her very much wanted pregnancy. They considered and consulted on the decision with a team of doctors and essentially decided to end the pregnancy. She gave birth

and they called her son Thomas. They sat with their son for 12 hours after the birth. She said she chose to broke her own heart because she did not want her baby to suffer. I would really ask all members of the Legislative Council who are due to debate this legislation next week to please reflect on what they intend to say.

I appreciate, as do all pro-choice advocates, that this issue is emotive, obviously, and that people's feelings are guided by their own value systems. But there has to be compassion on this issue and I feel that that has been absent in this debate. There are women and families in New South Wales that have had terminations of pregnancy at a later gestation. These are not easy decisions. Their decisions were considered, their decisions were thoughtful, their decisions were compassionate and their decisions were made in consultation with their doctors, who found these procedures medically appropriate. There is going to be no difference if this bill is successful. Those who would condemn people for making such a decision are purposefully ignorant of the circumstances surrounding the choice to not continue with a pregnancy at a later gestation. Women are not making these decisions on the fly. They are not making them flippantly and to suggest so is highly insulting to women everywhere.

I have met with and talked to women in New South Wales who have been through this. Like I said at the start, they have been sitting through members of Parliament, members of churches and members of the media telling them that they are murderers, saying that abortion is going to increase, saying that late-term abortions are going to increase and saying that it is going to be an open slather. That is not the case in other States that have decriminalised abortion or in other countries. I would really like to ask that you treat this issue with compassion and I thank the members that have done so so far. Like I said at the start, they have been sitting through members of Parliament, members of churches, members of the media, telling them that they are murderers, saying that abortion is going to increase, saying that late-term abortions are going to increase, saying that it is going to be an open slather. That is not the case in other States that have decriminalised abortion, or in other countries. I would really like to ask that you treat this issue with compassion. I thank the members of this Committee who have done so, so far.

Ms ABIGAIL BOYD: Would anyone else like to comment on that issue?

Ms McCARTHY: I would really like to place on the record my 50 years working in family planning and, strange and spurious as it may seem, being the Cleo sex advisor for 10 years where I had 200 letters a week, that this is never a frivolous issue. Nobody expects to deal with an unplanned pregnancy. Rationally of course if you are not using contraception that might seem foolish. But the reality for most people's lives is that unintended consequence of an unplanned pregnancy, they often do not appear in a relationship until this fact is announced in a relationship, and decisions have to be made. We just need to acknowledge that it is the woman who is pregnant, it is the woman who requires autonomy, it is the woman who requires the discussion with the partner if the partner is part of the relationship still. You just have to trust the women to be able to make those decisions.

The Hon. ROSE JACKSON: Thank you for coming. It is quite a contrast to yesterday morning, looking out at your faces. I want to talk a little bit more about some of the issues with the current situation, because as my colleague the Hon. Niall Blair noted, yesterday we had evidence that suggested that the current situation for women in New South Wales is working perfectly well, that the laws do not need change, women can access abortion if they want it, but that having the procedure in the criminal code sends a message that we would rather that they did not. I want to dig down into the current situation, particularly in relation to women in rural and regional New South Wales because I do not think their voices are being heard, partly because that is because it is particularly difficult for them to come here and tell those stories. Ms Fernandez and a couple of others mentioned in their opening statements that currently under the present arrangement in New South Wales how are women in rural and regional New South Wales being disadvantaged in their access to this healthcare service?

Ms FERNANDEZ: We know that right now women living in regional, rural and remote communities really struggle to access comprehensive reproductive health care. We know that while it remains in the Crimes Act there is often practitioners not willing to provide those services, and we know that across all of our health care that in regional areas often it is underfunded and undersupplied, so particularly in reproductive health care women in regional areas struggle. We hear stories of women in regional communities who have to travel unacceptable distances to access comprehensive health care. We know that women in Wagga Wagga, such as Kelly, are travelling for up to 500 kilometres to access the reproductive health care that they need. Women travelling across the border to the Australian Capital Territory or Victoria to access that comprehensive health care. We have heard of paramedics in regional areas, such as Nick in Bega, who has had to respond to a backyard abortion where a woman has been forced into really difficult circumstances and put in a really distressing and life threatening circumstance for herself.

We know that the current criminal legislation is forcing women, particularly in rural and regional circumstances, to make very difficult decisions, to travel unacceptable distances. We know for women who are at risk of or experiencing poverty this can particularly be a barrier as well, to afford the travel to access reproductive health care and afford what can sometimes be overnight stays as well and those costs, and what that means for women who have children, who have families who depend on them, and the ability to be able to travel and access those services.

Ms McCARTHY: You used the phrase that somebody said that they would rather they didn't have abortions and the criminal code was a way of discouraging them.

The Hon. ROSE JACKSON: Yes, I think someone referred to it as a symbol of that, yesterday.

Ms McCARTHY: It is actually a legal instrument, and it is not a symbol, and it is an extremely heavy-handed way to be an educational motivator to not have an accidental, unintended pregnancy.

The Hon. ROSE JACKSON: I want to ask in my limited time about some of the amendments. I might only get to one so I will start with the proposed changes around conscientious objection for doctors. We heard quite a bit about this yesterday, about a doctor's right to refuse to provide women who are seeking information about termination, because they themselves have a conscientious objection to the procedure. Obviously, the woman as the patient has a right to access healthcare services, so we have a balance that we are trying to strike there between a woman's right as a patient to access a healthcare service and a doctor's right to have a conscientious objection to providing abortion services. In your opinion are we getting the balance right in this proposed legislation, or do you feel there is scope for amendment, or what is your view about the proposal on that balance in the legislation that is put forward?

Ms MacDONALD: As you said, what this provision is around conscientious objection is looking at how do we strike this balance between the rights. And we hear a lot about the rights of the doctors for their right of freedom of conscience and religion, but we are also balancing that with the woman's right to life, health, autonomy and non-discrimination. We at the Human Rights Law Centre really believe that it is essential that we maintain this current provision as it is in the bill at the moment in order to strike that balance. We would certainly caution about any further amendment to that provision.

We have heard from the Australian Medical Association, we have heard from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists [RANZCOG], that doctors have an existing duty of care to their patients, that this requires them to act in their patient's best interest and that this means referring patients to other health practitioners so they can receive the health care they need where they have a conscientious objection. This exists already under their duty of care and this is consistent with what the human rights framework would say about this. The United Nations Committee on the Elimination of Discrimination against Women is clear that governments should ensure that women are referred to alternative health providers when there are conscientious objections.

Similarly, there was a recent Canadian appeal court case that has considered this question about how to balance these rights and they found that the duty to provide an effective referral strikes the right balance between equitable access to health care and freedom of religion. If anything, I would say the current framing lands in the favour of the right to freedom of religion and conscience. Our recommendation for this is that it should be addressed by NSW Health, that they should take steps to monitor how it is operating as it is being implemented, but also to make sure that services are in practice accessible and available to women across New South Wales, including in the rural, remote and regional areas that we have heard, and if not, work towards ensuring the availability of services including through providing funding for those services. We also recommend that the five-year review look at this issue as well.

The Hon. TREVOR KHAN: My question is to Ms Wendy McCarthy, seeing she has been a long termer in this exercise. One of the criticisms we copped from, amongst others, Archbishop Davies yesterday was that the working group, of which I have been part, was deficient in not having consulted with the churches before introducing this bill. From your long time in campaigning what do you say would have been the outcome if we had gone to the likes of Archbishop Davies with our bill?

Ms McCARTHY: I think they have offered unsolicited advice regardless of whether you have gone to them, really.

The Hon. TREVOR KHAN: And that unsolicited advice is that it is bad.

Ms McCARTHY: I cannot speak for them, but as I hear it, I hear that they are asking for more time, which is a non-issue as far as I can see. That they are asking for superior consultation as a special interest group.

I do not accept their role as a special interest group. We live in a secular State and churches have their role and humanists have their role and just plain old men and women citizens have their say. I come from the community and I believe all the measurement of community, certainly since the 1980s, has said, over 70 per cent of people, this is a matter for a woman and her doctor.

When I was acting as an advisor to Malcolm Fraser on women's issues in the late seventies and early eighties, we commissioned an *Australian Women's Weekly* survey about this matter, and the resounding result from over 70 per cent of the population—in pockets it got up to 80, interestingly mostly in rural areas—this was a matter between a woman and her doctor. It has never wavered since we have been asking the community. The churches are not hearing what the women are saying.

The Hon. TREVOR KHAN: Thank you. Ms Fernandez, you spoke before of the—I will call them somewhat different circumstances of women in rural, regional and remote areas. Would you like to comment in particular with regard to the impact of the current law on Aboriginal and Torres Strait Islander women?

Ms FERNANDEZ: We know that for many vulnerable women at the moment, the ability to access services and comprehensive reproductive health care is very challenging, and we know that there are specific provisions that are proposed that would have potentially adverse impact on Aboriginal and Torres Strait Islander communities. If we are thinking about the provisions around conscientious objections, we need to make sure that there is adequate provisions for providing information and referral to ensure that particularly women from Aboriginal communities have access to the reproductive health care that they need and have that response.

We know that also for Aboriginal women who are living in remote communities, the access to adequate health care is a significant challenge that they face, and that there are often cultural barriers as well to engaging with the healthcare system. So having the current legislation in place, whilst it impacts on the availability of services, also the criminality can be something that hangs over women's head in a very significant way, not just in a symbolic way. So this is deeply problematic for vulnerable communities and particularly for Aboriginal and Torres Strait Islander women and communities.

The Hon. TREVOR KHAN: In the time that I have got left remaining, I would like to float with any or all of you to suggested amendments to the bill. The first one is one that would require women going for a termination to have counselling, and the second is for there to be a 72-hour cooling-off period between consultation and termination. I invite any of you to comment on the wisdom of such amendments.

Ms CANNING: The Queensland Law Reform Commission and the Victorian Law Reform Commission considered both of these issues. In terms of counselling, we believe that the current bill addresses it appropriately and we are supportive of that. I think one of the most important things in that particular section is that, in terms of the counselling, it would be the medical practitioner that is performing the termination of pregnancy that would decide whether it is appropriate to offer counselling. We would stress that that particular clause cannot be used by conscientious objectors as a way to impede care for women.

There are a lot of women that come to a clinic and it is at the end of their decision-making process. So they have consulted with their family, with their friends. They have consulted with their GP, perhaps, and they have decided that this is the best option for them. I have worked with a number of clinics and a number of hospitals both in Queensland and in New South Wales that do offer counselling to patients where they believe that there is a need to offer that counselling. I think that mandated offers of counselling and mandated requirements for counselling disrespect women and disrespect their own decision-making processes and their own values system. That is what I would say in terms of counselling.

When it comes to cooling-off periods, that is really dangerous. For women that are fleeing violence, for women that are in rural, regional and remote areas, a 72-hour cooling-off period could actually make the difference between accessing the service or not. In terms of women fleeing violence, they might get to their GP, they might get to the clinic and they are able to do it today or tomorrow. They need to do it in a certain time frame because sometimes a termination of pregnancy is actually part of their plan to escape the violent relationship. For people in rural and regional areas, they only have a specific amount of time that they can come to a more metropolitan area to access a termination of pregnancy.

Having then to return to their community and come back for the termination of pregnancy—it is just not workable for them. I think that sometimes this misses as well that pregnancies are a time-sensitive issue. The vast majority of terminations of pregnancy happen before nine weeks pregnant and that would mean that they would be able to access a medical termination of pregnancy. Making them wait another three days would mean that they might have to access a surgical termination and the difference in cost there is ridiculous. It is about \$400 difference in cost and that increases however far you get into gestation.

The CHAIR: Does anyone else want to add to that answer? Would you like to indicate that you agree with that answer?

Ms MacDONALD: I would just support what Ms Canning has said and just add that I think these amendments would be hugely problematic, that they would create unacceptable barriers to women accessing reproductive health rights and indicate a fundamental lack of distrust, both in women and doctors, in making these decisions.

Ms McCARTHY: I would second that and say I cannot think of any other health procedure that requires mandated counselling or counselling. I would also comment that in my long experience, that people offered counselling at the institutional base mostly do not want it. They have taken counsel from their most intimate friends. This is a deeply intimate matter to women.

The CHAIR: We did hear that yesterday.

Ms McCARTHY: They do not need to tell the story yet again when they have made the decision.

Ms PULLEN: We had several women from regional and rural areas share their stories with us, and we do support several regional chapters. For those women, the cost of travel to an urban centre—whether it be a regional one or Sydney, Newcastle or Wollongong—makes up anywhere between 50 and 75 per cent of the cost of accessing abortion. So if you are going to add only an extra three nights accommodation or an extra trip there and back, the cost will then put it beyond the reach of most of the women who spoke to us, which again—as has been pointed out—pushes people further into later-term abortions.

Ms FERNANDEZ: I would agree with what has been said. I would just add that we know from other circumstances that mandated counselling does not actually deliver the best outcomes for people who have experienced trauma. I understand that I think NSW Health have done some work around this, particularly around paramedics and their experience. So I think that mandated counselling has been shown to not actually deliver the best outcomes for the patient or, in these cases, the woman.

The Hon. NATASHA MACLAREN-JONES: I just want to begin with the opening comments made by Ms Fernandez. You referred to a Senate inquiry. What year was that?

Ms FERNANDEZ: I think it was 2013. There was a bill put before the Federal Parliament to amend Medicare funding for sex-selective abortion, and so there was a Senate inquiry undertaken into that issue to investigate whether or not it was occurring in Australia. The findings of the inquiry were that there was no robust evidence to support that the practice was occurring in Australia—that the sex ratios in Australia were as they should be expected. And the other findings were that the approach around this issue should not be legislation but should be community education and that specifically if an instance was occurring in rare cases, if it had been, that legislating against such a practice would potentially not have the appropriate consequences because then women would not necessarily be able to be open with their practitioner and have all of the information and make empowered choices, as they may need to.

The Hon. NATASHA MACLAREN-JONES: Are you aware of further studies that were done in 2015—SBS investigation that looked at it? It was conducted by a number of doctors that looked at sex-selection terminations across Australia and actually looked at it from State by State and actually found that there were cases, and they indicated 279 in New South Wales. Then obviously we have got the further study, the La Trobe one, which has been talked about more recently. Were you aware of both of those studies?

Ms PULLEN: I am familiar with those and happy to speak to them if it assists. I will start off by saying that I spoke extensively to a member of our committee who would be giving this evidence here today, were she not in India dealing with a family issue. The first thing she said was, how distressed she was with how this issue has been discussed, when it particularly targets her community. A lot of the language around, particularly the La Trobe study, is not careful in describing the communities in question—which are migrants from India and China. She felt that implied that people from her community hated girls, and hated their daughters.

I asked her what she would like me to say if gender selection came up, particularly with reference to the La Trobe study. That study says that there is some evidence of gender preference in women born overseas in India and China. What it does not say, and the study's author actually said, it does not show that gender selective abortion is taking place. The study's author says that what they think might be happening, is either gender selective abortion or gender selective IVF is taking place overseas. People are travelling overseas to access this service. It is worth noting though, and it came up yesterday, that India has a ban on sex selective abortion.

It has it at a legislative level that it is unlawful and it still takes place. Which goes to what Ms Fernandez is saying about a community education approach being the most valuable way to deal with it. India and China are most often mentioned in this context. There is a strong cultural son preference in those communities and those countries. I want to talk a little bit about what is called cultural competence. That is a buzz word so I will explain it to you by way of analogy. During the last Federal election, the Prime Minister was out walking around in Eastwood. He said to a woman, who he presumed was Chinese, ni hao. She said to him; I am Korean.

If you think about this in a practical sense, as the committee member who spoke to me about this said; if I go to a doctor they are not going to be able to tell if I am from Rajasthan or if I am from Tamil Nadu. And those two parts of India have radically different views on literacy for girls. They have radically different numbers around gender-selective birth preferences. She also said the doctor would not know if her family had been here since 1850. So when we are talking about how you are going to enforce such a law if you made it, you are going to require communities who do not get the best outcomes out of our health system as it is, to be surveilled by their doctors. In the 15 minutes that they get—for the \$37 that Medicare pays—when a doctor is trying to deliver primary care. To assume that doctor can discern, which part of which country someone is from, and what the cultural attitudes might be around gender preference, is extremely fraught.

It also leaves open the issue, and she said to me; Catholics do not have a unified position on abortion and contraception, so to assume that anybody from any community is able to be profiled on the basis, she said, was extremely fraught and would be the sort of thing that would isolate people from their doctors. There is one further point I would like to make on this. There has been a lot of commentary about this, talking about certain communities having a strong son preference. In Australia, there is some evidence that we are not the gender most discarded. A couple of years ago, the National Health and Medical Research Council [NHMRC] looked into whether or not our guidelines around IVF gender selection should be changed. There was a great deal of media from a number of families who said they had spent between \$30,000 and \$50,000 to go overseas to select for girls. There was an American expert quoted who said:

At my clinic, 70 per cent of the people we see are here to select for girls.

His clientele was almost exclusively Australian. So if you are going to talk gender preference, it is a much more complex and nuanced picture than some of the commentary around migrant communities might suggest. At a practical level, you are then going to have to assume that doctors are going to have to surveil all their patients for gender preference. At what point are you going to start doing that if you are a practitioner?

If someone comes along and says, I am considering having a baby, what vitamins should I be taking? I presume they will know to quit smoking but what should I do with my diet, and makes a throwaway comment about wanting to have little pink ballet shoes, what is the doctor's obligation going to be to make a notation of that in case that woman has an abortion down the line? If their partner comes along to one of their scans, and says, I cannot wait to start being a soccer coach. What obligation are you going to place on doctors to surveil patients to give effect to this? We know from overseas examples that outlawing gender selection does not work. The burdens it could place on practitioners and women are such that it would be unworkable, and would probably isolate people from the health care that they need. Thank you for the indulgence of the long answer.

Ms MacDONALD: Could I add to that as well. I fully support everything that Ms Pullen has said about the lack of evidence around this and the extreme risk of harm that a ban could cause. There is no evidence that decriminalising abortion would have an impact on sex selective abortions. I understand there remains concern that maybe this still exists in spite of a lack of evidence. So I wanted to address, where there is male bias sex selection problems, and there is evidence that this exists in some countries, what do we know about the best way to deal with this? If not abortion bans, how should we be dealing with this as a problem?

We know from the World Health Organisation [WHO] and from United Nations [UN] agencies, that where this does occur, the drivers are deeply-entrenched social, cultural, political and economic factors. So where it occurs, the problem is not with abortion law. The problem is with systemic discrimination against women. The appropriate response is not banning sex selective abortion. Doing that places the burden of this much larger structural problem on women and doctors, with a considerable risk of harm to women. And as we have heard from the Australian Medical Association [AMA], it is asking doctors to be mind readers.

So what is the response where this occurs? The La Trobe study, cited in these debates, is very clear about what a recommended response is, which is to focus on social, cultural and economic policy responses to tackle gender discrimination in all its forms. If we really want to address gender discrimination, what we need to be doing is addressing this more broadly. We need to be looking at better valuing the unpaid care work of women, addressing violence against women, looking at the underrepresentation of women in positions of power. It is really

clear, the evidence is really clear, from WHO and from UN agencies, that the answer to this perceived problem is not bans, the answer is addressing gender discrimination in all its forms.

The CHAIR: We need to move on. For the benefit of members, that was my question time as well because that was the area of questioning I was asking about.

Reverend the Hon. FRED NILE: If you want to be a successful coach, coach women's sport.

Ms McCARTHY: That is the lovely thing, is not it? The soccer coach can now coach his daughter.

The CHAIR: Order! Do not encourage disorderly conduct in the enquiry, the Hon. Niall Blair.

Reverend the Hon. FRED NILE: It is widely known from science and technology, and common sense, that in pregnancy the entity in utero is a life and human being. What is the position of the Human Rights Law Centre on the interests of the human in utero when it comes to termination of pregnancy? Does that human being in utero deserve consideration in law from a human rights perspective? If not, why not?

Ms MacDONALD: In my opening statement I was really clear about the international human rights law framework that applies. The international human rights perspective makes it very clear that there is a duty to guarantee safe access to abortion services, and that includes decriminalising abortion. So our perspective is very much that from a human rights perspective, abortion must be decriminalised and we support passage of this bill.

Reverend the Hon. FRED NILE: But you have not answered the question about the rights of the human being in utero?

Ms MacDONALD: The right to life occurs at birth. The human rights perspective is clear on this issue.

Reverend the Hon. FRED NILE: So you say that the baby in utero has no rights until it is born?

Ms MacDONALD: That is correct.

Reverend the Hon. FRED NILE: That is your official position.

Ms MacDONALD: Yes.

Reverend the Hon. FRED NILE: We have had many recommendations put forward on how to improve this bill, such as putting in amendments to ensure that women are not coerced into abortion, and amendments to rule out abortion on the basis of sex selection and disability. Do you support any of those recommendations?

Ms MacDONALD: Sorry, I could not quite hear you. I am not sure the microphone is working.

Reverend the Hon. FRED NILE: We have had many recommendations put forward on how to improve this bill, such as putting in amendments to ensure women are not coerced into an abortion, and amendments to rule out abortion on the basis of sex selection and disability. Do you support any of these recommendations?

Ms MacDONALD: Our position is that the best thing at this stage for access to reproductive health is to pass the bill in its current form. I am happy to comment—I am not sure if there are specific amendments that you wanted further comment on.

Reverend the Hon. FRED NILE: Will you comment if you know of any of the amendments?

Ms MacDONALD: Yes. Our submission is quite clear about what our position is, I think, on the amendments and that we support passage of the bill in its current form.

The CHAIR: As amended in the lower House?

Ms MacDONALD: As amended in the lower House, yes.

The CHAIR: Which is what we are dealing with.

Ms MacDONALD: We have expressed in our submissions some concerns about the lower House amendments and we make clear recommendations that the appropriate way for these to be dealt with is for NSW Health to monitor the implementation to ensure that there are not barriers to access for women accessing reproductive health services across New South Wales and for them to be considered through the five year review.

Ms CANNING: I think the best way to improve this bill is to make it an Act, and I think everyone on this panel would agree with that.

Reverend the Hon. FRED NILE: That seems to be one of the issues in these hearings, is that in my opinion and that of the people I represent, there are three people involved in this issue: the doctor, the mother and the unborn baby. It seems that all of you do not have any concern for the unborn baby.

Ms PULLEN: I might take that one, if I can. I will share another story from our community: "My mother sought help to control her reproductive options in the late 1940s after birthing two babies already. The male doctors told her that they could do nothing for her. She went on to have five more babies and loved the seven of us all. Finding out with the sixth child that she was a carrier of a genetic disease that would cause her son to have a shortened lifespan impacted us all. Even more so was the knowledge that she lived with for the next 70 years. And that was that we, as her children and grandchildren, also have to deal with the knowledge that she passed this defective gene onto her daughters. They could, then, in turn have a son with this degenerative and incurable disease and a daughter who could carry on that gene again. The disease is not eradicated in our family. Can you imagine waiting to see if it might pop up again in future generations, and can you imagine the range of decisions that we have had to make?"

This woman is my aunt. So when she talks about the members of her family who do not know if they are a carrier of a genetic disorder, she is talking about me. And this is a sex-linked genetic disorder. There is no cure. I also have an entirely unrelated medical condition that makes pregnancy and childbirth very dangerous. Depending on which study you read, it starts at nine times more likely to kill me than the average woman and goes up from there. So when we are talking about whether or not I can be trusted and women can be trusted to make loving and difficult decisions about ourselves and our families, the amendments that are being proposed will have real and in some cases deadly consequences.

None of my aunts made anything other than a loving decision about their families. But what you could do if you make some of the amendments proposed is leave me to die in childbirth, leaving behind a grieving and widowed partner and a son whose very brief life will be full of pain and indignity. So to suggest that women do not take appropriate care and think about everyone who may be involved is absolutely appalling.

The Hon. GREG DONNELLY: I will commence by saying thank you very much for your detailed submissions and the opportunity to provide us with some time to speak today. Ms Canning, it is utterly appalling, some of the things that have been said in this debate both inside and outside the Parliament, and I want to put that on the record. I cannot imagine what emotion and angst was associated around your experience and others as well.

Ms CANNING: Yes. It is not my experience. It is just the emotion that I feel on behalf of women that are being told they are murderers.

The Hon. GREG DONNELLY: Of others, sorry. And I just want you to know—and I will make this point—that is, those offensive, extreme comments made by participants in this debate—and that have come from various sides but the one you particularly talked about—brings no good reflection on them. In fact, quite the opposite. I want to assure you that is not the position of the people around this table. I speak for myself and I believe that others, if they did not agree, would say so. So I think we have an agreed position on that. We want to sort of work, which is a challenging process for all of us, in a most respectful way. So I just want to make sure that you do not think that those comments from a politician or a politician there, of whatever party, is a position that we hold around this table. First of all, with my limited time could I just go through some words, then lead into three questions?

Ms CANNING: Yes.

The Hon. GREG DONNELLY: I only have five minutes, and perhaps less now. I would like to focus on the terms of reference for the inquiry, which is specifically directed at the bill. I commence with these couple of paragraphs, which I just want to put to yourselves as a group just to set my further comments in context. I commence with the premise that you all have, all of you, and no doubt others appearing in this inquiry that we here for later today and yesterday, to strongly advocate for and on behalf of, as you sincerely believe, the absolute unqualified right of a woman to determine whether or not they carry a pregnancy to full term and birth. So that is the clear unequivocal position that I accept in your submission before us today. I acknowledge your sincere belief that abortion should be removed from the New South Wales Crimes Act, and no-one can deny that sincere belief. Can I also say—and I do not in any way say this in order to be provocative—that deliberate pregnancy termination is not healthy for the unborn. Deliberate pregnancy termination, in fact, extinguishes the life of the unborn.

Ms McCARTHY: Could you please speak more directly into the microphone?

The Hon. GREG DONNELLY: I apologise. With that said, which I think gives a context—

Ms McCARTHY: I missed that last bit.

The Hon. GREG DONNELLY: Okay. I will read it again. I will read this paragraph. Can I also say that deliberate pregnancy termination—so we are not talking about miscarriage—is not healthy for the unborn. Deliberate pregnancy termination does extinguish the life of the unborn. That is just a matter of fact. Having said that—and it just sort of, I guess, paints the stark truth—can I ask these three questions? And I have listened to your answers from the other witnesses.

As far as statutory regulation goes, so this is the creation of an Act—and this is what we are looking at as Parliamentarians, as members of council—to deliberately terminate a pregnancy—so this is what we are talking about—is there any Act in Australia, anywhere else, in any other Australian jurisdictions—that you see as—and I will use the term—a "gold standard", the best Act that we should be looking at to inform ourselves about the debate next week? If so, why? Can I just go to my second question? I will get them out first. My second question is exactly the same question. As far as statutory regulation goes with respect to the deliberate termination of pregnant, is there any other Act in any overseas jurisdiction that we should look to as a gold standard to try to regulate abortion in this State—because this is what the Act is going to do—and if so, why? And is it your submission to this inquiry that there is no other possible amendment regarding this bill that is worthy of the Legislative Council supporting? I just want to get the three questions out.

The Hon. NIALL BLAIR: You did, just.

The Hon. GREG DONNELLY: Okay.

The CHAIR: Order. We will allow that to proceed.

The Hon. NIALL BLAIR: I am only joking.

The CHAIR: Would you like to address part or any of those questions?

Ms CANNING: The NSW Pro-Choice Alliance was launched in May of this year with the aim of implementing legislation in New South Wales that was very similar to the Queensland Termination of Pregnancy Act 2018 and Victoria's similar legislation that it passed in 2008. This bill is modelled on the Queensland legislation, and as such we support it. As I said before, the improvement that we could see with this bill is to make it into an Act. We will leave it at that.

The Hon. GREG DONNELLY: Those two States were the gold standards?

Ms CANNING: We support the bill as it is currently drafted and that was our aim.

The Hon. GREG DONNELLY: Any other?—because there are four parties—

Ms MacDONALD: The bill is broadly consistent with the legislation that we see in Victoria and Queensland and we support the bill on that basis.

Ms PULLEN: We have had the benefit of extensive considerations in other States and there is consensus around what deregulating laws look like—

The Hon. GREG DONNELLY: Okay, thank you for that. That was the first question. The second one regards overseas jurisdictions. Looking overseas, we know that abortion is regulated in a number of jurisdictions within state bodies or jurisdictions within individual States if there are States and Territories. Is there any Act overseas that we should be turning our eyes to, because it regulates abortion better, in your view, than perhaps what we are contemplating now?

Ms McCARTHY: None that I am aware of.

The Hon. GREG DONNELLY: Okay no, that is fine.

Ms MacDONALD: I would say that our view is that the best outcome, at this point in time, for women's reproductive health is to pass the bill in its current form. If you are asking me, if I sat down personally and drafted this bill, would it look different?

The Hon. GREG DONNELLY: Yes, that is what I am saying—if you did it.

Ms MacDONALD: Perhaps it would but that is not our parliamentary process. We have a bill that is consistent with Queensland and with Victoria and it is a bill that we support in its current form.

The Hon. GREG DONNELLY: Is that the position?

Ms FERNANDEZ : Yes, we would support what has been said. As I have clearly stated already, we support the bill in its current form and oppose any amendments.

The Hon. GREG DONNELLY: There is nothing overseas that is worthy of us looking at? Because we have to make a decision next week about this.

Ms McCARTHY: There is nothing overseas that is worth you looking at. We support the bill.

The Hon. GREG DONNELLY: Thank you for that. My final question is, is it your submission to the inquiry—today, here, your testimony—that there is no other possible amendments, regarding this bill—that is going to be considered next week by the Legislative Council—that you believe are worthy of the Legislative Council, as a body, supporting?

Ms CANNING: No, we have already addressed that.

Ms FERNANDEZ : We have been clear on that.

The Hon. GREG DONNELLY: None at all?

Ms McCARTHY: We stand by our submission, as presented.

The CHAIR: We have gone well overtime. As I indicated, I forfeited my time because I was going to ask about gender selection. That is why I allowed that conversation to continue—because it was the question that I would have asked. Thank you, ladies, for coming in and for making the time at such short notice and for the work you are doing in the communities that you are involved with.

(The witnesses withdrew.)

(Short adjournment)

KAREN WILLIS, Executive Officer, Rape and Domestic Violence Services Australia, affirmed and examined

DENELE CROZIER, CEO, Women's Health NSW, affirmed and examined

ANN BRASSIL, CEO, Family Planning NSW, sworn and examined

DEBORAH BATESON, Medical Director, Family Planning NSW, sworn and examined

The CHAIR: Welcome to the second session of the hearings for the inquiry into the Reproductive Health Care Reform Bill 2019, conducted by the Standing Committee on Social Issues. We have three submissions that we have received: 15, 31 and 38. I ask for any opening statements, up to five minutes, and then we will go on to questions.

Adjunct Professor BRASSIL: Dr Bateson and I thought we would do our statement together and keep it within the time limit.

Ms WILLIS: Firstly, I acknowledge the traditional owners of the land on which we meet and I pay my respects to the Elders, past, present and emerging. We come today in support of the passage of this bill as it stands. As an organisation, who, over the past 12 months has provided over 40,000 occasions of service to 18,000 individuals across Australia and, in New South Wales 10,000 occasions of service to over 3,000 individuals, who have experienced sexual violence—90 per cent of those being women—the issues of abortion are of constant concern to us.

When women contact us to say, "I have been sexually assaulted and that is shocking, but now I am pregnant", the devastation that you hear in their voice and the discussion about what to do next is heart-rending for them and their families. One of the things we need to tell women when providing their full range of options—the three options that people have when they are pregnant—is that if they do choose abortion, it is still under the Crimes Act in New South Wales, and the ramifications of that. The pain in women's voices when they say, "You're telling me that if I go ahead with this, I will be a criminal? What about the crime was committed against me, does that not matter?"

These are the things that our counsellors are working with women on, on a daily basis. The removal of abortion from the Crimes Act and placing it in the health care Act, where women who have to make that terrible choice can be treated with dignity and respect and, if they make a choice to tell their practitioners about the trauma and the crime that they experienced that caused them to be pregnant, then they will also be treated within a trauma-informed framework, so that the least possible damage can be done in their recovery process—not only from the crime that they have experienced but the subsequent decisions that they have had to make.

Ms CROZIER: Women's Health NSW and the 21 community non-government organisations and women's health centres, are, I believe, an essential part of the New South Wales healthcare system. Our aims are to provide services to women based on their value systems and needs and to help them access the healthcare system when required. We have always operated from the premise that a termination of pregnancy is a medical intervention and should not be in the Crimes Act. We support the Reproductive Health Care Reform Bill 2019 as a good balance between legal and medical practice as it occurs in New South Wales. We have found that the criminalisation of abortion has added to the problems that women experience when seeking a termination of pregnancy, regardless of the reason—whether it is because of contraception failure or unexpected sex, cancer treatment, medical complications, sexual assault or domestic and family violence.

The stigma and vitriol remains in public discussions, particularly from those who are active against termination of pregnancy, to the point that when we are talking about access to abortion services, or criminalisation or decriminalisation, the conversation is actually talking about women. Some of the disrespect that is in the debate actually traumatises women and it is certainly disgusting to be dismissed as a trivial matter or simply wanting to play video games, as someone said the other day. While we support the right of each of us to have individual belief systems, we support the New South Wales healthcare system to provide the care and medical system that women need. We believe that is where the discussion should be taking place.

We think that women choosing to have a termination of pregnancy is a very personal and scary choice. You are entering into a medical system that you may not have had any knowledge or previous information about. To enter a medical system and to be treated with disdain or dismissal is really quite outrageous. To actually be given punishment for your needs is really quite untenable. The current laws do not support a woman making her own choice. Cultural attitudes supported by the Crimes Act 1900 continue to promote judgement and punishment and really limit women's access to health care. Access is particularly difficult for Aboriginal women. We think that women need support, information and compassion. We think the health care system needs to be able to continue to manage the professional interventions required. Thank you for the opportunity.

The CHAIR: Thank you. Professors, you have five minutes collectively. I need to hold you to that for fairness.

Adjunct Professor BRASSIL: I agree completely with what these two women have said today so I am not going to repeat it. We will go to the questions later. Thank you for the invitation to present to this inquiry. We are entirely in support of the current bill as it stands and would like to see it passed in its current form. I am Adjunct Professor Ann Brassil and I am the chief executive of Family Planning NSW. I am a clinical psychologist and have worked in the health sector for about 40 years. I have worked significantly in mental health and in health services management—hospitals, community health centres—and for the past 13 years as CEO of Family Planning NSW.

Family Planning NSW is the leading provider of reproductive and sexual health at the community level. It works in the areas of clinical services, professional education and research. Everything we do in Family Planning is based on evidence of best practice. We are very committed to seeing evidence-based decisions inform the law within New South Wales, rather than issues of ideology. We could not practice if our services were not evidence based. We would like to see these best-practice principles applied to decision-making.

Adjunct Professor Dr BATESON: I am Dr Deborah Bateson. I have worked in reproductive and sexual health for 20 years. The majority of this time has been in Australia, apart from one year. I am the medical director of Family Planning NSW, which is the largest family-planning organisation in Australia. In my clinical practice, which spans these 20 years, I have provided health care to women from a huge variety of backgrounds, including women in rural and remote areas. I have provided my practice around their reproductive health issues and needs and this has of course included decisions about their pregnancies. Our special focus at Family Planning is on people from marginalised and at-risk populations, including young people, newly arrived migrants and refugees, people living with disabilities and people of Aboriginal and Torres Strait Islander background.

As you have heard, Family Planning NSW strongly supports the Reproductive Health Care Reform Bill 2019 in its current form. There has been great unity across key medical groups, which all support this bill in its current form. It is actually degrading to continue to support a law from 1900 that means that women cannot make a decision about their own reproductive health care needs. It is completely out of step with today's patient-centred approach to medicine. The current law also acts as a very significant deterrent to doctors in the provision of abortion services for fear of prosecution. It is hard to imagine that in 2019 we are having to argue for the rights of women to decide on their own health care. It is well past the time to address this matter and remove abortion from the criminal code. We look forward to contributing to this discussion.

The CHAIR: Thank you very much. The Committee has resolved to share the questioning in five-minute units or blocks, in broadly alphabetical order. The Hon. Niall Blair is the first cab off the rank.

The Hon. NIALL BLAIR: Thank you, Chair. Thank you for coming today and for your submissions. Ms Willis, yesterday we heard some testimony that the laws are not really being enforced and that in fact in some cases they are providing protection for women, particularly against coercion towards abortion, where they can basically say, "No, I am not going to do that because it is illegal," even though it is not being enforced. Do you want to elaborate on your opening statement and provide some of your experience in relation to the way that the law is intersecting with people who come across your organisation?

Ms WILLIS: Certainly. As I said, when providing information to women who contact us about pregnancy as result of sexual assault, because we are providing them with their full range of options on the pros and cons for each of those we certainly do inform them that it is still a crime under the Crimes Act and that them requesting an abortion purely on the basis of sexual assault is not a legal request. The distress that this causes is quite extreme. The coercion that we may hear is more on the other side of the fence, where the offender—usually their partner—will seek to stop any termination of pregnancy. Obviously a person who is pregnant and about to have a child is much more controllable than a person who is not.

When it comes to domestic violence we know that while the controlling behaviours will usually kick in within four to six months of the relationship occurring that the physical violence, which of course is just one aspect of domestic violence, will most often not begin until the first pregnancy—usually somewhere around six to seven months of pregnancy—where the woman's options of leaving are quite restrained by the fact that she is now pregnant. "Barefoot and pregnant" was the old saying—I think that is the other end of the coercion. I think at the moment the law supports that. Removing abortion from the law and making it a health care issue, where the individual who is attempting to access that health care support is the decision maker, will reduce the coercion rather than increase it.

The Hon. NIALL BLAIR: So the law in the Crimes Act at present is not protecting women?

Ms WILLIS: Definitely not.

The Hon. NIALL BLAIR: Thank you. Ms Crozier, you mentioned in your opening statement some of the reasons why women are accessing abortions. If we believe some of the correspondence and even some of the witnesses from yesterday, you could get the picture that it is just about people who do not want pregnancies anymore and we should just surround them with love and provide adoption services. Do you want to just elaborate on some of the reasons and complicated situations that may lead to women having to go down the path of an abortion, to expand the picture that it is not as simple as someone not wanting a pregnancy or a child?

Ms CROZIER: I can make a couple of comments on that. I think that some of the conversations start saying some abortions are okay because it is a medical complication and it is not okay if a woman does not want to continue a pregnancy. I think even that concept is a bit of a value judgement. It is not our job; it is the job of the confidence in that woman's life to know why she has decided that to continue a pregnancy does not suit her values and needs at this time.

Having said that, I was refreshed during some of the debates over safe access zones where it was finally realised that there is an enormous—I mean, a couple going to an abortion clinic who were being berated and yelled at may have gone because she has been diagnosed with cancer and needs to go through some treatment that is not compatible with carrying a pregnancy. There are circumstances where women have had three or four or five pregnancies and the lining of the uterus is not thick enough to carry a pregnancy. Some forms of diabetes are contradictory at that time in that woman's life. If you have got a weak liver or a weak back you cannot carry a pregnancy.

There is this presumption that it is all just about women's decisions. It is all about decisions, but it is always a decision within a context and each context will be different depending on the circumstances. We understand there have been statistics from South Australian clinics that clearly showed that at one time 70 per cent of women seeking an abortion did so because the contraception failed. So this concept that women are just willy-nilly out there being reckless is an insult to the big picture. We need to talk about it from its highest common denominator, not attitude and—

The Hon. NIALL BLAIR: My time has expired. I was interested in that confidence within the individual comment, but that might come up later.

The CHAIR: We need to move on to the next member of Parliament.

Ms ABIGAIL BOYD: Thank you all very much for coming and for providing your expert evidence. I think the Hon. Niall Blair has stolen some of my questions, but drilling down into the idea that is often painted in the media of women making this flippant decision, as though not only abortion is somehow easy to go through and easy to decide to do, but also that pregnancy is a walk in the park for all women, could you, particularly Ms Brassil, elaborate on the realities of what it is like for somebody actually making the decision?

Adjunct Professor BRASSIL: I might pass to Deborah some of the clinical issues about the complexities of pregnancy. I myself have two children. Neither of those pregnancies was a walk in the park and I will not tell you the gory details of what that experience was like, and having a really difficult pregnancy twice was not a consideration for me in terms of continuing with having the children. However, surely this is not the point. Surely the point is that we are trying to remove abortion from the Criminal Code.

Whether women should have the right to make these decisions themselves, given their circumstances, given the complexities in their life, given the complexities in their relationships, their health status, the health status of their children, the health status of their family members, their social circumstances, et cetera—these are very difficult decisions to make, and women do not take these decisions lightly and we should trust women to make decisions about their own health care. At the present time the system does not allow women to be trusted to make decisions about themselves, yet in so many parts of life we rely on women to make enormous decisions that have massive social ramifications, but in this area we still have the anachronistic view that women cannot make these decisions themselves and they must be controlled by the law.

Ms ABIGAIL BOYD: Before we allow other members of the panel to answer, just coming off that is this suggestion that women need mandatory counselling, presumably because they cannot make their own decisions, but underlying that, yesterday we heard two lots of reasoning for that. One was that women have not really thought about the decision before they make it, and the other one was that women do not adequately understand the health impacts of having an abortion. Could you respond to both of those things?

Adjunct Professor BRASSIL: I am going to put my clinical psychologist hat on. I am still a registered psychologist and I worked in mental health for 25 years. How do you mandate counselling? How do you do that?

Is there such a thing? Women know whether they need advice and support about the decision making that they go through. Women, by the time they come to the decision that they want an abortion, have by and large been through that process. You cannot add anything to that process except fear and concern by having mandatory counselling.

At the same time it is really important that women feel they have access to these services and if they have not been in a position to access them prior to coming to you and they say or you feel or they indicate that they want to have an extended conversation, of course we supply those services. We supply excellent services and counselling. We have social workers and psychologists—all of those people—to support women, but it has to be their choice. We need to trust that women know what they need when it comes to decision making. That is not something that you can mandate and it is very demeaning to think that women must have this mandate. I can think of no other area where it is mandated that women would need mandatory counselling.

Adjunct Professor Dr BATESON: I will add in: I have worked in this area for a long time and, as we have heard, seen many women who have gone through that decision-making process, and often they are coming to see me because they just want information. They have already made their decision, but they need information, and obviously on the law as it stands the decision is made by the doctor. The evidence is absolutely there that many women indeed have made that decision and actually have no need for counselling, and in fact it would be adding unnecessary delays and burdens to that woman accessing abortion.

You also mentioned that there was an idea that maybe women would miss out if they did not have counselling on learning about some of the so-called "health outcomes" associated with abortion. I hear from many distressed women who have actually been on the internet, been on Google, and they have ended up in very spurious anti-abortion websites, which have given all sorts of non-evidence-based information, which can make women feel very scared. I think what we need to do is remove abortion from the Crimes Act. We need to ensure that we have good evidence-based websites where people can read what is the truth and what is not.

I think at the moment women are often open to scaremongering and myths and misinformation. In my job what I am doing is taking a full history—a full social, medical history. I am, of course, asking about whether there are any areas where maybe someone would benefit from some counselling, and I would absolutely arrange that, but that is part of my duty of care as a doctor, it is regulated by my medical profession. This does not need to be regulated in law; this is what happens with us as doctors. We have a duty of care to our patients.

Ms ABIGAIL BOYD: Thank you, I have run out of time. I apologise for the background noise.

The CHAIR: I beg your pardon, we were resolving a problem.

The Hon. ROSE JACKSON: Thank you for making time to come along. I wanted to pick up on a line of questioning that my colleague Ms Boyd was asking in relation to some of the evidence that we heard yesterday that women would be getting abortions for any reason. Specifically I wanted to ask about later-term abortions. Again there was the suggestion that the passage of this legislation would lead to an increased number of women deciding later in their pregnancy for any reason that they did not want to continue. I understand that there is some evidence in relation to why women are currently seeking later-term abortions and I wanted you to talk about some of your experience of that and the actual evidence as to why the very small number of women who are seeking later-term abortions are doing that, just to respond to this idea that it is a sudden change of mind six months into a pregnancy that they do not want to continue.

Adjunct Professor Dr BATESON: I will answer this as a doctor and I will just say that that sudden change of mind just does not happen. That is not a reality. I think there has been a lot of misinformation. We know that abortions beyond 20 weeks are extremely rare and beyond 22 weeks are even rarer. We think less than one per cent of abortions happen at that time. They are always for very complex reasons. We have heard, I think in the previous day, about the need for that 22-week limit because of what we call the morphology scan, that is where foetal abnormalities are detected, and that happens between 18 and 21 weeks, and sometimes repeat scans have to happen as well, so women need time to make their decisions. These later abortions happen for severe maternal concerns and issues. These are never ever taken lightly, they are always within the context of a multidisciplinary team. There are many considered professionals involved in this in a compassionate way.

Sometimes there are situations where, you know, from domestic violence—we have heard about it earlier—there is sometimes a delay in the diagnosis of a pregnancy and this is always for very traumatic reasons. There are no sudden changes of people's minds. It is just not happening. And we look at the data—there has been some misinformation about the Victorian data on those abortions after 22 weeks. If we do look at the data sources there has not been any increase since the decriminalisation in Victoria in 2008. We need to look very carefully at that evidence and that data. There is no suggestion that those abortions would increase.

Adjunct Professor BRASSIL: Can I add something to that? I would like to give you an example of a friend of mine. She found out when she was about 20 or 22 weeks pregnant that the fetus that she was carrying was malformed and she did not understand what that meant. She and her husband have a very Christian background and so they went through this very traumatic process of trying to understand what was happening to this fetus and the viability of this potential baby. Along the pathway around the late 20s weeks they found out that this child was developing with no lungs and this was not going to be a baby that survived post birth because it had no lungs. This is a very good example of why people have late-term abortions. This is the true example.

Because of their religious beliefs and their emotional needs they decided to carry that baby to term and to deliver that baby and to hold onto that baby until it fully passed away, and then they buried that baby. I can tell you that would be a decision I would find enormously difficult to make. If this was your wife, if this was your daughter, if this was your sister, would you say to them: "You cannot have an abortion. This fetus is non-viable. We are determining that you have to continue with this pregnancy until 37 weeks or 38 weeks when we induce it." Or would you make that the family's decision?

These are heartbreaking cases. This is what we are talking about from 22 weeks. We are not talking about frivolous decisions. It is really frustrating to hear people give examples of cleft palates—as if that would occur. Women are responsible, caring, empathic human beings going through awful situations that are devastating and this is what they are trying to deal with. It should be their decision whether they carry that baby to term and have a "live birth" which is not interfered with from a neonatal perspective or whether they terminate that pregnancy in utero. That is a deeply, deeply personal issue for them and their family.

The Hon. TREVOR KHAN: I am moved by the evidence.

Adjunct Professor BRASSIL: It is a true story.

The Hon. TREVOR KHAN: I will just go to a couple of the amendments that are proposed or seem to be proposed. One is a proposal that there should be a 72-hour cooling off period, so called, between consultation and the termination being performed. What do you say about such an amendment? I am not going to direct any of this to anyone. I will leave you to make the decision.

Adjunct Professor BRASSIL: I will start. I mean, do we have no faith in women? Do we not believe that they are able to make decisions that are well thought through by the time they come to you? The later, if the woman has made a decision about having a termination and it is a fully informed decision and they are positive about moving forward, all you do is create more harm. This is a very difficult decision for a woman. A woman never, ever chooses to have a termination lightly. It is not a form of contraception. It is a difficult decision; they have made it. All you do is create more harm by having cooling off periods because what you are saying is, "I don't have faith in you that you know what you're doing. Take some time."

Adjunct Professor Dr BATESON: And I will also add that that creates unnecessary delays and burdens. We have been talking a little bit about women in rural areas. Already they have great challenges in needing to access an abortion, with travel and accommodation. To add on a mandatory so-called cooling off period only, as Adjunct Professor Brassil says, has potential for harm. And women have, as we know from the evidence—they make their decision and I think I agree that it is an insult to women, actually, to say that a cooling off period is needed. It is just a way of adding an additional barrier to women.

Ms WILLIS: I think we can also add for women in rural and regional areas that access to things like respite care for children while they travel to cities or elsewhere for three or four days to make arrangements and then have a cooling off period and then have the procedure that they have agonised is an additional burden. I would also suggest that particularly when we are talking about rural and regional women who are farmers and so on that saying to the cows, "Yeah, sorry, honey. You're not going to get milked for three days because the law says I have to have a 72-hour cooling off period. See you when I get back," perhaps is not the position that we want to put our farmers in.

The Hon. TREVOR KHAN: Ms Willis, I will direct this to you, perhaps in the context of what you talked about. I am from Tamworth. There are circumstances where women would travel, for instance, from Tamworth to Newcastle—I was aware of this in my practice—for a termination, some of them young women, some of them young women experiencing domestic violence. How would you see a 72-hour waiting period applying to those women, whatever the circumstances of why they are getting the termination?

Ms WILLIS: I think that what we are doing is just talking about adding additional burden.

The Hon. TREVOR KHAN: And potential exposure? They might not want their parents or their partner to know.

Ms WILLIS: Absolutely. And also being in a strange town for three or four days while they wait further damage can be caused. It is also about honouring women's decision-making and control over their own lives and not punishing them, because that is what we are really talking about here. By the time a person gets to a practitioner who is going to provide an abortion they have found out they are pregnant, they have gone through the decision-making, they have spoken with family or friends, they have looked up websites, they have probably spoken to their local GP, they have got their information, they have made the decision, they have made an appointment to go and see a provider, they are already there, they are ready to go. What we are talking about with a 72-hour cooling off period is nothing other than punishment for making that dreadful decision.

The Hon. TREVOR KHAN: Let me ask you this: Do you agree with the proposition that the evidence would seem to indicate that between one in four and one in three women experience a termination at some time in their life?

Ms WILLIS: Yes.

The Hon. TREVOR KHAN: Do you agree that women who are accessing terminations are from every socio-economic group; is that correct?

Ms WILLIS: Absolutely.

The Hon. TREVOR KHAN: So this is not a Left or Right issue; this is a pure women's health issue that affects potentially all women from every socio-economic status.

Adjunct Professor BRASSIL: Yes. Can I answer?

The Hon. TREVOR KHAN: Yes, absolutely.

Adjunct Professor BRASSIL: We run a research centre and we do a lot of data reports around reproductive and sexual health indicators. There is no data collection for abortions in Australia. There is also no contraceptive prevalence rate. There are lots of things we do not collect and we should. So it would be massively helpful to collect information about abortion rates. But there is derived data that is referenced to the South Australian data systems and it is the case from the derived data—it is pretty solid but it is not as pure as you would like it to be—that it is about one in four women at a population level experience abortion in their lifetime. It may be that some women have two and some women have none. It is a statistical figure. By the way, there is no evidence that a woman has abortion after abortion after abortion. It is not a form of contraception. That is just scaremongering. But it is absolutely the case and therefore it is something that women are dealing with all the time but they are not able to speak about it. You would be sure that they are not able to speak about it to their families.

The CHAIR: I can understand that.

The Hon. NATASHA MACLAREN-JONES: First of all I thank you for the work that your organisations do to support women to access not only health services but a number of other broader services. Obviously today we are talking about women; yesterday everything was about women. But there has been a lot of discussion about the fact that this bill does not use the term "woman"; it talks about "person". I am interested in your view as to whether the bill should have been drafted using the word "woman" rather than "person".

Ms CROZIER: It says "women and persons", and that is to take into account the transgender women, I understand.

Adjunct Professor BRASSIL: In our industries we are very careful to be inclusive of all people with a cervix. That may not be something that people who do not commonly mix across gendered communities appreciate, but in our world we are very, very clear that there is a normal curve around gender, like there is all around most other things. It is not just people who identify as women who have cervixes and women who are able to have children. From our point of view it is the most inclusive term. Clearly most people who have babies are women.

Adjunct Professor Dr BATESON: I will just add that the bill has been crafted by experts, expertly crafted, and they have used best practice in drafting this bill. I will obviously absolutely support what my colleague said: that we do use inclusive language. From the legislation—the people drafting the bill, I will say, have taken that best practice, is my understanding. Obviously "people" is inclusive of women and we are talking about women here today.

The Hon. NATASHA MACLAREN-JONES: The other thing I am interested to know about is your views in relation to whether or not there should be an official list that is made available, published, of medical practitioners that would assist with terminations.

Adjunct Professor Dr BATESON: Maybe I will take that one. I think the reality at the moment is that we have a lot of stigma around abortion. Part of what we are doing with decriminalising abortion is actually removing that stigma. We have done some research, actually, with GPs across New South Wales—including in rural areas—which was published a couple of years ago, and we have some very powerful quotes where the GPs will say, "Look, I want to provide this service but, in fact, there is too much stigma around it. I know that I might be vilified." This is a terrible thing. So people are fearful of putting their names on a public list. What we know now is that in Victoria, where it has been decriminalised, there is a government-run public list and it is easy to find out where you can go to get an abortion. This is part of the real trouble, particularly in rural areas: People simply—women—do not know where to go. So I think it is something we absolutely need to work towards so it is publicly available.

The Hon. NATASHA MACLAREN-JONES: Any other comments in relation to public listings? No? Thank you.

Reverend the Hon. FRED NILE: Thank you for coming in as witnesses. You mentioned earlier in your evidence how much care you take with counselling and so on. Have you ever had a survey of the abortion clinics— we have one just across the road—how much counselling they give to women considering an abortion?

Adjunct Professor BRASSIL: I will answer that. As a clinical psychologist, I would like somebody to give a definition of what counselling means. "Counselling" is a term that very broadly means that you are actually having an open conversation with people about their issues and concerns in a non-judgemental, non-directive way. That is proper counselling. That can be carried out by a range of health professionals and quasi health professionals and it can include doctors, nurses, psychologists, social workers, support care workers, Aboriginal health workers, bilingual community educators who are trained to work within the context of non-judgemental counselling.

In an abortion service situation, you have a lot of people with those qualifications and capabilities. All of the people who work in abortion care are health professionals. They are trained to understand what are the principles for having open discussion and non-judgemental conversations with people about their issues and needs. It does not have to be a referral to somebody else; they just need to take the time to carry out the initial assessment of the person in front of them and work with the issues that are there. So, yes, all abortion providers have people with the training to provide these services, but they may not wear a hat called psychologist, social worker or counsellor.

Reverend the Hon. FRED NILE: Are you speaking of the private abortion clinics? Have you got any experience? Have you investigated the abortion clinics? Because I have.

Adjunct Professor BRASSIL: Yes, I know lots of people involved in the provision of private abortion clinics. The people that I know best are the doctors and the nurses. They are already trained to carry out [*Inaudible*]

Adjunct Professor Dr BATESON: I will add to that. Many of my colleagues who I spend a lot of my professional time with work in the private clinics, and they are all absolutely committed to ensuring that they give the best care possible to that woman who is coming in. They have a duty of care to actually ensure that they are aware of all her needs. If that may include needing counselling, as we talked about before—and it was explained in terms of that term "counselling". They may not need to see a counsellor but they may. Certainly I know my colleagues working in the private clinics have access to extra counselling if ever it is needed. Some women will avail themselves of that and some will not, but that is their choice.

Reverend the Hon. FRED NILE: From my investigation, it appears that the girl or woman wanting an abortion does not see that doctor at the abortion clinic.

Adjunct Professor BRASSIL: Does not see a doctor? Excuse me?

Reverend the Hon. FRED NILE: Does not see that doctor.

Adjunct Professor BRASSIL: Sorry, I do not understand.

Reverend the Hon. FRED NILE: They do not see the doctor till they are having the abortion. You are talking as if the doctor is giving her counselling and advice.

Adjunct Professor Dr BATESON: The doctor has to provide the abortion

Reverend the Hon. FRED NILE: She does not see the doctor. She sees a female secretary woman.

Adjunct Professor Dr BATESON: I think what would happen or what you are meaning—

Reverend the Hon. FRED NILE: I am speaking of my investigations. I have had my secretary visit the abortion clinics and pretend she wants an abortion, and she has received no counselling and they were quite pleased to process her into the abortion situation.

Adjunct Professor Dr BATESON: Just to clarify what would happen if a woman goes to an abortion clinic: She would be assessed and seen maybe by an expert nurse who, again, is thoroughly trained working in that setting to provide an assessment about whether counselling is needed or not. Then, of course, the woman has to see a doctor for the provision of the abortion, whether it is a medical abortion or a surgical abortion. But there is a thorough assessment of her needs to make sure that those are met.

Adjunct Professor BRASSIL: Can I just say the process of medicine is not mechanistic. It is caring, nurturing, empathic. I thoroughly support what Dr Bateson has said: that they are assessed by appropriate professionals prior to entering the clinical scene. But for all of you who have had some sort of procedure you walk into the procedure room and you are there with nurses and doctors. You are not treated as a piece of meat. You are in conversation with them. If any of the clinicians in the room had any concern that you had not made a decision or that you were wavering or that you were being coerced, it would be over, red Rover, and we would be back to basics.

The Hon. GREG DONNELLY: Thank you all for coming today. I have got very limited time, so forgive me for speaking quickly to get through. I have just got a small number of points that should not take too long. Take it that your submissions are read and take it I have been listening to your evidence this morning as closely as I could under the circumstances. You are representing separate organisations, so perhaps if we could get you to—sorry to do this—perhaps just down the line answer the question. But could I just get the three questions out onto the table, and we could deal with them.

First of all, as far as the statutory regulation with respect to the deliberate termination of a pregnancy—this is abortion what we are talking about, because we are looking at the Act that will come out of the Parliament, okay? So we are looking at what is going to come out the other end. Is there an Act in any other Australian jurisdiction—so anywhere else in Australia—that you see as the gold standard, if I use that term. It is not meant to be provocative, but the gold standard, the best that you see that we should looking at? If so, why? Perhaps if we could quickly go down and say either what that might be or, if it is not, move on?

Ms WILLIS: Rape and Domestic Violence Services Australia fully supports the bill in its current format.

Ms CROZIER: Women's Health NSW thinks this is the best legal and medical balance in the current bill.

Adjunct Professor BRASSIL: That is our opinion as well. Family Planning NSW supports the bill in its current form.

Adjunct Professor Dr BATESON: As well, Family Planning NSW supports the bill in its current form.

The Hon. GREG DONNELLY: It is the same question, although I am inviting you and giving you the opportunity to reflect on any overseas jurisdiction you might be aware of to nominate in terms of what might inform us as the Legislative Council members or part thereof who will deliberate the bill next week to make a decision about how to support or not support the bill. So it is the same question, but reflecting on overseas jurisdictions that you may be aware of. Is there any gold standard that exists, so to speak? If so, what would that be? Once again, we will go down the line.

Ms WILLIS: Many countries, especially in the First World, have legislation that ensures women's right to access abortion. Informing the New South Wales laws, those who put those laws together looked at the international experience, plus also legislation across Australia and developed this current bill. Again, I would say that we are at best practice and we support the bill in its current format.

The Hon. GREG DONNELLY: But the proposition before the Legislative Council, which is the amended bill from the Legislative Assembly, it is a position, Ms Willis, that that is best practice?

Ms WILLIS: Yes.

Ms CROZIER: I think turning this bill into an Act would be the best way to improve it. I think this is designed for Australian structure in New South Wales.

The Hon. GREG DONNELLY: Just to be clear, this is New South Wales legislation.

Ms CROZIER: Yes, correct. I think this bill suits this country.

Adjunct Professor BRASSIL: Family Planning NSW runs an international development program in up to 10 countries overseas. I have the advantage of being able to work closely with family planning organisations across the world. My answer to you is, this is Australia, this is New South Wales. Every country is different, its circumstances are different, its development status is different. We support the bill in its current form and do not think it is sensible to go further than we have.

Adjunct Professor Dr BATESON: I would say the same. There is no more appropriate bill than the one that we have before us, so the bill in its current form, and we support the bill for New South Wales.

The Hon. GREG DONNELLY: Just two quick questions before my time runs out. I will direct this to Professor Brassil, if you do not mind, but others can jump in: I understand in your answer to one of the questions that you said, and correct me if I am wrong, that there was no data currently available in Australia which is collected on any systematic basis with respect to pregnancy terminations.

Adjunct Professor BRASSIL: Correct.

The Hon. GREG DONNELLY: We will see it in the Hansard tomorrow but I understood that you—

Adjunct Professor BRASSIL: No Australian data.

The Hon. GREG DONNELLY: Yes, of course. With respect to that point—and I believe you said it is important to get that information so that we are dealing with facts—would you support an amendment in the Legislative Council, if moved next week, to place within the legislation a provision that would require the accurate reporting of pregnancy terminations in New South Wales, which would be done in a de-identified way—so no names or identifying figures—that would then be aggregated by NSW Health and reported on a regular basis?

Adjunct Professor BRASSIL: My answer to you is that I think it is the wrong place to do it. It is not the business of the legal system to dictate parameters around the items, data definitions and data collection processes. If it is within the legislation it is likely to be fraught, because it is not relying on the right groups. I am an advocate for good information collection through the right bodies. We should refer this to the health Ministry and its bureau of data and information.

The Hon. GREG DONNELLY: There was just one more question, if you do not mind, because I am interested to hear. With respect to this proposal, if an amendment was proposed next week in the Legislative Council, bearing in mind your very clear position that you support the bill as introduced by Mr Alex Greenwich in the Legislative Assembly, if a bill was—

Adjunct Professor BRASSIL: No, with the amendments. We support the bill as it currently stands.

The Hon. GREG DONNELLY: Yes, as amended by the lower House. My question was—because this is a very live matter with respect to what we do next week—if there was a proposal put forward to introduce an amendment in the House next week that in the Legislative Council debate around the amendments the House sought—that is, through the amendment—to remove the amendments moved—in other words, delete the amendments moved in the Legislative Assembly—and restore the bill to the original bill that went into the Legislative Assembly, would your organisation support that proposal?

The Hon. TREVOR KHAN: It ain't going to happen, Greg.

The CHAIR: Order! It is a valid question.

The Hon. GREG DONNELLY: The proposition is—

The CHAIR: You are welcome to answer or not answer that as you feel.

Adjunct Professor BRASSIL: We are very clear: we support the bill in its current form.

The CHAIR: Yes, which is what this inquiry is into. Normally I do not ask questions because we run out of time, but I will ask on the issue of gender selection, particularly to Family Planning but also other members of the panel can comment, it is very topical, it is in all of the papers today. What is your experience, your perspective and what is your advice to us around the issue of gender-selection procedures?

Adjunct Professor BRASSIL: There is no evidence that sex selection occurs. So for us to introduce rulings in relation to gender selection on the basis of no evidence would be irresponsible, because we would be in a situation where we are making it up and we could create enormous harm. We should be doing no harm by introducing these amendments. We completely support the position within the current bill that NSW Health should

do a review and we should understand what it is we are talking about before we move forward. The Latrobe review is inconclusive.

Adjunct Professor Dr BATESON: I would add to that. We have no evidence. Any legislation around this would be impossible to put into practice. As a doctor, the thought of having to interrogate a woman about her intentions, as it has been quoted, you know, to read her mind, will act as a deterrent to doctors providing abortions, it will act as a deterrent to women potentially seeking abortions. I think we have to act on the wisdom of the World Health Organisation, who has looked at the issues—

The CHAIR: Order! I insist on silence while people answer questions.

The Hon. GREG DONNELLY: I apologise.

Adjunct Professor Dr BATESON: —of gender imbalances across the globe and, in fact, the law is no way to tackle this. These are social issues, if at all they are occurring. I have worked in this area for many years and I have never come across a woman who has asked.

The CHAIR: Ms Willis, point 8 in your submission covers this issue, but do you want to comment?

Ms WILLIS: We would absolutely support the comments by both Minister Hazzard and Attorney General Speakman in the lower House that after this 12 months of review, if there is an issue identified, the response should not be a legal issue but should be an issue of gender equality. We have a framework through Our Watch, the Change the Story part of the national plan to reduce violence against women and their children, that shows us what we need to do in our communities to improve gender equality and they should be the responsive we find there is an issue. After 40 years of working in the women's health area I have never come across this, so I would be wildly surprised if we do have an issue.

Ms CROZIER: I think my colleagues have spoken very well on the issue and I agree with them. Thank you.

The CHAIR: Thank you. That concludes your evidence to the inquiry. It has been very helpful. I appreciate your flexibility to come in during your busy lives on short notice.

DANIELLE McMULLEN, Vice President, Australian Medical Association (NSW Branch), affirmed and examined

VIJAY ROACH, Obstetrician and Gynaecologist, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, affirmed and examined

JUDITH KIEJDA, Assistant General Secretary, New South Wales Nurses and Midwives' Association, affirmed and examined

The CHAIR: Welcome to the third session today of the evidence into the hearing on the Reproductive Health Care Reform Bill 2019 being held by the Standing Committee on Social Issues. I welcome our witnesses.

Dr McMULLEN: I correct my title: I am Dr Danielle McMullen.

The CHAIR: Oh God. I apologise for that.

Dr McMULLEN: That is all right, thanks.

The CHAIR: We have submissions for Dr Roach and Ms Keijda—submissions numbered 39 and 23 respectively. Dr McMullen, have you made a submission?

Dr McMULLEN: Yes. AMA (NSW) has made a submission.

The CHAIR: We will see if we can locate that. Do you have a copy of that with you?

Dr McMULLEN: Yes.

The CHAIR: I recognise that we have received 13,000 submissions. Some have slipped through but we are on top of it. We will get that to members.

Dr McMULLEN: We have copies here.

The CHAIR: I invite you to make an opening statement of up to five minutes.

Dr McMULLEN: Thank you for having me here today. My name is Dr Danielle McMullen. I am a GP in Sydney and the vice-president of the Australian Medical Association (NSW). I come before you today to represent both the AMA but also to share my experiences as a GP who will deal with the real life consequences of the decision made by this Parliament.

Abortion is not just an abstract political concept for me. It is one of the many parts of the experience that I share with my patients every day. For my patients, abortion is often unexpected, it is often tragic and it is never a decision that I have seen them make lightly. AMA (NSW) supports the Reproductive Health Care Reform Bill 2019. It is sensible, moderate and based on existing legislation that we know works elsewhere in Australia. New South Wales is the last State in Australia to decriminalise abortion and this should be a source of embarrassment to us all.

We support decriminalisation because it will remove the stigma for both doctors and patients attached to abortion being with in the Crimes Act. This is in line with AMA policy—that abortion is a healthcare service and should be treated as such. The amended version of the bill that passed the lower House is still something we can support, even though we regard the amendments as unnecessary, given the strong regulatory framework that already exists to govern the safe and ethical practice of medicine in this country.

However, we would strongly oppose any further amendments. In the light of the recent media, we felt the need to highlight that particularly amendments regarding gender selection would cause us deep concern. That is not because we are blind or uncaring, unethical or immoral: It is that we know that any complication of this legislation will impede access for women seeking termination for any reason.

We also hold deep concerns regarding the ramifications for doctors. If such amendments were to pass it would potentially make any doctor providing abortion services after nine weeks party to a crime. That is because we can now, with technological advances, find out fetal sex from about nine weeks gestation and that this is becoming relatively common practice. Therefore, if a women seeks termination of pregnancy after this point, any laws prohibiting gender selection as a reason would require doctors to be mind-readers of sorts to ensure no crime was being committed. This would have the effect of delaying or preventing the delivery of care.

We would also say, as we heard before, that there is nowhere evidence of women approaching their doctors seeking termination of pregnancy on the grounds of gender selection. If there was evidence that this was

happening, we are confident that under current arrangements or under the bill as proposed doctors would be within their rights to refuse a termination based on gender selection being the primary reason. A gender selection ban would not result in its ostensibly desired outcome, but what it would do is delay and prevent treatment for the women of New South Wales. That is not to say we should ignore it as an issue and we would support ministerial inquiries or referral back to the Ministry of Health for investigation of gender selection as an issue: Again, a more social issue than procedurally through legislation. There are definitely better ways of pursuing the issue.

As such, we would call on Parliament to pass this bill without further amendments. We would also like to commend our Minister for Health and Medical Research, Minister Hazzard, for his leadership on this issue. We are aware that there are many other members of Parliament supporting the bill. This leadership shown by our health Minister and others has been notable and their willingness to tackle an issue that has been left for too long is appreciated and recognised by the AMA and by the medical profession.

The CHAIR: Thank you Dr McMullen. We have your submission. We are distributing it to the members. It was a little error on our part there. Dr Roach?

Dr ROACH: Thank you very much and thank you for the opportunity to speak to the Committee. I have been an obstetrician for more than 20 years. I have had the opportunity to look after women during all of that time and I have delivered more than 6,000 babies. I have also looked after women in pregnancy when there has been miscarriage or ectopic pregnancy or still birth, during normal birth and in abortion. I represent the peak body that is responsible for training and standards in women's health, training specialists and general practitioners who hold a diploma.

Abortion is part of health care. It is not a crime and it should not be part of the Crimes Act. The first principle is that women have the right to autonomy over their own bodies and that that right should be respected. A woman does not have to justify the choices that she makes about her own body. The second point is that the Australian public trust their doctors. They trust us to act ethically. They trust us to act with integrity and to the highest clinical standard. You trust us in every single aspect of medical care. The great risk of legislating the way that doctors should consult, should consent, should counsel risks undermining the doctor-patient relationship and the faith that the public has in the medical profession.

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Doctors and nurses provide health care. We do so with compassion and kindness and respect. We do not judge and we do not impose our own moral position upon the patient. This bill should pass, albeit with the imperfect amendments, because we should not be the judges of the decisions that a woman makes about her own body. We should not stigmatise women. We should not control women. The role of the medical profession is to care and to nurture and to support women with respect, love, kindness and compassion. And we are not talking about a theoretical woman, we are talking about your, our, my daughter, partner, sister, friend, your fellow parliamentarians. They deserve access to the best health care. They deserve kindness and compassion and not judgment and you can be confident in us, your doctors, my members, my colleagues, in general practice and midwifery and in specialist practice, that we will deliver health care safely and ethically. I commend the bill as it is to the Parliament and hope that you will support it.

Ms KIEJDA: The NSW Nurses and Midwives Association [NSWNMA] appreciates the opportunity to speak to this Committee. The association represents 66,000 nurses and midwives in New South Wales. Nurses and midwives are registered health practitioners who may assist in the performance of an abortion. The Reproductive Health Care Reform Bill 2019 if passed will provide clarity for health practitioners providing care for women choosing to have an abortion. Abortion has remained in the Crimes Act 1900 for 119 years causing uncertainty for women seeking abortion services, as well as uncertainty for the health practitioners. The NSWNMA is committed to being a significant and professional voice in the health policy debate. As advocates for patient safety as well as representing nurses and midwives in New South Wales we support the decriminalisation of abortion in New South Wales and recommend the New South Wales Legislative Council support the Reproductive Health Care Reform Bill 2019 in the form passed by the New South Wales Legislative Assembly.

The association supports the motion passed by the New South Wales Legislative Assembly on 10 August 2019 that this House supports the right of women to make the choice that is right for them, which includes respecting their rights to access safe, legal abortion. Currently, health practitioners, including nurses and midwives, are required to rely on common law precedents to determine whether an abortion is lawful and therefore is able to be performed without risk of criminal prosecution. This causes a great deal of uncertainty for women seeking health services, and for health practitioners. It is imperative that the New South Wales Parliament reform

the law relating to abortion. Where the provision of a particular health service by health practitioners is entirely reliant on common law, it is the responsibility of the Government to ensure that legislation is enacted to provide clear and unambiguous guidance as to what is authorised. Health practitioners should not have to interpret judgments from case law in order to make an assessment as to whether a particular treatment or service is lawful.

The current State of the law poses an unacceptable risk to nurses and midwives who work in reproductive health and maternity services. Nurses and midwives have a professional obligation to use their expertise and influence to protect and advance the health and wellbeing of individuals as well as communities and populations. It is on this basis that the NSWNMA advocates for the protection of the health and wellbeing of individuals who are accessing reproductive health services. Nurses and midwives are required to provide person/woman-centred care. The Nursing and Midwifery Board of Australia provides the following description of person-centred practice:

Person-centred practice is collaborative and respectful partnership built on mutual trust and understanding through good communication. Each person is treated as an individual with the aim of respecting people's ownership of their health information, rights and preferences, while protecting their dignity and empowering choice.

In order for nurses and midwives to practice in a manner that is consistent with their accepted professional standards they must respect women's rights and preferences and empower them to have choice in their healthcare decision-making. The association advocates for the legislative reform on the basis that if passed this bill provides clarity and protection for nurses and midwives and will enable them to wholly engage in person/woman-centred care where the person in their care is seeking an abortion.

The NSWNMA is also one of the 73 supporter organisations of the NSW Pro-choice Alliance. The NSW Pro-choice Alliance recommends the repeal of sections 82 and 84 of the New South Wales Crimes Act 1900 and the implementation of legislation similar to Queensland's Termination of Pregnancy Act 2018 and Victoria's Abortion Law Reform Act 2008. The NSW Pro-choice Alliance seeks changes to the law that regulate abortion as a health procedure, ensure consistency with contemporary clinical practice and public health standards, empower women with the right to choose what happens to their own bodies, guarantee equal access to safe, high-quality health care and align with international human rights obligations. The NSWNMA recommends that the New South Wales Legislative Council support the Reproductive Health Care Reform Bill 2019 in the form passed by the New South Wales Legislative Assembly on 8 August 2019.

The CHAIR: Thank you for the opening statements. As you are probably aware, the Committee has resolved to rotate between the members five minutes each on questions and answers in alphabetical order.

The Hon. NIALL BLAIR: Thank you for coming in this morning. We have heard a little bit this morning about the impact on women and the uncertainty around the way the law is at the moment. I want to concentrate on the health professionals. Would you all agree that a number that was used yesterday is around 30,000 abortions in New South Wales, is that roughly a figure that you would agree with?

Dr ROACH: I think there is enormous difficulty with that figure because of the Medicare coding.

The Hon. NIALL BLAIR: It is a large number though, tens of thousands? Not hundreds—

Dr ROACH: I think that would be reasonable.

The Hon. NIALL BLAIR: —not millions, but let us say it is around that sort of area. We know that the law at the moment is not in a lot of cases being implemented, although some were advocating yesterday that it should be policed heavier, particularly towards the medical profession. Ms Kiejda, in your opening statement you are saying that health professionals are having to make an informed decision themselves about whether what they are doing is legal or not. Let us say it is tens of thousands, not hundreds, that must create huge uncertainty for your industry as professionals to consciously be going through and participating in something that is a crime in this State, would you agree?

Dr McMULLEN: Yes, I think that is certainly one of the concerns that we hold as the AMA, that abortion being in the Crimes Act is not only harmful for women but it also places their doctors and other healthcare team at risk. It impedes access to care because women, and also their doctors, are concerned about the Crimes Act framework that it sits within at the moment.

Dr ROACH: We have a very simple job, which is that we see a patient and we take a history and we examine them and then we look after them. That should be as simple a job as we should have. We should not be wondering about whether the way in which we are delivering health care is legal or not legal. That should be something that is clear to us through our training and through our understanding. Then what we should do is look

after the person who is in front of us. So, to place any additional burden or concern or wonder about what we are doing will surely impact on the way that we interact with our patient and is to her detriment.

Ms KIEJDA: Nurses and midwives want certainty and clarity and the issue with having to rely on case law is not just the having to rely on case law but it is the interpretation of that case law. They are all open to whatever the judge of the day is thinking about. We need a situation in New South Wales where nurses and midwives understand exactly where they stand in delivering this important health care.

The Hon. NIALL BLAIR: At the moment in Queensland, Victoria and other States, that is not a concern for the professions because they have already gone down this path. How has that experience been for your professions in those other States? What feedback have you had from health professionals? Has it taken away that uncertainty? Is it allowing better access to services for women? Is it providing a clearer path for your industry?

Dr McMULLEN: I have not actively sought feedback from my interstate counterparts but we anticipate that in New South Wales removing abortion from the Crimes Act would aid access for women and reduce the uncertainty for healthcare practitioners. What we do know from our interstate people is that we have not seen the floodgates open and we are not seeing a rush on terminations compared with now. We would argue that some of the fearmongering proposals around what will happen with a removal from the Crimes Act are not going to happen based on interstate experiences.

The Hon. NIALL BLAIR: Would you agree with that, Dr Roach?

Dr ROACH: Yes, I agree with that. I think the answer to your question is that clinical care is so nuanced that by removing that aspect it can only improve clinical care.

The Hon. NIALL BLAIR: This might be a question that you are unable to answer, but are there insurance implications for healthcare professionals in New South Wales because of abortion sitting in the Crimes Act here and not in other States? Are you aware of that as an issue?

Dr ROACH: No, not to my knowledge.

The Hon. NIALL BLAIR: Thank you.

Ms ABIGAIL BOYD: Thank you very much for coming in today to give your expert evidence. I thank you, Dr McMullen, for your article in *The Sydney Morning Herald* today, which I read with great interest. In that article you state that gender selection is a highly emotive issue but has nothing to do with the legal status of abortion. Yet in the lower House this issue was brought in as something that was potentially relevant. Do you see that as a bit of a red hearing, and can you talk us through what would happen on a practical level if that amendment was made in this bill?

Dr McMULLEN: Thank you for the question. We very much see that as a red hearing and that this amendment is being inserted as a way to try to derail the decriminalisation of abortion more broadly. The question around gender selection and termination is only possible because of technological advances. At the moment you can find out the sex of a fetus from about nine weeks through non-invasive pre-natal testing. That is a test where a sample of the fetus's DNA within maternal blood is taken and therefore the fetal sex can be found out. That means that we now potentially have to have a discussion around the social impacts of gender selection and family balancing, but it is certainly not related to the termination of pregnancy. In the final comments of the last group we heard that there is no evidence that women come to doctors seeking termination of pregnancy for gender selection. They do not present with that as their request.

The implications of putting in further amendments to the effect of banning termination on the grounds of gender selection require doctors to be mind readers. We would have no way of knowing whether women had had non-invasive pre-natal testing with another doctor. As Dr Roach has said previously, the doctor-patient relationship is built on trust. Our role when women and patients walk in the door is to not come at them with preconceived ideas and judgements. They present to us seeking health care. We take a history, we examine them and we provide the necessary education, conversation, counselling and care that is appropriate for them. It is a shared decision-making process and the cloud of legislative framework, if it was there, around gender selection and having to question and interrogate women about their reasoning does not fit within our framework of providing quality healthcare for those women.

Ms ABIGAIL BOYD: Dr Roach, feel free to comment on that as well, but I am also interested in a 2005 review that RANZCOG did of literature in relation to the mental wellbeing of people once they had an abortion. It showed that there was a positive impact on wellbeing in the short term and there was no evidence of

significant long-term harm to wellbeing. What do you make of the suggestions that women need some sort of mandatory counselling when requesting an abortion?

Dr ROACH: If I could just add to what Dr McMullen said, one of my great concerns when I listened to the discussion and debate in the lower House around the issue of gender selection was that there was a huge reference to overseas populations in their own countries and in New South Wales. One of the things I found very concerning was that the discussion around the amendments effectively suggested we should concentrate on gender in a way that would end up with racial profiling. Frankly, that is offensive. It was interesting because in the discussion around gender selection the word "offensive" was thrown around all the time and when we talk about abortion we talk about the term "offensive". I think we should add in the fact that racial profiling is absolutely offensive and is not something that this country or Parliament should accept. This would end up precluding people from seeking care.

We already know that women in general will be anxious about seeking care around abortion because of all the stigma associated with it. To have women who happen to have a certain racial background or religious background walking into a doctor's office assuming that the doctor may well be questioning them on that basis would be a huge disservice. In terms of mental health, you are correct. There was a question raised around whether—with abortion being so highly emotive—abortion impacts upon a woman's mental health at the time or over her lifetime. We have no evidence for that at all. I think that is very important. We should also raise a question around the fact that a woman who is denied an abortion or has difficulty accessing an abortion can have her mental health be put at risk. My understanding is that one of the recognitions in the law as it stands at the moment is that if a woman's mental health is at risk then it is not unlawful to perform an abortion. It is exactly the opposite of how it might be argued.

The Hon. ROSE JACKSON: I just wanted to pick up on the points you were making about mental health and I would ask you to comment on propositions that women should be required to have mandatory counselling before a termination. That suggestion has been made and obviously it is grounded in the idea that women do not fully understand the consequences of termination of pregnancy, including the suggesting that there are physical health consequences for them. Firstly, are you aware of any evidence at all that a termination of pregnancy has negative physical health consequences for women; and secondly, how would you respond to the suggestion that women be required to receive mandatory counselling before any termination of pregnancy?

Dr McMULLEN: The suggestion that women do not understand what they are getting into does not give women enough credit. Women do not come to the decision to have a termination of pregnancy lightly. It does not matter what gestation; it is always a challenging decision. As we have said before, their first point of call is often their general practitioner. I see these women. I work around the corner from a university and I see lots of young women as part of my practice and I can tell you that it is never an easy discussion. It always runs over time and there are lots of tissues. It is tough. That is true even for women who come into this quite clear that a termination is their only option for whatever reason. Nevertheless, we continue to have a full and frank discussion about all options available.

That is part of providing health care. That is why we as doctors have found the attempts by all of these amendments to legislate how we do practice quite offensive. We know how to do our jobs and part of our job is counselling all patients. If you come to see me about your blood pressure I will counsel you on what blood pressure is. If you come in with an unplanned pregnancy I will counsel you through what a pregnancy means; what it is; what your thoughts and feelings are about it; and what options are available for continuing a pregnancy, keeping the child, looking at adoption as an option and the termination of pregnancy, and there are various options available for that depending on the stage of pregnancy.

This often happens over a number of consultations and that in effect providing what we would consider informed consent around pregnancy management and around termination of pregnancy already includes a degree of counselling. To enforce that women who already have a clear decision in mind and have weighed up the risks and benefits, because with any medical procedure there are risks and we need to make sure women are aware of these if they are undertaking a procedure. But if they are aware of all that forcing them into long and painful discussions about what is already a difficult issue that they have spent many hours and days and weeks considering would be unfair to women, and also to the rest of their family and their healthcare team. We also need to consider our rural and remote patients and colleagues and access to care can be difficult in those areas and this is obviously a time sensitive issue, so women do need quick access to care that is supportive care and we would strongly caution against compulsory counselling.

Dr ROACH: I would echo those comments and emphasise the fact that counselling or discussion or informing a patient, consenting a patient eventually if they choose to have a procedure is inherent in medical

practice. Therefore, adding another layer seems unnecessary. The other thing we know is that women who have worked themselves up to going to have a conversation often will already have made a decision prior to seeing a health professional as to the direction they wish to take. To add in yet another burden will end up with that patient being more reluctant to go and see someone and potentially being more confused. Finally, defining what counselling means is problematic. Does it mean referral to a psychologist or a psychiatrist or a committee? Counselling is a very very broad term and yet, as Dr McMullen said, it is something that is inherent in our practice, that is what we do every day with every patient.

Dr McMULLEN: Can I add, there is availability currently for women who are struggling with the decision. There are MBS item codes available for non-directive pregnancy support counselling. It is fairly easy. They are trained psychologists or other mental health workers or general practitioners who have extra training in how to provide such counselling for women who are having difficulty with a decision and it is relatively easy to seek out who has an interest in that area. There are frameworks available for women to get specific counselling about decision making that is non-directive at the moment.

The CHAIR: Do you want to add to that?

Ms KIEJDA: All I was going to say is I totally agree with my healthcare colleagues here. From a nursing and midwifery perspective it is part of our practice obviously within our scope of practice. Our aim is just to provide supportive care and empathy with anyone that we are providing care to.

The Hon. TREVOR KHAN: I am going to direct my question to Dr Roach, but I will invite all of you to comment on it if you wish. Doctor, in a submission and also in a letter you had previously written in support of the original bill before any amendments the issue of conscientious objection was referred to. My recollection is that in the letter you advanced the proposition that there should be a conscientious objection provision but there should also be a requirement for referral on. Am I correct in my summary?

Dr ROACH: Correct.

The Hon. TREVOR KHAN: As the bill was then amended, in a sense it was brought back a level not requiring referral or explaining that a referral was not necessarily in the formal sense of a referral but giving some additional information to the patient that would allow the patient to go elsewhere. Is that how you understand it?

Dr ROACH: Yes.

The Hon. TREVOR KHAN: That is clause 9 of the bill. It will be no secret if I tell you that members of Parliament, particularly in the upper House, have received thousands, I think we might be at 7- to 8,000 emails. No doubt generated with the assistance of data bases that developed during the same sex marriage debate.

The Hon. GREG DONNELLY: I hope you have read them all.

The Hon. TREVOR KHAN: I have actually read a heck of a lot of them.

The Hon. GREG DONNELLY: Good. I haven't.

The Hon. TREVOR KHAN: Between 10-20 per cent of those emails, which clearly are not written by members of the medical profession, refer to their concern about doctors being forced to refer patients on. How is it that 10 per cent of these thousands upon thousands of emails are expressing a concern for the medical profession's obligation to refer people on when that is not a concern that you seem to have expressed in your letter?

Dr ROACH: I think there are a few issues there and particularly with terminology. The first place I would start is that there is an extraordinary irony in all of this which is that people who are talking about their own conscientious objection or their own conscience are actually making judgements on the conscience of others, particularly the women who are choosing to have an abortion or not. I do not think they recognise that or are aware of that. They sit back on their own morality while judging the morality of others. The statement that we made and we stand by is that we respect the conscience of our members, we respect the conscience of each person in society and that they should be aware of their own and they should live by that.

However, we chose to be doctors, we were not made to be doctors. We chose to be doctors. In choosing to be doctors we have a duty of care to the patient and if the patient seeks our care and we are unable to deliver that care, and there are other reasons why we cannot deliver it, we might not have experience in that area, we might not have a skill in that area. If we are unable to provide that care, and it may be because of conscientious objection, then it is our duty, and I think a better term would be transferring the care or providing information to

the patient so that she is then able to access the care that she seeks. The other part of that is that we have no right to impede that woman from receiving care as well.

The Hon. TREVOR KHAN: Dr McMullen, you do not have to add to it if you do not wish.

Dr McMULLEN: I would strongly support Dr Roach's statements. The AMA had similar feelings around this issue. We think that a lot of it is getting caught up in the wording of referral. In the medical world the word "referral" under MBS guidelines is a piece of paper with certain information on it. Where I think the intent of the bill was "refer" in the more colloquial sense. As in, provide information so as not to impede access. From the general public there is perhaps a misconception that this obligation does not already exist, and it does. In our practise of medicine we are held to account by the medical board's code of conduct and as part of that we need to not unreasonably impede access to care when we cannot provide it for any reason. We do not think that the bill goes any further than our current professional obligations already to provide access to healthcare. That is where we have come from in the same way.

The Hon. TREVOR KHAN: I take it in terms of the submission you have seen from Dr McCaffrey that deals with the conscientious objection, do I take it you reject that as inconsistent with the current position of RANZCOG?

Dr ROACH: Correct.

The Hon. TREVOR KHAN: Ms Kiejda, one issue that arose yesterday in the context of the 22-week issue was the position of nurse/midwives in the public hospital system who may be exposed to the possibility of a post-22 week termination. Are you aware of what provisions apply for nursing staff within the public hospital system if they have a conscientious objection towards participating in a termination in a public hospital? Dr Roach and Dr McMullen may know as well.

Ms KIEJDA: To be honest, I do not have any personal information from members on that issue. But I think it would be extremely rare unless it was for a medical reason.

The Hon. TREVOR KHAN: I am not saying it is a common circumstance but it was a proposition raised yesterday.

Dr ROACH: I can give you a very clear answer to that because I work in hospitals and we definitely have situations in which the staff, be they medical staff, nursing staff, clerical staff, who have a conscientious objection to abortion and absolutely that is respected. And we have sufficient staff in order to allow them to step out of the situation and not be involved. We would never ask or coerce a staff member, nursing or medical, to be involved in a procedure that they considered to be wrong for whatever reasons they did. but we would also not allow that fact to impede the care of that woman.

The Hon. TREVOR KHAN: Do I take it that there is nothing in this bill that will change what is the pre-existing practice?

Dr ROACH: No. That is how we practice today.

Ms KIEJDA: Could I just add that we are part of the national body of the Australian Nursing and Midwifery Federation and they certainly do have a policy that absolutely says that respect has to be paid to any conscientious objection.

The CHAIR: Okay. Thank you. The Hon. Natasha Maclaren-Jones has deferred for the moment.

Reverend The Hon. FRED NILE: I note that your organisations have come out supporting the bill. You have thousands of members, how did you ascertain the views of your members on this bill? Or did you?

Dr McMULLEN: I can speak for AMA NSW. Our process of forming positions on issues such as this is through our State council and there has been long and frank discussions about this for some years now. This has not been a rushed process. We have taken our position with due consideration and would also note that we have not had high volumes, at all, of negative feedback. In fact, the very small single digit number of negative feedback from our membership, so we have—which is unusual for us. When there have been other issues in the past where we have gotten more negative email responses from our members. We have been quite pleased with that this week.

Reverend The Hon. FRED NILE: Have any of the organisations actually surveyed the membership, members of the AMA or the organisation.

Dr ROACH: Or our colleagues? We have not done a formal survey but I understand your question. This is something that, there has been this discussion that the bill just arrived. This particular bill just arrived but this conversation has been going on forever and so therefore this is something that we have had discussions about, debates about. You referred before to some colleagues statements and their AMA statements, these are developed by committees with broad consultation and they have to go to a very rigorous process before we will issue them publicly. One of the things that I decided was actually to use the statements that we had made over the years and I rejigged them rather than rewriting any new positions. We are not actually espousing the new position at all. We are espousing one that has actually been developed by the profession and has been held by the profession for a very long time.

That does not preclude the fact that we do have members who have expressed different opinions, and we have Dr McCaffrey's submission here, and we acknowledge that, we recognise that. Our college, the medical profession, is a broad church and going back to the question that was asked before, we respect that fact. I do not think that doctors should all believe what I believe but we need to set a certain professional standard. The medical board sets a professional standard for us and as leaders in our organisations that is also our responsibility. I think that everything that we have said has been consistent with the professional standards and with the position that the college has held for a long time.

Reverend The Hon. FRED NILE: Thank you. Just a general question for Ms Kiejda. You are probably aware that in the UK two midwives was sacked and court battles ensued when they refused to participate in delegating, supervising and supporting staff who were involved in carrying out abortions. Will you support midwives with a conscientious objection to abortion, to refuse to delegate supervise and make rosters for staff who are carrying out abortion procedures?

Ms KIEJDA: Actually I am not aware of that particular thing that you mentioned there but we do have a policy that supports conscientious objection and, like Dr Roach said, we would operate in exactly the same way.

Dr ROACH: Can I just add to that, do you mind? Which is to say, we have to deal with that today. Before this bill is passed we actually are already confronted with the potential that a nurse or a midwife or a doctor does not want to be involved in this process. We respect that already so we will not change. Independent of whether this bill passes or not that will be how we practice.

Reverend The Hon. FRED NILE: There is no discrimination against those doctors or nurses?

Dr ROACH: No. Not at all.

Dr McMULLEN: We would support. People, as Dr Roach said, doctors and other health practitioners and patients and members of Parliament are all entitled to their own opinions and values but we would like this bill to pass so as not to impede access to the women seeking care.

Reverend The Hon. FRED NILE: I have also heard of other situations where young doctors, male and female, who graduate and apply to work in a hospital, and they are asked this question, "Are you willing to perform abortions." Apparently, if they say no then they do not get that position in that hospital. Are you aware of that situation?

Dr ROACH: Not at all. And, in fact, I would put to you it is actually the opposite which is that there are religious hospitals that actually prevent women accessing that sort of care.

Dr ROACH: We could talk about the fact that—first of all I think that that is completely incorrect it would be discriminatory and I would have thought that would be illegal. In fact, there is the opposite problem which is that there are many hospitals who, because of their religious beliefs, actually prevent women from accessing full care. We can have situations in which a woman is booked into a particular hospital, planning to have her baby there, and when the circumstances change and there is a reason for a termination, has to transfer to another hospital in order to receive that care.

The Hon. GREG DONNELLY: Thank you Chair. Thank you all for coming along. I have limited time so sorry for apparently speaking quicker. First of all, Dr Roach, how long have you been the president of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists?

Dr ROACH: Since November last year, but it feels like longer.

The Hon. GREG DONNELLY: Probably after this particular inquiry, we will probably put a couple of extra couple of years on it. November 2018, thanks for that. Can I perhaps just make just a couple of comments to set up the competing paradigm that we have got here if you do not mind. I just want to read the words because I have tried to crystallise it. What we have got is this situation where we have got organisations—and we had

some earlier today and yesterday, and indeed yourselves—clearly articulating a position very strongly for, and on behalf of, women. And this is very sincerely held obviously, your position. But there is an absolute and unqualified right of a woman to determine whether or not to carry their pregnancy to full-term and birth. That is an absolute position that I understand your organisation is essentially putting. If I am wrong just please correct me.

I make this point: I also acknowledge very clearly, and I do not think there is a lot of debate around this particular point although there has been a great deal of heat about it but this will be reflected further on next week in the Council, about the view that abortion as a medical practice, or as a medical procedure should be removed from the Crimes Act, okay? That is clearly on the table. But the third element though which I think is really important because it has been missed and it has not been mentioned at all with respect to any of your contributions in your submissions or any of your contribution thus far in your testimony.

Can I also say that the deliberate termination of a pregnancy is not healthy for the unborn. The deliberate termination of a pregnancy actually extinguishes the life of the unborn. That is an incontrovertible medical fact that as a medically trained person you would agree with because that is what the practice does. Having said all that can I just ask you, I presume you are aware that the bill back in 2016, introduced by Mehreen Faruqi from The Greens called the "Faruqi bill," that dealt with the decriminalisation of abortion, you are aware of that matter? And you are aware that at the time—sorry, perhaps I will ask you—are you aware what position your organisation took at the time in regard to that bill?

Dr ROACH: The same position that we take today.

The Hon. GREG DONNELLY: Pardon?

Dr ROACH: The same position that we take today.

The Hon. GREG DONNELLY: That position was to remove abortion from the Crimes Act but, and this is this significant difference, not create a regulatory framework for abortion in this State, that abortion would be conducted without statutory regulation, that is your understanding of what RANZCOG did back there?

Dr ROACH: I think I do not understand the terminology that you are using, I am sorry.

The Hon. GREG DONNELLY: Forgive me, and this is really important because it is a key point, so I might ask for some indulgence about this, please. The issue of understanding that what we are doing is very clear. With respect to the Faruqi bill back in 2016 which was rejected in 2017 by the Legislative Council, abortion was taken out of the Crimes Act—this was the proposition—as indeed is the case with the Greenwich bill. But with respect to the Faruqi bill, what it did then was it left abortion as a medical procedure not under any law. It did not have a statute like we are proposing here. I think you would understand what I am saying here. The Parliament is creating a bill that we are working through now. Do you understand the difference? You do not understand the difference.

Dr ROACH: No, I do not understand the point that you are making or—well, maybe—

The Hon. GREG DONNELLY: With due respect, this is at the heart of the matter—

Dr ROACH: And I am willing to understand.

Ms ABIGAIL BOYD: He is a gynaecologist. He does not know about our legislative processes.

The CHAIR: Order! The Hon. Greg Donnelly is running out of time for his questions so let's just get to the question.

Dr ROACH: I am very willing to answer the question but I am not sure that I—if you tell me what the—

The Hon. GREG DONNELLY: I am trying to understand that RANZCOG back in 2016-17 supported the Mehreen Faruqi bill which took abortion out of the Crimes Act and left abortion not covered by anything—no statute, no law.

Dr ROACH: May I ask then what would be the practical implications of that for me as a practitioner?

The Hon. GREG DONNELLY: I just want to connect it to what we are doing now so that there is continuity here. You supported that proposition back then. With respect to the Alex Greenwich bill—

The Hon. TREVOR KHAN: No, it is not the Alex Greenwich bill, with respect.

The Hon. GREG DONNELLY: Okay.

The CHAIR: It is the Legislative Assembly bill that we have got now.

The Hon. GREG DONNELLY: Okay. With respect it is the bill that went into the Legislative Assembly on 1 August, which was primarily sponsored by five people including the Hon. Trevor Khan. That is on the record. There is no—

The Hon. TREVOR KHAN: I am quite proud to admit that.

The Hon. GREG DONNELLY: That is fine. But what that bill did, and this is the bill we are having to make decisions on and vote on next week, was take abortion out of the Crimes Act, which is the same as what the original proposition was, but to create a special—I use the term not in any colourful way—or particular Act which would regulate abortion in New South Wales, which is different from the original proposition. I understand the position of RANZCOG is that you supported the Faruqi proposition. With respect to the bill that went into the Legislative Assembly on 1 August, you supported that bill and endorsed that proposition.

Dr ROACH: Correct.

The Hon. GREG DONNELLY: That bill went through the Legislative Assembly and received some amendments—we have a little bit of a discussion about those—and it popped out of the assembly. Now we have had a week of deliberation over that bill. So the bill that popped out is different from the one that went in and the position, as I understand it, in your submission on your final page is that you are indicating that we should support the bill with no further amendments.

Dr ROACH: Correct.

The Hon. GREG DONNELLY: We should not, and that is your position. I am not being clever here, but it was support for it to be completely outside the regulation, support for the original proposition, support for the amended one, so I am just going to this point—and please forgive me for taking time. If there were some amendments passed in the Legislative Council next week, and I have no idea, whatever they might be, what will be the position of RANZCOG in regard to that? I say that to you not trying to trick you, because I do not know what might pass, but I am saying at least theoretically if something passes and that bill is amended so it is different from the one that came from the Legislative Assembly, what will the position of RANZCOG be?

Dr ROACH: I think I understand your question, which is the implication that over time we have changed our position. We have not changed our position. Our position has actually remained exactly the same. We have said exactly the same thing forever. We believe that abortion should not be in the Crimes Act, we believe that it is a healthcare procedure and we believe that that is how it should be treated. Now, you are quite right in pointing out that as doctors we have a little bit of confusion in understanding exactly what these things meant, but when the original bill was presented we thought that it was acceptable. When the amendments went through we gave opinions on that but now that those amendments are through we think the bill as it stands is acceptable. We believe that as it is at the moment it serves the needs of women and doctors in New South Wales and therefore there is no reason for that to change from where it is now. We would urge that the bill stands as it is now. Anything beyond that is theoretical and we would have to take it on its merits.

The Hon. GREG DONNELLY: My question is: If the Legislative Council passes—

Ms ABIGAIL BOYD: Point of order: He has had his turn.

The Hon. NIALL BLAIR: Point of order: He has just answered it. He said it is theoretical and they would need to take it on its merits.

The CHAIR: Order! I am sorry, Mr Donnelly, I have two points of order and I think we need to get to the question very clearly.

The Hon. GREG DONNELLY: If it passes, what would be the position of RANZCOG? That is what I finished with.

The CHAIR: So—

The Hon. GREG DONNELLY: If there was one amendment passed next week—

Dr ROACH: But what would that amendment be?

The CHAIR: Fair question.

The Hon. GREG DONNELLY: I do not know, but—

The CHAIR: Order! Does anyone else from the panel want to make any comment around that? I will move on to my own questions. I have a quick question for the midwives. I have had some feedback that there is some confusion within the sector about the impacts of the bill. You touched on conscientious objection. Are there any other issues around the bill that your members are feeding back that are different to those of GPs that they are concerned about?

Ms KIEJDA: No. Any feedback we have had is just to see the bill through as it is currently presented.

The CHAIR: Conscientious objection—

Ms KIEJDA: We have a policy on that and it is like Dr Roach said: No-one is ever asked to do something that they do not want to do and they are certainly not vilified or anything—it is their own decision. So no, we do not have issues.

The CHAIR: I just wanted to check on that and make sure that your profession was comfortable with the bill as well.

Ms KIEJDA: Yes.

The CHAIR: Thank you for coming in this afternoon on relatively short notice and offering us your professional advice. We appreciate it.

(The witnesses withdrew.)

(Luncheon adjournment)

KYLIE WARD, FACN, Chief Executive Officer, Australian College of Nursing, sworn and examined

SALLY JOPE, Board Director, Central Coast Community Women's Health Centre, affirmed and examined

The CHAIR: Good afternoon and welcome to this afternoon's hearing in the inquiry into the Reproductive Health Care Reform Bill 2019 which is being undertaken by the Standing Committee on Social Issues of which I am the chairman. Is there anything you wish to add about the capacity in which you appear today?

Ms JOPE: I am representing the Central Coast Community Women's Health Centre. I am a director on the board. I am not currently a chair but I have been a chair for the past five years. I have had extensive experience working and living on the Central Coast.

The Hon. GREG DONNELLY: A beautiful part of the State.

The CHAIR: I invite you both to make an opening statement of around five minutes, starting with you, Adjunct Professor Ward.

Adjunct Professor WARD: The Australian College of Nursing would like to thank the New South Wales Standing Committee on Social Issues for this opportunity to provide an opening statement and discussion in relation to the inquiry into the Reproductive Health Care Reform Bill 2019. The Australian College of Nursing is the preeminent and national leader of the nursing profession, influencing policy discussion and debate at national, State and Territory levels throughout Australia. We are the member, in collaboration with the Australian Nursing and Midwifery Foundation, of the International Council of Nursing. The Australian College of Nursing is also a higher education provider and registered training authority and provides extensive continuing professional development and education for nurses throughout Australia.

There are almost 400,000 registered and enrolled nurses in Australia, as reported by the Nursing and Midwifery Board of Australia, with approximately 102,000 New South Wales. We know and respect that health professionals in the community will have different views about the topics being discussed today. The Australian College of Nursing strongly supports access, equity and safe health care for patients irrespective of age, socio-economic disadvantage or geographic isolation. It also supports evidence-based health care and the right for people to have choice and dignity of their individual and specific health care needs. Decriminalisation of termination of pregnancy by registered health professionals ensures safe quality care for women and allows health practitioners such as nurses and doctors to provide care without risk of being incarcerated. Termination of pregnancy is a health issue and should not be considered a crime.

Deciding to end a pregnancy is a very personal choice and discussions with a health care provider can explain the risks and benefits of the various procedures. Nurses have a pivotal role in providing advice, informing women of their options and safely, holistically and professionally caring for them, thus enabling women to make the best decisions while taking into consideration the personal circumstances. This includes the physical, psychological, spiritual, mental health and wellbeing needs of individuals. Availability of safe facilities for women to receive terminations considering their social and economic circumstances is a priority for the nursing profession, as is consistency in national legislation—I know that we are federated. Criminalisation of abortion and unavailability of proper resources particularly impacts women from disadvantaged communities who lack the financial means to pay for a termination or who need to travel long distances to access one.

The Australian College of Nursing fully supports the introduction of the Reproductive Health Care Reform Bill, which seeks to decriminalise abortion in New South Wales. New South Wales is the last remaining State in the country where women can be criminalised for their reproductive rights. The Reproductive Health Care Reform Bill 2019 will ensure that a woman who intends on making this decision will not be committing an offence under the State's criminal code. Regulation of the procedure will mean that patients are treated safely and lawfully. Additionally it will mean health practitioners—and I really need to reinforce this—such as nurses and doctors will not be at risk of being incarcerated for supporting women in their choices regarding the reproductive system. As key patient advocates, nurses have a pivotal role in protecting women and informing them of their options. The Australian College of Nursing acknowledges the initiative of Independent Alex Greenwich, MP, as well as the grassroots campaign led by the Women's Electoral Lobby roundtable on abortion law reform. Thank you.

The CHAIR: Thank you, Professor Ward. My records indicate that we do not have a submission from your organisation.

Adjunct Professor WARD: Not specifically, no.

The CHAIR: Okay. I just wanted to confirm that. Ms Jope, do you have an opening statement?

Ms JOPE: As I said before I am representing the Central Coast Community Women's Health Centre, which has been operating since 1976—Gosford, Wyong and Woy Woy. We are co-signatories to the submission by the NSW Pro-Choice Alliance. I am also a member of the board of Women's Health NSW. As a bit of background, I am a member of the community, a mother and a grandmother. I have worked in the community welfare field all of my life. I have worked in social welfare, social research and policy advocacy. I am not just a board director; I am also a member of a group on the Central Coast that is supportive of law reform; however, at this point I will talk to the Community Women's Health Centre's submission, which you would all be familiar with. It was co-signed by 70 organisations. I think the main point that I would like to make—and this is talking to my submission that I put on the website—is that over 70 per cent of New South Wales adults support abortion law reform. Over 70 per cent want it off the criminal code. That is a really important issue.

It is not a crime for a woman to get adequate reproductive health care. For a woman to consider terminating an unwanted or unplanned pregnancy is not a flippant decision. It is usually made in consultation with a partner. It is not just a woman's right to choose; is a parent's right to choose. Many of the women who make this decision are already parents. They already have children and this is an unplanned—they decide it is an unwanted pregnancy. It has such a significant impact on the family. Some women will decide to go ahead. Each woman has the right to choose. Central Coast Community Women's Health Centre meets with young women who are just starting out on their lives and find themselves pregnant—it is an unwanted pregnancy and would have a huge impact on them—right through to women in their 30s and early 40s, probably, who have had some problem with their contraception. We think it is really important that terminating the pregnancy is not a crime and that they should have adequate access to safe and affordable health care to respond to this issue.

The Hon. NIALL BLAIR: Thank you for coming along. Professor Ward, yours is a registered training organisation?

Adjunct Professor WARD: Yes.

The Hon. NIALL BLAIR: I think "continuing professional development" is offered as well—is that correct?

Adjunct Professor WARD: Correct.

The Hon. NIALL BLAIR: Is the area of conscientious objection covered in any of the training modules either for nurses entering the system or as part of professional development?

Adjunct Professor WARD: It is actually in the regulation to be a licensed professional. The Nursing and Midwifery Board of Australia—who are the regulator reporting to the Australian Health Practitioner Regulation Authority [AHPRA]—has a statement about conscientious objection. Every nurse who commits to re-registering each year has a requirement to continuing professional development. Part of that is understanding our responsibilities with the code of conduct and the code of ethics.

The Hon. NIALL BLAIR: So that is existing?

Adjunct Professor WARD: Yes.

The Hon. NIALL BLAIR: There is a provision that if a nurse does not want to participate in a procedure that they can raise that?

Adjunct Professor WARD: Absolutely.

The Hon. NIALL BLAIR: How is that raised and what happens in relation to that?

Adjunct Professor WARD: A nurse—and I am not being specific to termination of pregnancy—

The Hon. NIALL BLAIR: No, generally.

Adjunct Professor WARD: —it could be generally.

The Hon. NIALL BLAIR: Yes.

Adjunct Professor WARD: If a nurse feels strongly about a procedure or patient or whatever it might be they would talk to their colleagues and the manager and let them know that they have a conscientious objection. Somebody to provide alternative care would be provided. What is also in the code of conduct is that it is not okay for a nurse to pass on their personal opinions to a patient. We respect our colleagues as professionals—I am a registered nurse. We would provide somebody who did not have a conscientious objection to provide that care.

The Hon. NIALL BLAIR: Are there protections for a nurse who makes an objection in this manner having it used against them?

Adjunct Professor WARD: I think it is implicit within the profession—it would probably be an exception; it certainly is not the rule. We are very respectful professionally.

The Hon. NIALL BLAIR: Sorry, I mean can it be used against the nurse within their workplace?

Adjunct Professor WARD: Absolutely not.

The Hon. NIALL BLAIR: So there protections—

Adjunct Professor WARD: There are protections. The regulator would provide that protection, if need be.

The Hon. NIALL BLAIR: Okay.

Adjunct Professor WARD: However, I have never known that to be needed to be exercised.

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The Hon. NIALL BLAIR: Is it widely utilised?

Adjunct Professor WARD: I do not know that organisations record statistics around this, or even have the necessary reporting but, intrinsically, because we know our code of conduct and code of ethics, you know as a nursing manager and as a nursing executive that it is implicit in supporting the profession.

The Hon. NIALL BLAIR: So there does not seem to be problems at the moment with that issue? It is readily available, it is accessed and it cannot be used against a nurse for raising an objection?

Adjunct Professor WARD: It is not new to this topic. It is embedded in our nursing code and really in our moral fibre.

The Hon. NIALL BLAIR: What about the bill that we are discussing at the moment? Have you had a look at the areas of conscientious objection, and does that raise any other concerns in this area?

Adjunct Professor WARD: No, we support any health professional's right, in terms of conscientious objection. The most important thing for nurses, and I would say the same for our medical colleagues, is always the protection of patients. It would be referral to somebody so that care could be provided by somebody who did not conscientiously object.

The Hon. NIALL BLAIR: Regardless, anyway, what is in the bill is part of the registration process.

Adjunct Professor WARD: That is right, yes. We support that because we would anyway.

The Hon. NIALL BLAIR: Ms Jope, thanks for coming along. You mentioned 70 per cent of people are supportive. That is obviously a statistic. A number of witnesses have used that as an example because of some surveys that have been carried out previously. Do you want to give us a snapshot of the interactions that you see within your community? You can talk as a board member or as a member of the community, but that number that is used, do you see that as consistent with what you would see, and your knowledge of the process that we are looking at here in New South Wales? Would that still be consistent in your community?

Ms JOPE: Yes, just to give you a bit of a picture of my community, my daughter lives close by. She has four children. I am involved with those children and the school community as a result of that. My daughter's friends know them and I know the school community. I would hazard a guess that no one in the school community, so women of childbearing age, have any understanding that it is in the Crimes Act for a start. "Really? It is a crime?" I am sure some would know, but the majority would not. So there is that.

From my understanding—and it is not rigorous social research—most women that I know, and most men that I know also would say, "It is a difficult decision but it is your decision and your right to choose". I have to say, I am not sure of the source of this figure but, given that it has been put around by fairly esteemed organisations, I would have faith in it, yes.

Ms ABIGAIL BOYD: Thank you both very much for coming along today, for providing your evidence and for giving your submissions. Ms Jope, I am particularly interested in your experience as someone from the regions. I find a some of this debate has been centred around the impressions people get of what accessing abortion might be like within the cities. Could you talk to us about the particular barriers that you see people in regional New South Wales facing?

Ms JOPE: Given that the Central Coast is not the most regional of regional New South Wales, but the Central Coast—which is the former local government areas of Gosford and Wyong—sits between Sydney and Newcastle. In Gosford there is one clinic that offers both surgical and medical terminations. That clinic is often booked up and there is a waitlist, especially around public holidays. People would then be forced—I am talking about surgical termination—to go to Newcastle, which is about another 100 kilometres, or to Sydney, which is a similar distance. Based on my own experience, for women with children, to take time out for surgical abortion they would have to extend their childcare, and they may or may not want people to know why they are doing that. That is an issue.

The cost is a barrier, and that is probably everywhere. Given the Central Coast's socio-economic statistics, and the fact that the women we see at the women's health centre are usually mainly from a lower socio-economic background, the cost is a significant barrier. We attempt to support—we have a very small amount of money made from donations where we can help subsidise maybe six people a year, so it is not a lot.

Ms ABIGAIL BOYD: If this bill was passed, how would you hope that access would be improved?

Ms JOPE: I guess, for me, I am not sure. It is important that it is not a crime. It is important that the stigma of it potentially being a crime is taken away. The next steps of affordability and access would be about—hopefully, once it is off the criminal code—easier provision on the Central Coast.

Ms ABIGAIL BOYD: We had comments yesterday that when we are looking at the conscientious objection of doctors, and whether or not they should be obliged to give information to patients about somewhere else to go, we had a suggestion that in this day and age people could just look on the internet and find that information themselves. So, putting a doctor in that position was, on balance, unfair. How easy is it for someone on the Central Coast to find a doctor who would carry out the procedure, or refer them to the right place?

Ms JOPE: I think many women come to the women's health centre because they would know that we are pro-choice, we are able to offer that referral and we have a relationship of a kind with a provider in Gosford. You are right, they would go on the internet. I think it would depend on their relationship with their GP, obviously. You would hope that a woman has a relationship with a GP who is going to support her to make the decision that works best for her and her family.

Ms ABIGAIL BOYD: A couple of other amendments that have been suggested are a cooling-off period and mandatory counselling, both of those would involve delay. How do you see the impacts of those amendments if they were to be passed on regional people, in particular?

Ms JOPE: I think the potential for delay is the biggest issue. You do not want to delay a termination any further than you need to. The other thing is that, out of respect for women, their partners and their families, I would assume that they have already thought about this seriously. I think a cooling-off period is ridiculous in that it is unnecessary. There has already been a period. There is already a process of counselling once a woman has gone to her GP. Her GP has probably talked to her about that decision. She then goes to a clinic. The clinic already talks to people about that decision. They already make that assessment. So I see no purpose to extend that at all.

The Hon. ROSE JACKSON: I just wanted to pick up quickly, Professor Ward, on the conversation that you were having around conscientious objection, and just specifically the proposition that has been advanced by some that the current clause and conscientious objection should be amended so that healthcare professionals are not obligated to provide information to patients as to where they might access other services. I wondered if you had any reflections on that. I think your experience and the experience of the people you work with, around what kind of position that might lead patients in, if that information is not provided to them, or if there are no other provisions made for them to access the care that they are requesting.

Adjunct Professor WARD: Thank you for that question because we believe that there should be provisions made. We fundamentally know what the nursing profession stands for because we could be talking about voluntary assisted dying in Victoria. There are many areas where conscientious objection comes into place. The nursing code of conduct recognises individual nurses have their own personal beliefs and values but outlines specific standards which all nurses are expected to adopt in their practice.

In particular, the nursing profession must avoid expressing personal beliefs to people in ways that exploit the person's vulnerability, are likely to cause their unnecessary distress or may negatively influence their autonomy in decision-making. We would see that by not giving a referral could have an impact on somebody's ability to make a decision. I appreciate that there is the internet and there are other ways, but it is a very difficult time for women, making this decision, so we would see that it is a health professional's responsibility to refer.

The Hon. ROSE JACKSON: Great. The next question I have just was about some of the consequences of criminalisation. I think you both touched on it but I want to give you the opportunity to perhaps in your case, Professor Ward, talk about some of the confusion and uncertainty for healthcare providers and, in your case, Ms Jope, maybe that is that stigma that you referred to. I think it is important that we get a full picture of the consequences of the current arrangement. There was evidence yesterday that women can get abortions. Everything is fine. We do not need to change the law in order to ensure access. But I think we should get a clear picture of some of the consequences of the current arrangement.

Adjunct Professor WARD: The challenge with the current arrangement is that it is inconsistent. I know we are here in New South Wales but it is inconsistent with the law in every other State and Territory. Registered professionals are registered nationally. As people move about in their roles, in New South Wales it is the only health-related matter under the Crimes Act. It would not be a port of call for a nurse or, I would suggest, any health professional to read the Crimes Act to see where they might be implicated.

First and foremost, we are here to serve our community. Men and women who choose to do nursing are all about the care, the people and the honour of the role that we have to serve. The vulnerability comes where this may be tested. As our colleagues earlier said it should not have to be on the preface of potential case law that our ability to provide care is fitting, really. From that perspective, we did provide a submission to Queensland last year. Nurses around the country want to be able to provide access through dignity. There is a stigma around this. For health professionals it really is around supporting women's rights and choices. We should not have to have the threat of case law or being tested for us to provide the work that we love and want to do in the most trusted and ethically respected profession for doing that.

Ms JOPE: I think there are instances where people have been charged under the current law. Also, there is that shock from finding out that, for a lot of women, what they think is just reproductive health care falls under the criminal code. It is a difficult decision. It is not an easily entered-into decision. Then to find out that it remains a crime—you are correct—adds to the stigma. It also makes it a topic that women are less likely to share. That adds to the stress if they are unable to share with their friends and their family.

Not many women talk very much about terminating a pregnancy because of the social stigma. It is not an easy decision. It does carry some grief and loss with it. Having it as a crime and a potential crime as well just adds to the pressure on women, who are already doing a significant amount of work and carrying a significant load in the community.

The CHAIR: Always when you are talking the buzzer goes off. Don't think that is an indication that you have to stop.

Ms JOPE: Okay. No, I did not.

The Hon. ROSE JACKSON: It is just the five minutes for us.

The CHAIR: It just so happens that you are the second one answering questions, so don't baulk when you hear that.

Ms JOPE: Sure. Thank you.

The Hon. TREVOR KHAN: I take it you would not agree with the archbishop who gave evidence yesterday not only that it should remain in the Crimes Act but that there should be more prosecutions taking place under the current law.

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

The Hon. TREVOR KHAN: You know that opponents of this bill have talked about the need for good mental health of women. If, as you have described it, retaining it under the Crimes Act adds stigma and stress to women—either of you can comment on this—is it the case that in fact that stigma and stress and the secrecy involved increase the chance of negative psychological impacts upon women who have experienced a termination?

Ms JOPE: Yes.

Adjunct Professor WARD: The World Health Organization acknowledges that countries and regions where there is not the provision for legal termination have higher rates of morbidity and mortality. What I would like to say in conjunction to that is that this law is 119 years old.

The Hon. TREVOR KHAN: If I may correct you: It is older than that.

Adjunct Professor WARD: Oh, it is older. Thank you.

The Hon. TREVOR KHAN: It is in the Crimes Act but there was another law before that.

Ms JOPE: It is based on an older one, yes.

Adjunct Professor WARD: It was established in a time when women did not have any rights, have any vote and in a system that was paternalistic: And if you were not a white women, you had even less rights.

The Hon. TREVOR KHAN: Sure.

Adjunct Professor WARD: And disadvantage. So for our mothers, grandmothers and great-grandmothers who had no choice, I think that it is absolutely timely that we make a decision now that reflects society and choice and dignity. The nursing profession is very, very strongly advocating that and, of course, we are 90 per cent female. We see this as professionals and we understand lack of right.

Ms JOPE: I would like to add to that. For women I know who have terminated a pregnancy and who have already got children, and that is a significant number of women who terminate pregnancies, it is an unplanned pregnancy; and then, you know, maybe I have three, maybe I have two, maybe that is enough, maybe our family cannot take anymore. But they have already had children. They know what they are doing. They know what the consequences are. They do not need the added stress. They will go through a period of, I would say, grief and loss around this but they are really making that decision based on the benefit for their whole family, not just about them.

The Hon. TREVOR KHAN: One of the propositions put yesterday by at least one of the priests was something along the lines of—putting it in its generalised terms—what women should do is carry the pregnancy through to its end and then adopt out the kid. Indeed in some of the thousands of emails that we have received, that is a repeated theme: That women essentially are obliged to carry a pregnancy through to its end and then look at other alternatives in terms of that child. Have you a view as to that as the method of dealing with an unplanned and unexpected pregnancy?

Ms JOPE: Women, probably, since the dawn of time have been dealing with unplanned and unwanted pregnancies. I cannot imagine a woman—we know what has happened to children who have been adopted out. I know of children who have been adopted out by young unwed mothers and the impact that has had on those women and on those children. Many of them have ended up in fabulous families, but there has been that gap, okay. And for some women, they will do that and they will continue to do that. But can you imagine a woman who has already, any woman—particularly a woman that has already got children—carrying through a pregnancy and then going back to work and saying, I adopted it out? Can you imagine the impact on her family of a woman carrying through a pregnancy and saying to her children, we adopted that out?

Adjunct Professor WARD: I do have an opinion about the priest's comments. I will refrain from saying them. What I will say is this. A woman's body and her reproductive organs are her right to make a choice, and not society's to decide that she is a vehicle, or a vessel, to deliver. What is not being discussed in this moment is considerations around the unacceptably high levels of child and women rape and sexual assault, of domestic violence that we should be addressing with great rigour, and the issues that women face that are not taken into consideration in the holistic approach of making a decision about what a woman would do.

The nursing profession absolutely advocates that a woman's, not only physical health, but mental and psychosocial health comes into place in the decision-making. Carrying a baby to term, because of religious or other beliefs, is unacceptable in her whole well-being. We certainly feel that many factors come into place. It is always an individual choice. It is a difficult decision and health professionals are best-placed to provide advice. Doctors, nurses, psychologists, social workers—there is a whole team of highly trained professionals to work with women on their individual needs, rather than doing a blanket rule.

Ms JOPE: Can I just add to that. That religious framework that is being forced on that woman is often not her own. We live in a secular society. I think as a society we have agreed that we have all got our own spiritual and religious frameworks. I find it really difficult to expect that the rights of a fetus—an unplanned pregnancy—should outweigh the rights of an adult female. We have a very dated perception of women if that is what we think. That she should just be hosting a child.

The Hon. NATASHA MACLAREN-JONES: I am particularly interested in late-term abortions—so 22 weeks and above. We are seeing, obviously, more evidence where babies that are born prematurely are surviving. There is evidence that has been given to us and a lot of research that has been done, particularly in America where you see a lot more late-term or partial birth abortions. Cases where during the termination the

baby is born live. I am interested in your understanding of the current legislation and what the procedure would be in that case?

Adjunct Professor WARD: The majority, in excess of 90 per cent, of terminations occur in the first trimester. We are talking a very small percentage. My understanding is in those cases where a late-term abortion is required, some of the testing around genetic abnormalities or otherwise can only be detected at 18-20 weeks. So we are talking a very low per cent. I would suggest, in extreme cases, where that decision would be made, it would not be easy on any mother, or any family, and would be in consultation with a multi-disciplinary team.

The Hon. NATASHA MACLAREN-JONES: Sorry, I was not clear. I was more interested in the situation where during the procedure the baby was born alive, or delivered alive. What is your understanding of the current legislation in how a nurse or a medical practitioner would deal with the baby in that situation. Does this need to be strengthened?

Adjunct Professor WARD: I do not have enough information to tell you. I would only have an opinion.

Ms JOPE: I am surprised at this issue. The one thing I would say about late-term abortions is that they are more likely the higher the barriers are for early-term terminations. The majority of cases are where there is some defect or some significant illness, or whatever. That must be a really difficult decision for parents. That is all I can say on that.

The Hon. NATASHA MACLAREN-JONES: Thank you.

Reverend the Hon. FRED NILE: Thank you very much for coming in and giving us the benefit of your wisdom. I notice your submission from the Community Women's Health Centre is very brief. But you have had a lot to say and you obviously have strong views on this issue. You just said a moment ago, that we are not a Christian society, or something like that—a secular society.

Ms JOPE: Yes, a secular society.

Reverend the Hon. FRED NILE: But our society is a Christian society. That is one reason why we have these abortion laws because of the belief in the sanctity of life, that every life is sacred including that of the baby in the womb. Do you see any issue about the rights of the unborn baby or child? You have not mentioned that. Do they have any rights?

Ms JOPE: I do not think they have rights over an adult.

Reverend the Hon. FRED NILE: But do they have any rights?

Ms JOPE: Well, I do not know. I understand Australia to be a secular society. I do not understand that the laws of any particular church outweigh any others, or any particular religion or philosophy. So while I understand the role of Christianity through the history of white Australia—

The Hon. TREVOR KHAN: Sorry, I have heard a number of noises from the gallery up until this point. I would ask, that if it happens again, that the gallery be cleared.

The CHAIR: I must say I did not hear that. I would just point out to the public gallery—you may not have been here this morning. We have had two days of hearings. We have had very respectful hearings and I very much commend the public gallery for that for the last two days with these emotional issues. But you must listen in silence. You must not make any noises about the evidence being given—and that applies to all evidence being given. If it does continue I will ask for the person involved to be identified and removed. Who was giving evidence? I do apologise for cutting you off. Ms Jope.

Ms JOPE: I have probably lost my train of thought now.

The Hon. GREG DONNELLY: It was about the secular society. I think you were saying Australia is a secular society.

Ms JOPE: Well that is it. We have a lot of discussion in our community at the moment about whose religious rights should have preference. I respect your religious framework that you work with and I would like you to respect mine.

Reverend the Hon. FRED NILE: I certainly do respect them but I am still focusing on the rights of the unborn child.

Ms JOPE: So as I said before, I do not think the rights of the unborn child outweigh the rights of an adult female to make a decision about whether she continues with an unplanned and unwanted pregnancy. That is my position.

Reverend the Hon. FRED NILE: So you do not want to give any consideration to the rights of the unborn child?

Ms JOPE: I think I just have.

The CHAIR: I think the witness has answered the question, Reverend Nile. We have got one minute left.

Reverend the Hon. FRED NILE: I have no more questions.

The CHAIR: Thank you Reverend Nile. The Honourable Greg Donnelly.

The Hon. GREG DONNELLY: Thank you both for coming along this afternoon and providing us with an opportunity to ask some additional questions in regard to at least one case in your submission. Perhaps going to Reverend Fred Nile's point, could I just make a statement. This is a highly charged debate, but hopefully this is a statement of fact. I am not asking you to agree, but I would like to make it. My thinking is, looking at the bill before us, which is what we have to adjudicate on next week when we get a chance to debate it, I commence with the premise that yourselves, both people at the table here this afternoon, and I say this most respectfully, strongly advocate for and on behalf of, and this is done most sincerely, the absolute and unqualified right—perhaps I will withdraw that because I do not think I should be making this claim in regard to the representative from the nurses organisation.

Adjunct Professor WARD: Sure.

The Hon. GREG DONNELLY: This relates more to the community organisation, because they are different, so I ought not lump you in together, but just go with me here: The absolute and unqualified right of the woman to determine whether or not they carry their pregnancy to full term and birth. That is the very strong case that is being put before this inquiry, that they have the absolute right, and I look at this debate we have got about abortion coming out of the Crimes Act and that is obviously animating this debate very strongly, and this bill in particular. Can I also make the observation that pregnancy termination, the termination of a pregnancy, is not healthy for the unborn—and I do not make a frivolous comment.

Adjunct Professor WARD: No.

The Hon. GREG DONNELLY: Deliberately terminating a pregnancy actually extinguishes the life of the unborn. Therein lies a statement of fact, and for me anyway, unlike the Hon. Fred Nile, I do not bring any religious prejudice to this. So we have competing positions about the exercise of rights, which I think you have elucidated quite well and I think it is right, the question of right or rights, the conflict, and which should prevail. I think it is important to understand that it is not just a matter of religion that animates this, it is a sense of what we are dealing with here as a matter of fact. Can I deal, first of all, with some questions in regard to the matter of nurses and particularly the matter of conscientious rights. I do not know whether you are able to do this, but with respect to the code of practice that you have referred to—and thank you for doing that because I was quite ignorant of that—does it have an official name, just so we know what it is? And if you do not know the official name of the code, can you help to inform us?

Adjunct Professor WARD: We can guide you to the website.

The Hon. GREG DONNELLY: No, that is fine.

Adjunct Professor WARD: The NMBA, the Nursing and Midwifery Board of Australia, code of conduct, code of ethics.

The Hon. GREG DONNELLY: Thank you, we can get the link for that perhaps.

Adjunct Professor WARD: Yes, or we could send it.

The Hon. GREG DONNELLY: Thank you for that because the issue of conscience is one of the hot button issues—

Adjunct Professor WARD: Yes, and we talk about cultural safety and there are all sorts of things in there.

The Hon. GREG DONNELLY: Yes, I get it. You have said—and if I say this incorrectly, pick me up—that there would not be consequences for a person exercising a conscience choice. How is that enforced if in fact it got contested? How does a person who feels that their conscience has been challenged exercise that and protect themselves in the context of that code? Could you explain that?

Adjunct Professor WARD: Yes, and perhaps I should have said there should not be because I cannot speak on behalf of every employer, but there is an expectation—there is a Fair Work Act, we have a whole system to support employees around a code of conduct. We are bound by our professional code of conduct as well as an organisational code of conduct. So for me it almost is black and white if a person feels safe enough to report. Every organisation should have governance and policies around escalation of safety of employees' health and wellbeing.

The Hon. GREG DONNELLY: Perhaps what I am saying is—and there is no imputation by me that there are a whole bunch of crook abortionists out there, or those who run abortion practices or abortions conducted inside hospitals—that as legislators we have to think of not just these issues where everyone is being good, but perhaps more importantly, if there is a contrary issue in terms of the problems, if the conscience is being challenged. I hope you understand that. That is a particular concern. Is it your submission, and again I am sorry, I have not had the chance to move on to yours, I have run out of time, but with respect to the position of nurses, with respect to the conscientious objection provisions which are in the current bill—and can I ask you have you read those provisions?

Adjunct Professor WARD: We fully support the current bill.

The Hon. GREG DONNELLY: Which includes obviously the conscientious—

Adjunct Professor WARD: Yes.

The Hon. GREG DONNELLY: And there would be no argument to change or enhance those in any way?

Adjunct Professor WARD: No, we support the bill as is, and we have contributed to the bill. We have been part of the discussion. Whilst we are professionally bound, and I mentioned voluntary assisted dying, we are having great professional discussions around emerging issues, for example, in Victoria and nurses' roles in voluntary assisted dying. This is not new to us, but we support the bill.

The CHAIR: I think we might need to clarify that, Greg. You said there were no questions around enhancements or changes to the amendments? Is that what you—

The Hon. GREG DONNELLY: No, I am sorry.

The CHAIR: And you said, "No". I do not know if you understood the question.

The Hon. GREG DONNELLY: No, I am sorry—because we are just so pressed for time. Just to be clear, we obviously have a bill that came in to the Legislative Assembly on 1 August. It has worked its way through there and it is coming to the Legislative Council next week. So at the moment we are deliberating through this process of having an inquiry.

The CHAIR: We are dealing with the amended bill.

Adjunct Professor WARD: Yes.

The Hon. GREG DONNELLY: So it is not the original bill but the amended bill.

Adjunct Professor WARD: Yes.

The Hon. GREG DONNELLY: I will ask you again: It is clause 9 of the second print, that is the amended bill.

Adjunct Professor WARD: Yes.

The Hon. GREG DONNELLY: Have you read and do you understand the provisions of clause 9?

Adjunct Professor WARD: Yes, I have, and we support the bill, we support the amended bill. Word for word I cannot tell you—

The Hon. GREG DONNELLY: No, but in principle—

Adjunct Professor WARD: In principle.

The Hon. GREG DONNELLY: It is not a trick question, I am just saying that the position of the organisation that you represent here today is that you support this provision as it stands and you would not endorse any further changes to it.

Adjunct Professor WARD: Yes, I would have to consider the changes.

The Hon. GREG DONNELLY: Okay, that is fine. Thank you.

The CHAIR: As the last questioner, Professor Ward, I think you said quite early in your evidence that the need for the reform, taking it out of the Criminal Code into the health code, is so that health practitioners are not at risk of imprisonment.

Adjunct Professor WARD: Absolutely.

The CHAIR: Is that a live issue in the mind of health practitioners?

Adjunct Professor WARD: As I mentioned, when we become nurses, doctors, health professionals, you do not think you need to look at the Criminal Code. Now that this has raised awareness, certainly throughout Australia, and we have seen inconsistency, we have seen Queensland move forward, it is raising to a conscious level of concern for health professionals that we would not want to see any health professional face criminal charges for providing care. So I think that because it is such a strong issue now, you will know with health professionals that it will not stop us with what we are doing because we will always advocate for the best interests and the rights of patients, but we should not be compromised in doing that.

The CHAIR: You are probably the wrong person to ask, but does it have implications for legal liability and insurance and things like that?

Adjunct Professor WARD: Not that I am aware of.

The CHAIR: Ms Jope, you have obviously made a very brief submission for yourself, but you are endorsing the signatory to the submission from the earlier witness today, Professor Bateson, the Medical Director, Family Planning NSW?

Ms JOPE: No, the Pro-choice Alliance.

The CHAIR: The Pro-choice Alliance, so you are endorsing a bigger submission.

Ms JOPE: Yes.

The CHAIR: I just want to touch on the issue of adoption. My extended family has adoption. I have friends who have gone overseas to adopt babies. Is adoption an active option in discussing the future for I guess predominantly young women but any women around the issue of their unwanted child or baby?

Adjunct Professor WARD: We can both answer.

The CHAIR: Please do. We have not heard any evidence as to that.

Ms JOPE: Of course it is a consideration.

The CHAIR: It is discussed?

Ms JOPE: I am sure, yes.

Adjunct Professor WARD: Adoption rates in Australia are quite low, which is why overseas adoption is considered, or surrogacy. All these issues, there is such a spectrum. We have given evidence in the Senate inquiry into the high rate of stillbirth. We do not want to lose babies that people want. There is such a spectrum that the nursing profession covers.

The CHAIR: I understand that. My friends went overseas because they wanted a baby and generally very few babies are available for adoption. Obviously there are children available through fostering.

Ms JOPE: I have to say, there are a lot of children in foster care.

The CHAIR: That is right. I said that. There are a lot of children in foster care for adoption that do need homes.

Ms JOPE: There are a lot of children that do need stable homes.

The CHAIR: It is a different issue if you want a baby.

Adjunct Professor WARD: And long-term foster care too.

The CHAIR: Do you think we need to work on destigmatising adoption, as a society? I think you said there is stigmatisation to adoption.

Ms JOPE: I think there is more than a stigma. Having been pregnant myself and going through that process, the majority of cases you want to go through that process to have a child, and that child to be part of your family. Some women choose, if they have an unwanted pregnancy, to go through it and then adopt it out, not many. I think the obviousness of being pregnant and then not being pregnant and making that choice to adopt would be really difficult.

The CHAIR: We have seen that. Thank you for your evidence.

Adjunct Professor WARD: I add, I think the whole notion of family needs to be really explored because where we have come from and where we are going are going to look very different. I think the whole concept of how people come together and create family is a real pivotal time in our history now of how that will look into the future.

The CHAIR: It is very different, is it not?

Adjunct Professor WARD: Yes.

The CHAIR: Thank you for coming in today, spending your time and expertise in presenting evidence to this inquiry, we appreciate it.

(The witnesses withdrew)

RACHEL WONG, Managing Director, Women's Forum Australia, sworn and examined

BERNADETTE TOBIN, Director, Plunket Centre for Ethics, sworn and examined

ROCKY MIMMO, Chairman, Ambrose Centre for Religious Liberty, sworn and examined

The CHAIR: Welcome to the hearing of the inquiry into the Reproductive Health Care Reform Bill 2019 by the Standing Committee on Social Issues. I am Shayne Mallard, the Chair of the Committee. I invite you to make an up to five minute opening statement each.

Mr MIMMO: I seek leave to make a couple of comments that are not contained in my submission, if I may?

The CHAIR: Yes.

Mr MIMMO: The narrative in terms of the bill as described is misleading. I do not think for one moment it is about the decriminalisation. That matter of decriminalising could easily be accommodated by having a consequential Act within a renamed bill, if you like. It could be called an abortion rights bill or a termination rights bill which would more correctly address the subject contained in the bill. That is a matter for your Committee. You might like to make it as one of your recommendations, that it is a misleading name in terms of somehow decriminalising abortion. That is not the case. It clearly is the case that it is a bill that grants freedom of an abortion without restriction up to 22 weeks and with some limited restriction beyond 22 weeks.

The Hon. GREG DONNELLY: Are you talking about 22 weeks, sir?

Mr MIMMO: Well, 22 weeks is in the bill at the moment. That is not my submission. My submission, if I could go to section 5, is that the term 22 weeks should be considered by the Committee that perhaps 13 weeks might be more appropriate if it is the will of the Parliament to totally grant the issue of abortion to a woman. In terms of section 5 it refers constantly throughout the bill to "the person". I am not sure what the reason for that is and it seems to be inconsistent with Acts of Parliament dealing with this matter in other States. It should correctly refer to the woman who requests an abortion.

If for some reason or other it is the intention of maybe a sponsor or co-sponsor of the bill to use the word "person" and that that could somehow involve a trans male who is pregnant or becomes pregnant, then I think that that scandalises the whole issue of what we are dealing with here. We should identify the person who is seeking the abortion is in fact "the woman" requesting the abortion. That I think would help to clarify the remainder of the bill where throughout the bill the use of the word "the person", the first person, and so on, just lacks clarity and it makes it difficult for people to precisely understand who is requesting the abortion and to whom the health professional needs to respond to.

I would encourage people, or at least the Committee chair, to have a look at the reasons why—if it is the mind of the Parliament that somehow a woman has a right to seek a termination, why is not 13 weeks the benchmark, instead of 22 weeks? There is no difference, in fact, at 13 weeks which denies a woman as it would be at, say, 22 weeks. The reason why I look at 13 weeks is clear: It is the end of the first trimester and at that point, the shape of the fetus or the shape of the unborn child is clearly visible in scans. There are limbs clearly visible, the eye sockets are there, the head is apparent. There could be no mistake, at that point, that you are dealing with a human life; no mistake, even if there is some argument—and I understand some people may have views that life does not really commence in the womb until after the first trimester or until the embryo forms into a fetus. But at 13 weeks it is unmistakable and that ought to exercise your Committee chair, I put.

The CHAIR: I will have to end it there, Mr Mimmo; that is over five minutes. We will come back to you with questions about some of the issues you have raised. We have got your submission, which is number 40. Members have read your submission, as well. We will come back with questions, do not worry.

Mr MIMMO: And in particular the question of conscience, please.

The CHAIR: I am sure that will come up. It comes up in all of the sessions we have had.

Professor TOBIN: Thanks very much, Mr Chairman. Three points: I think the vice president of the Australian Medical Association [AMA], writing in *The Sydney Morning Herald* this morning, has belled the cat. This bill, as it is written now, will authorise doctors to go way beyond their professional training and competence. She makes the point with respect to what she calls gender selection; I imagine she means sex selection. What she is saying is doctors—their role is the care of the patients health. This prohibition on an abortion for gender selection would require them to be mind readers. I think what she has done is to show that the bill as written—and the bit that I am referring to in particular is section 6 (3) (a), (b) and (c)—the parliament would be legitimising,

authorising and encouraging doctors to go beyond their professional competence and training. That is my first point.

The second point is that again the vice president of the AMA writing in *The Sydney Morning Herald* this morning makes the point that doctors struggle to discern coercion. She asks the parliament to do something to support—ask the parliament to get the relevant ministry to provide some kind of support and training for doctors to recognise coercion. Again, the bill does not accommodate that but the bit that I draw your attention to is the way that the section 7, the requirement for information about counselling, is written. I think it is written in a very paternal—it is encouraging a kind of paternalism amongst doctors, which is undesirable in itself. But my main point is that it does not recognise the possibility of coercion.

The third thing is this—and with the greatest respect I say this: that it is a very good thing that the parliament is giving each member of the parliament a conscience vote. That recognises the significance to us of making judgements about right and wrong. I am sure that is what most women are doing when they are seeking and undergoing an abortion. It would, I think, be very—if I can say it respectfully—inconsistent of the parliament which is enjoying the freedom to decide in conformity with your sense of right and wrong, to take that freedom away from doctors. Some doctors sense of right and wrong in this matter goes just to the conduct of an abortion. For others it will go to everything associated with it, including facilitating it. As you would know from the Victorian so-called voluntary assisted dying Act, there are three or four things that count as facilitating. If you have a conscience vote, I think that you should not be doing anything that imposes on doctors a law which will require at least some of them to violate their conscience.

The CHAIR: Thank you, Professor Tobin. We have your submission, 41, which the members have read. Finally, Ms Wong.

The Hon. GREG DONNELLY: Can I just ask: With the third witness, is there a submission?

The CHAIR: Have you made a submission?

Ms WONG: I have, yes. I was told to bring it with me today.

The CHAIR: There are copies there?

Ms WONG: Yes.

The CHAIR: We will attend to that. Please proceed.

Ms WONG: Thank you for giving me the opportunity to speak to the Committee today. In summary, we at Women's Forum Australia believe this bill should be rejected in its current form because it fails women in this State, especially the most vulnerable women. I want to be clear that we are strongly against the criminalisation of women who have had an abortion. We believe there are systemic issues which mean women are not given all the support or information they need to make a real choice. Often, because of financial, emotional and other pressures, they feel like abortion is their only choice. Criminalising women is not appropriate, especially in light of the grief and suffering that they typically experience after an abortion. But this bill does not just decriminalise abortion; it is a radical departure from the current law. It removes protections for women, unborn children and health practitioners and it is totally counter-productive to the health and welfare of women.

Women's Forum Australia is an independent think tank established in 2005 that undertakes research, education and public policy advocacy about economic, social and health issues affecting women. We focus especially on addressing behaviour harmful and abusive to women, and that includes abortion. For our society to be genuinely pro-women on the sensitive issue of unplanned pregnancies, we have to consider legislation, policy and practices in a holistic and considered way. Simply focusing on giving women the apparent choice of an abortion whenever they want it does not address or resolve the crux of the problem. By just legalising abortion on demand without limits or safeguards, the Government is absolving itself of its fundamental responsibility to address the more complex underlying issues that make a woman feel, when faced with an unplanned pregnancy, that the only thing she can do is get rid of her child.

The shirking of this responsibility is all the more evident from the shambolic process around the introduction of this bill. It has been rushed. Key stakeholders—women—have not been consulted and the process has been clearly designed to suppress rather than promote debate and discussion. This is clear from how it was rushed through the lower House just last Thursday, with only three business days given for the public to make submissions; and now I am here, the following Thursday, at a hearing for an inquiry which will be wrapped up by next week. It was obvious from the debate in the lower House last week that not even the co-sponsors of this bill

had thought through the basic issues like appropriate safeguards for informed consent in circumstances where women are most vulnerable. The bill in its initial form did not even refer to it.

It was obvious that women were not put at the centre of this bill when we saw MPs voting down fundamental protections proposed in amendments, which quite frankly should have been in the initial bill. I am talking about protecting women from being coerced into abortions, protecting our unborn girls from sex-selective abortion practices in communities or families where sons are preferred—protections for which, I will add, the Premier has now signalled her support—and protecting our teenage girls seeking abortions who may have been victims of sexual abuse or domestic violence. It is an absolute disgrace that an issue so critical and significant for women could be treated with such disrespect. Women expect more from this Parliament and from our Premier, who is a woman herself.

Our strong view is that this bill is rejected in its current form on the basis that it is fundamentally flawed and has not been given proper consideration. The bill fails to address the support women really need. The Government needs to do research into the reasons why women feel abortion is their only choice. It needs to support real choice by addressing domestic violence, access and affordability of childcare and incentives for flexible workplace or study arrangements, and access to pregnancy counselling and psychological support or treatment.

The bill also ignores, I suggest for ideological reasons, the negative health risks of abortion for women. The Government needs to do research into these harms before proposing reform to ensure women are empowered with accurate and objective information when faced with an unplanned pregnancy. In our submission we have set out in detail what changes need to be made to the current bill should our top recommendation to reject it not be taken on. Some of our key recommendations, which I am happy to speak around, include: a robust informed consent provision specifically outlining a framework of safeguards to protect a woman's right to informed consent when faced with a decision to have an abortion; including criminal penalties for any person who coerces or attempts to coerce a woman into having an abortion; and penalties for doctors who perform abortions on a knowingly coerced woman; and prohibiting abortion on the basis of sex. This is an insidious practice and should not be allowed for any reason in this State.

The CHAIR: Thank you for your statement and the document you distributed.

The Hon. NIALL BLAIR: Professor Tobin, in your opening statement you mentioned *The Sydney Morning Herald* article this morning that the bill could encourage doctors to step outside their competence and their training. Under the registration system that we have with our doctors it is never acceptable for doctors to step outside of their competence or training, is it? And if they do aren't they delisted or isn't there action taken against them in every circumstance?

Professor TOBIN: No, the kind of circumstance I am thinking of—can I give you an extreme example?

The Hon. NIALL BLAIR: No. You said it was encouraging doctors to step outside their competence and training. No doctor can step outside their competence and training in any field and if they do they would be potentially charged or deregistered, wouldn't they?

Professor TOBIN: I respectfully disagree with what you are saying. If I can draw your attention to the fact that in section 6 (3) (b) the bill as written says that, "in considering whether a termination should be performed on a person under this section a specialist medical practitioner must consider:" And (b) is, "the person's current and future physical, psychological and social circumstances". Considering those things I respectfully submit goes way beyond the training knowledge, experience, expertise or medical doctors.

The Hon. NIALL BLAIR: You have a clear understanding of what they are trained in and you would say that if a doctor went into any one of those areas they are stepping outside of their competence and their level of expertise.

Professor TOBIN: No, what I am saying is that (b) is so wide that it asks a doctor to consider things a doctor simply is not trained to know, understand and appreciate. And, indeed, could not. How could the doctor know, understand and appreciate the person's future social circumstances?

The Hon. NIALL BLAIR: We heard from the doctors earlier today and they believe as a trusted profession that is regulated that they are the best people placed to provide guidance and advice in these areas. You disagree with that?

Professor TOBIN: It does not surprise me. A whole profession can be mistaken.

The Hon. NIALL BLAIR: A whole profession of doctors in this country is mistaken?

Professor TOBIN: No. That is not, with respect, what I said. Just as one professional can be mistaken, indeed a whole profession can be mistaken.

The Hon. NIALL BLAIR: I will rephrase. Do you believe the whole medical profession is then mistaken in this area?

Professor TOBIN: No, I do not.

Reverend the Hon. FRED NILE: She did not say that.

The Hon. NIALL BLAIR: That is why I asked, to clarify that. Professor Tobin said a whole profession could, therefore I posed the next question if this profession was, and she said no. I accept that answer. Ms Wong, in relation to the protections removed from women in your opening statement. Can you elaborate what protections under the current Crimes Act are being removed from women under the bill?

Ms WONG: As I mentioned one would be sex selective abortion. Under the current law abortion is only permitted for reasons relating to the woman's health and so sex selection would not be allowed under the current law.

The Hon. NIALL BLAIR: We have had a lot of discussion around this. Do you see anything that removes that at the moment in what is proposed here? We have heard a lot of evidence to say that is not an issue here in Australia.

Ms WONG: The Attorney General himself has said that the current bill will allow sex selective abortion.

The Hon. NIALL BLAIR: We have heard from the medical profession that does not occur.

Ms WONG: We have heard from the medical profession that it does not occur in New South Wales? We also have research from Latrobe University in Victoria that it is occurring over there and the period in which it has been most heightened has been since the introduction of their abortion law reform in 2008. The discrepancy between males and females in that State has increased alarmingly.

The Hon. NIALL BLAIR: There has been debate around that study and those stats which you may be able to read from earlier today in *Hansard*. Other than that, what other protections have been removed.

Ms WONG: Just on that point. I think the critical point is that this bill will permit sex selective abortion. That is the point. Whether there will one or 10 or 100 I do not think that is what we are concerned about. Obviously that is concerning if there will be hundreds, but the point is it legalises this practice. The question we need to be asking is do we want that in this State. Other protections it removes: At the moment because abortion is allowed for reasons relevant to the woman's health or life, social reasons are not allowed. This gives some sort of protection to a woman who may be coerced into an abortion.

The Hon. NIALL BLAIR: You are saying that at the moment there is around 30,000 abortions that are happening not for social reasons but are only happening for the reason you spelled out, for medical reasons.

Ms WONG: If there are abortions currently happening for reasons that are not medical I think we need to be looking at whether or not we want that to be the case, rather than saying what is happening.

The Hon. NIALL BLAIR: Should we police that harder, should we? We know they are happening. Everyone agrees they are happening.

Ms WONG: I think this is an opportunity to look and ask ourselves do we want abortion for social reasons? Yes.

Ms ABIGAIL BOYD: I will start with Ms Wong. Just picking up on that evidence you gave in relation to domestic violence and reproductive coercion. We have heard from doctors and also from people who work at frontline domestic violence prevention services that abortion being criminalised is something they object to. When you look at the Safe State package of reforms for domestic and family violence prevention they very clearly state right at the front that decriminalisation of abortion is one of the fundamental steps to achieving some kind of improvement in relation to the domestic and family violence epidemic. Yet you give the opposite view, why is that?

Ms WONG: Unfortunately I have not been around to hear the other statements. But my question in relation to that would be, how does abortion solve domestic violence? We definitely know there are women who are being coerced into abortion, which I would say is also a form of domestic violence. We know that women seeking abortions are often pressured by their partners or other family members. Just last year during proceedings, during hearings on the bill which got passed in Queensland there was a doctor who herself admitted to performing

abortions on knowingly coerced woman. That is disgusting in my opinion and I hope that is the opinion of everyone here as well.

Ms ABIGAIL BOYD: Doctors and experts in the field are telling us that it is more likely to be the other way around. That people are being coerced into keeping the pregnancy going and not to have an abortion.

Ms WONG: Any coercion of a woman is unacceptable. This bill is regarding abortion and I think we need to put in place provisions to protect women from abortion coercion.

Ms ABIGAIL BOYD: Professor Tobin, you talked about section 6, which is the termination by medical practitioner after 22 weeks. You said it puts doctors beyond their competence and training. Is that in comparison to the current situation? Are you referring to the current situation as well?

Professor TOBIN: I was not making a comparative point. My point goes just to what this legalises.

Ms ABIGAIL BOYD: Are you aware that section 6 is actually more strict than what we have in the current law in relation to terminations after 22 weeks?

Professor TOBIN: No, I am sorry to say I am not aware of that. My point is that by putting it that way the law, which as you know has an educative effect, legitimises the doctor making a judgement about this very wide set of circumstances. On my view some are unknowable but go way beyond her training and competence.

Ms ABIGAIL BOYD: Okay, but the current law is written like this. This is a status quo. What we have added with the lower House amendment is that we now have to have two doctors, whereas at the moment you only have to have one.

Professor TOBIN: Thank you for pointing that out. I am not aware of that, so it is not a comparative point. If I may go to the two doctors issue, truly, we know that means walking across the corridor and getting your colleague to sign the form.

Ms ABIGAIL BOYD: Mr Mimmo, I am sorry if you said this in your opening statement and I did not hear it, but could you just tell me what your qualifications and expertise are?

Mr MIMMO: In terms of what?

Ms ABIGAIL BOYD: Anything. I do not know what your background is. Do you have any medical experience or experience in reproductive health? I am just curious as to what your background is.

Mr MIMMO: No, I have legal qualifications. I have a Master in International Law and the human rights aspect of it. I have been involved in moral issues over many years and have given previous submissions to Parliament.

Ms ABIGAIL BOYD: Thank you. Is the 13 weeks that you suggested, instead of 22 weeks, based on legal grounds?

Mr MIMMO: No. I do not understand the 22 weeks. The explanation given for that is that it is a point of viability. That viability was determined by the World Health Organization. It determined that at 22 weeks an unborn child can exist outside the womb of the mother. The second reason given was because they want to bring it into line with the Queensland legislation of 22 weeks. There has been no other explanation as to why 22 weeks ought to be the case. I am saying we should reduce it to 13 weeks because at 13 weeks the opinion of a woman or the partner or husband, who may have an opinion, would have been formed. If there is a legitimate reason why abortion ought to extend beyond 13 weeks then the two-doctor question should come into it at that point.

The Hon. TREVOR KHAN: Professor Tobin, you were asked questions by my colleague Ms Boyd about the post 22-week period. I think she might have mistakenly suggested that the addition of two doctors was made by the amendment. The original bill as introduced provided two doctors. The bill as amended provides that one of those doctors must have specialist expertise, such as an obstetrician. Are you still maintaining your position in essence that the involvement of two doctors is simply an arrangement of what could be described as tick and flick?

Professor TOBIN: Any two doctors might take it very seriously as the grave matter that it is. That is clearly the case. But the way it is written is open to tick and flick.

The Hon. TREVOR KHAN: Professor Tobin, the bill provides that terminations post 22 weeks are to be performed in a public hospital in New South Wales or another institution that may be added by the secretary of the department. Are you saying that two doctors, including one with a specialist expertise, in a New South Wales public hospital would engage in tick and flick on something that you describe as so serious?

Professor TOBIN: No, I am not making that claim. I am saying that the bill as drafted leaves open that possibility.

The Hon. TREVOR KHAN: Ms Wong, you talk in terms of essentially the intimidation of women and your concern with that in regard to this bill. Your organisation developed a position with regard to the safe access zone legislation, did you not?

Ms WONG: We did, yes.

The Hon. TREVOR KHAN: You opposed legislation that sought to prevent the intimidation and harassment of women in the vicinity of abortion clinics, did you not?

Ms WONG: That is what the legislation alleged it was to do, yes.

The Hon. GREG DONNELLY: Point of order: We are here examining the terms of reference before this inquiry, which is to do with—

The Hon. TREVOR KHAN: That is enough, I am moving on, Greg.

The Hon. GREG DONNELLY: No, shut up—

The CHAIR: Order! We will not have that sort of language in the Committee.

The Hon. GREG DONNELLY: I am taking a point of order and he has cut me off.

The CHAIR: Yes, and that is out of order.

The Hon. GREG DONNELLY: I am not going to sit here and just take it.

The CHAIR: Take your point of order so I can make a ruling.

The Hon. GREG DONNELLY: WE are looking at the terms of reference with respect to the bill before the Legislative Council. The member is now going into an area to do with not a bill but an Act of this Parliament that was passed last year. Can you direct the member back to the terms of reference before this inquiry, which are to do with the bill before the House?

The CHAIR: There has been some scope to look at other bills, amended bills and previous bills. I have allowed that. I understand that the Hon. Trevor Khan is saying he is moving on. I accept that.

The Hon. TREVOR KHAN: Ms Wong, are you aware that there is legislation enacted in New South Wales now that is designed to protect women in domestic circumstances from stalking and intimidation?

Ms WONG: Yes, I am.

The Hon. TREVOR KHAN: Do you not understand the concept that if there is a criminal law in place now that protects women from stalking and intimidation, precisely the form of intimidation and harassment you say you are concerned about is already covered under criminal law?

Ms WONG: I think because of particular vulnerability surrounding women who seek abortions and because this particular bill will remove protections for that and expand the law significantly it is important that there is a particular provision to protect these women.

The Hon. TREVOR KHAN: It is already covered in criminal law, Ms Wong.

Ms WONG: It is in criminal law but this bill is expanding the current law and is removing criminal protections for women and children. I think we need to include a particular provision in the current bill to protect these women.

The Hon. TREVOR KHAN: Ms Wong your organisation says that it supports the decriminalisation of abortion—that is correct, is it not?

Ms WONG: We support an amendment to the Crimes Act that would protect women from criminalisation, yes. But we do not support removing it completely from the Crimes Act.

The Hon. TREVOR KHAN: You have opposed, have you not, the Queensland legislation upon which the bill before our House is involved?

Ms WONG: Yes, we have.

The Hon. TREVOR KHAN: In fact, you opposed it at an inquiry before the Queensland Parliament?

Ms WONG: Yes.

The Hon. TREVOR KHAN: You opposed it before the Law Reform Commission?

Ms WONG: Yes.

The Hon. TREVOR KHAN: And you oppose this bill as well?

Ms WONG: We do, yes.

The Hon. TREVOR KHAN: Your history is to consistently oppose abortion law reform, is it not?

Ms WONG: Our history is to oppose extreme and radical legislation that removes protections for women and children in this country, yes.

The Hon. NATASHA MACLAREN-JONES: With the limited time I have got I am just going to focus on the submission that Ms Wong has provided. I thank you very much. Like a number of our submissions, it is quite detailed and I will endeavour to read it, along with all the other submissions that have come through. You made a number of recommendations in your executive summary. Could you please elaborate in relation to recommendation 11, where you say that you would like to see an amendment to the bill to remove clause 6, which would permit abortion of viable babies up until full term.

Ms WONG: Yes. As I said earlier, the current law allows abortions to preserve a women's life or health. We are very concerned that this bill would allow abortions on viable children up until full term with no restrictions, effectively, for any reason. This is dangerous to women and it is dangerous, obviously, to their unborn children. It is also completely inhumane.

The Hon. NATASHA MACLAREN-JONES: This is something that has been asked yesterday and again with witnesses today. Looking at the legislation as it is, in a situation where a termination has occurred and a baby is born and it is alive, what is your understanding of the legislation and what would occur after that?

Ms WONG: In relation to a baby who is born alive after an abortion?

The Hon. NATASHA MACLAREN-JONES: Yes.

Ms WONG: We saw in the lower House that an amendment that would have protected such children was voted down, and we think this is disgraceful. We think that there should be an amendment put in the current bill which says that a child born alive after an abortion would receive the same medical treatment that a child of the same gestation and medical condition would receive. We see no reason why that would not be the case.

The Hon. NATASHA MACLAREN-JONES: That is fine. I am happy to move on.

Reverend the Hon. FRED NILE: Thank you, Mr Mimmo, for your evidence and thanks to the other witnesses as well. Just one general question to you, Mr Mimmo, for you to give me your response. You made a big point about how in this bill, as you have said in your submission, the person seeking a termination is not referred to as "the woman". And you said, "The reason for this may be obvious to some, but escapes any purpose for which I can fathom." Is it possible that the mover of the bill, Mr Greenwich, is married to another man—

The Hon. GREG DONNELLY: Point of order—

Ms ABIGAIL BOYD: Point of order—

Reverend the Hon. FRED NILE: —and is that the explanation?

Ms ABIGAIL BOYD: What has that got to do with anything?

The CHAIR: Mr Donnelly got in just before you, Ms Boyd. Mr Donnelly, point of order?

The Hon. GREG DONNELLY: I will take the same point of order, Reverend the Hon. Fred Nile, that I took with the Hon. Trevor Khan, and that is this: This matter specifically deals with the terms of reference in the bill. It does not deal with matters to do with the Commonwealth Marriage Act, if that is where, Reverend the Hon. Fred Nile, you are thinking of taking this.

Reverend the Hon. FRED NILE: I am not taking it anywhere.

Ms ABIGAIL BOYD: Or the mover of the bill.

The Hon. GREG DONNELLY: Hang on.

Reverend the Hon. FRED NILE: I motioned the witness for an answer.

The Hon. GREG DONNELLY: I am just simply saying that there was a matter raised which we all know is particularly controversial and we just need to, I think, manage it.

The CHAIR: I have heard enough. I must say I was conferring with the clerk about a matter and I did not quite hear it, but I am going to just direct you, Reverend the Hon. Fred Nile, back to the terms of reference to specifically focus on this bill. Thank you.

Reverend the Hon. FRED NILE: Yes. I am speaking to the submissions we have, and the witness asked the questions and it is in his submission. Why does the bill omit any reference to a woman?

The CHAIR: You do not have to argue with the ruling. Just return to the bill. The submission is valid.

Reverend the Hon. FRED NILE: That is the reason I asked him the question.

The CHAIR: Let us hear your question, then, and I will hear another point of order if it is out of order.

Mr MIMMO: Chair, I am quite happy to answer what Reverend the Hon. Fred Nile just asked.

The CHAIR: I am going to ask him to restate it so it is clear, and rephrase it, if he needs to. Reverend the Hon. Fred Nile, back to you to restate the question or rephrase it if you need to.

The Hon. NIALL BLAIR: To the point of order, we actually did have a witness earlier that talked about why the term "people" was used. I think it is probably fair that we allow Mr Mimmo to put the counterargument to that, which I think is what he is going to do. Excluding identifying individuals in the Parliament and their motivations and their personal circumstances, I think that we probably should listen to the other side to that term.

The CHAIR: That is a helpful contribution, Mr Blair. Based on that, I agree. You may respond to that, Mr Mimmo.

Mr MIMMO: Thank you very much. The reason that I questioned why the person is not identified as the real person—that is in this case the woman—is because in the Queensland Act—and you will note if your definition, which is the definition in schedule 1—there is no definition of the person. In Queensland when they used the term "woman", the term "woman" was defined in the Queensland bill and now Act as any woman of any age. Now, that is remarkable. And the question was, when I was in Queensland, it was asked of senior Ministers, what happens if an 11-year-old or 12-year-old girl—or in this case my submission says a 14-year-old girl—falls pregnant? Would you require parental consent, for a start? Or would a doctor be at liberty to proceed with a termination in the first 22 weeks? I just point that out, that the bill lacks clear definition. There is nothing in the bill that tells you who the person is. One can infer who the person is, but clearly it does not say that at the moment. And it does not define the person in terms of age or capability or capacity to even make a request.

Reverend the Hon. FRED NILE: Thank you. You also made the point in your submission on page 4, would a medical practitioner agree to a termination of a person of 14 or 15 years of age if they requested the same, and you say the bill does not spell out a prohibition on such a request. Could you verify that?

Mr MIMMO: Thank you, Reverend Nile. I did say that. And the reason I say that is that a relevant Minister in Queensland said to me that he did not believe that a doctor would do that without parental consent. And my point to the Minister was, "Well, why do you not include it in the bill, to put it beyond doubt?" And there was no answer to that. He simply said that is the way "my party"—as he put it—wants to go. He did not agree with it. And I am not at liberty to say, because of the confidential nature, but the Australian Medical Association does have questions about that.

Reverend the Hon. FRED NILE: You also mentioned at the end of your submission the need for a full inquiry by the Law Reform Commission, that is warranted.

Mr MIMMO: Yes. I just heard—thank you, Reverend Nile. That is relevant because I just heard member Khan talk about the Law Reform Commission. I am staggered as to why the sponsor or the cosponsor are somehow attempting to avoid a full inquiry here. I mean, the issues are very, very plain. I do not understand why they will not allow a proper inquiry into this whole—not the process that the Parliament has adopted, but in terms of the ramifications of the bill. You know? What is required in terms of a termination? Would 13 weeks be adequate? Let the proper inquiry examine all of those matters. Anyway, I am not in the Parliament, so I cannot—

The CHAIR: I think it has moved beyond the sponsors to the Parliament. This bill is owned by the Assembly and now we are dealing with it. So it is our decision where it goes.

The Hon. GREG DONNELLY: Thank you. I have 1.66 minutes for each witness. That is how much I get for this inquiry, so can I ask, please, for the clerk to deliver these to the witnesses? I am very sorry. I have

just five minutes, so forgive me for appearing like a machine gun. Mr Mimmo, can I just take you—now, I do not assume for a moment that you are familiar, necessarily, with that document that you have just had put before you, but I wish to—

The CHAIR: I will give you extra time. Could the committee know what the document is?

Reverend the Hon. FRED NILE: Could I have a copy of the document?

The Hon. GREG DONNELLY: Sure, sure. It is the one we looked at yesterday.

The CHAIR: The guidelines?

The Hon. GREG DONNELLY: Yes.

The Hon. TREVOR KHAN: It has been tabled.

The CHAIR: Yes. Thank you.

Reverend the Hon. FRED NILE: It is health policy.

The CHAIR: We were not sure.

The Hon. GREG DONNELLY: The document is currently before the inquiry. Now, the matter of conscience is very significant in this particular bill, the issues around the matter of conscience rights for the specialists, the doctors, I would submit nurses and indeed allied health workers, because these, in my view, are all people who should be considered in the context of what the bill deals with, the termination of a pregnancy. I put it to you we have this scenario in New South Wales prospectively looking ahead. We have an Act that is going to regulate the practice of abortion coming out of the Parliament at some point in time with a conscientious objection provision in it. So that is in train.

An Act is going to come out that deals with conscientious objection. We have the speciality doctors organisation, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists [RANZCOG], which is a professional organisation for obstetricians and gynaecologists, which as a professional medical college has its own guidelines, its own internal disciplinary procedures, et cetera, et cetera. Thirdly, we have the operation the codes of practice. And we had earlier this afternoon, Adjunct Professor Kylie Ward, CEO of the Australian College of Nursing, who spoke about particular codes that operate with respect to nurses, of which we are finding out today for the first time exist—or at least I am—and hopefully we will get the link some time before we have to debate this bill.

Fourthly, there is this document you have now in front of you which I draw to your attention is actually a policy of NSW Health—let me use the colloquial term, the company policy for the New South Wales Government if you work within NSW Health. You will note on the front cover this document was published on 2 July 2014 and recently reviewed on 2 July 2019. For reasons unbeknown to us the chief obstetrician/gynaecologist of New South Wales has not made a submission to this inquiry and nor has he sought to appear before the inquiry.

This gentleman—I think it is a gentleman but if it is a woman, forgive the mistake—reports directly to Brad Hazzard, the health Minister, who is one of the primary sponsors of this bill. I specifically take you to page No. 7 of 9 and specifically paragraph "4.2 Conscientious objection". Can we just dwell on this? We have potentially an Act coming out of this Parliament dealing with conscientious objection. We have the professional colleges having their own procedures, guidelines and, dare I say it, disciplinary arrangements with respect to conscientious objection. Thirdly we have the matter of codes of practice to do with nurses—

The CHAIR: You have one minute, Greg.

The Hon. GREG DONNELLY: Yes, okay.

The CHAIR: I am just letting you know.

The Hon. GREG DONNELLY: I understand. And finally we have got their position with respect to conscientious objection with respect to the NSW Health policy. So we have in play four planks dealing with the matter of conscientious objection. That is the state of play now here in New South Wales. The position is we do not yet have an Act. We have a bill and in that bill we are familiar with the clause in it. My question is this: With all of that in play, can anyone in clear and unequivocal terms, if they can, here, explain to me whilst they are here what are going to be the conscientious objection rights with respect to medical specialists who undertake terminations, doctors who undertake terminations, nurses and allied health workers, and employees of NSW Health? That is my question.

Mr MIMMO: In terms of the bill—I can only be guided by what the bill says—the bill does require at least a violation of partial conscience. In fairness it does not say that the doctor needs to participate or be directly involved. But what is important to understand is that in international law, some of which is recognised in Australia, some of which is not, there are customs and practices here. Conscience to an individual, including a health professional, may be a very, very sacred and dear thing that goes to the very question of identity. And that identity is no different to that of the woman seeking the termination. She believes she has this right and if the law is passed she will have the right. The issue here is the doctor who wants to exercise a conscience fully should not be coerced to partially violate that conscience, because that doctor is not attempting to close down this service.

The doctor in this case recognises that the service is lawful for people who wish to participate in it. There is simply a question of if it is not a morality formed on your religious grounds—it could be a sincere, genuine belief held on social ethics grounds—that you do not, and no civilised society permits a killing, so to speak, unless in self-defence. But even that doctor who wants to exercise their conscience, if that person is confronted with a female who has a genuine serious health issue, may not be at liberty to exercise even their partial conscience. That is a question of fact, not a question of simply saying, "I will not do it," and leave the woman to the mercy of perhaps dying or being in serious danger of dying. That is not the issue. The issue is a request for a termination to a doctor who has a genuine conscience on it. That person should not be made some sort of a link to the possibility where it results in a termination.

The Hon. GREG DONNELLY: Connected to, through that link, that decision to—

Mr MIMMO: Yes. That is your doctor. Let me just go a bit broader. I would question the right of a person involved in health services, whether it is the allied workers or whatever, if it is a registrar or whatever the case is, who does not have some direct link to the possibility of an abortion or a termination occurring, whether they should be in this list of exercising their conscience. But there is nothing in the bill, for argument's sake, that says a nurse working in a hospital which accepts abortion can exercise a conscientious right. For those of you who might point out that the Fair Work Act allows religion not to be an issue of discrimination, that would not prevail in a case like this because the person is employed, the person wants to exercise a conscientious belief in the workplace, not because necessarily I have a belief but because I need to manifest it.

The CHAIR: Thank you, Mr Mimmo.

Professor TOBIN: Could I just add something? I think it might be helpful to separate the question of respect for conscientious objection from the particular issue of termination of pregnancy. Imagine this, and this is not common but happens: Someone comes in to see a doctor and this young man has the belief that his perfectly healthy leg or arm needs to be removed and the doctor does not think he should be part of this and has whatever conversations he can to help the young man but the young man is set on it. I do not think in that circumstance we would expect that the doctor who has the conscientious objection to conducting the procedure nonetheless has a duty to locate a doctor who he thinks would not have that conscientious objection. Of course he should treat the young man with courtesy—of course he should. But I do not think anyone in this room would think that if he is not prepared to do it himself he has an obligation to direct the fellow to someone he knows would.

You see this is the point about the abortion: One doctor might not be prepared to do an abortion quite late but not know who else amongst his colleagues would be. He might happen to know that but he might not know that. And why should we require of him that he knows it? But let me go back to my first point. Right throughout medicine there are judgements of conscience that have to be made—medicine is replete with them and medicine on the whole and by and large respects the judgement of the individual practitioner. And that judgement extends not just to conducting the procedure but recommending that someone go to someone else to have it done.

The Hon. NIALL BLAIR: Does that not contradict what you said at the start—that they do not have the competence to make all of those other assessments?

Professor TOBIN: No, they are two different points.

The Hon. NIALL BLAIR: Okay. I will read the transcript carefully.

Professor TOBIN: Okay. I am happy to speak further but I imagine—

The CHAIR: It has been raised and I do not have a problem with that.

The Hon. NIALL BLAIR: From my understanding of what we spoke about earlier you were saying that you do not believe that the doctor has the competence or the training to assess those other things, whether it is not just in their physical wellbeing but those other issues around the mental wellbeing et cetera. I am taking it though that you have just said that they do have the expertise to make those judgements, even using the example

of the leg, where you were saying that the doctor does have the skills and the competence to say, "No, removing that leg is not in your best welfare—your mental welfare, your physical welfare." So you are saying that they would have the skills and competence to be able to make that assessment but not on the other side if it was a person coming in for an abortion. Please, I might be confused.

Professor TOBIN: Yes, and perhaps the way I have spoken may have led to that confusion, so I apologise for that. What I am imagining is the doctor who is confronted by a young man with a perfectly healthy limb and the doctor would have the ability to remove it but, as a doctor, he makes the medical judgement that this would be in fact mutilation. It is not what a doctor qua doctor should do.

The Hon. NIALL BLAIR: But as a doctor would they not then think it is unusual that a person with a perfectly healthy leg has come in requesting—

Professor TOBIN: It is unusual.

The Hon. NIALL BLAIR: So they would probably maybe refer them for other care because—

Professor TOBIN: No. Do you mind me interrupting you?

The Hon. NIALL BLAIR: Sure.

Professor TOBIN: That is a different point. What your legislation, if it were about this matter, would do is say that the doctor has to refer the person to someone he knows would be prepared to do the procedure in those circumstances. That is the logical point I am trying to make.

The CHAIR: I think we have that point across.

The Hon. NIALL BLAIR: We will disagree on the interpretation I think.

Professor TOBIN: Okay.

The CHAIR: We need to move on. I have generally allowed witnesses to answer questions after the bell has gone, and they are seven minutes into answering after the bell.

Ms WONG: I would just add that I agree with the comments that have been made about the importance of protecting freedom of conscience and that for this to be a legitimate protection it has to extend to referral. To ask someone to refer for something that they do not think is in the patient's best interests or is a good medical practice for that patient is almost the same thing in terms of actually doing it themselves because, although they are not directly involved, they are passing that person on to someone who they know will do it, and if they do not think that is the right thing for that person they should not be asked to do that.

The CHAIR: I indicate to those in the public gallery that you cannot take photos or video in here, if that is what you are doing.

The Hon. NIALL BLAIR: To follow on: Does that include if the health of the patient is then in jeopardy?

Ms WONG: I think you need to look at that to see if the health of the patient is in jeopardy.

The Hon. NIALL BLAIR: Is it okay, though, if it could be argued in their medical opinion that the health of the mother is going to suffer unless they get further treatment—

Ms WONG: Unless they get an abortion?

The Hon. NIALL BLAIR: Yes, it could be abortion.

Ms WONG: Are you able to provide an example of that?

The Hon. NIALL BLAIR: There are many examples that have been carried out today and at other times.

The Hon. GREG DONNELLY: An ectopic pregnancy was used.

The Hon. NIALL BLAIR: Yes, okay.

The Hon. GREG DONNELLY: That was specific.

The Hon. TREVOR KHAN: It could be high blood pressure or diabetes.

The Hon. GREG DONNELLY: I just think "health" is a broad term.

The Hon. NIALL BLAIR: Or they need cancer treatment. They have gone to the local GP and maybe they have been diagnosed with cancer and maybe they are pregnant. There is an ethical and medical question around what happens from here? Is it not the responsibility of their GP, who has taken registration and an oath to put the interests of that person and their health at the forefront, even though they do not want to participate in the abortion side of things, they may want to continue as their doctor taking them through the cancer treatment. Should they not then be in a position to pass them on to someone else who is going to take care of the abortion side? If the advice from other medical practitioners is that the cancer treatment will not be conducive to a pregnancy being carried through and you have a case where both lives are now in jeopardy, is that not a situation where that could happen?

Ms WONG: I do think we have to be careful to distinguish between something that is an abortion, which is the direct and intentional taking of the life of an unborn child—

The Hon. NIALL BLAIR: Yes, because the child will not survive the cancer treatment.

Ms WONG: Yes.

The Hon. NIALL BLAIR: Therefore the decision of the mother is that she would like to terminate the pregnancy to then hopefully get through the cancer and maybe have the ability to have other children.

Ms WONG: The question you were initially asking was whether it would be appropriate in the situation of an emergency for a doctor to have to refer the patient to someone else. I guess what I am struggling to see is when that situation would actually arise—

The Hon. NIALL BLAIR: Okay, so the mother has presented to her doctor—

Ms WONG: Yes.

Reverend the Hon. FRED NILE: Can you let the witness answer the question?

The CHAIR: The Hon. Niall Blair will conclude with this and then we will wrap up this session.

The Hon. GREG DONNELLY: I think the question has to be very precise because we are not talking about the theoretical. There needs to be a specific proposition.

The Hon. NIALL BLAIR: A specific scenario is a person who is pregnant, who has been diagnosed with cancer and knows they have a course of cancer treatment that is going to, in the best expert opinion, lead to her not being able to carry that baby through to the end of pregnancy, so is wanting to have that pregnancy terminated to seek cancer treatment and has gone back to her local doctor to talk about the process of the abortion. The local doctor does not want to be involved in the abortion, but is happy to be involved in the cancer treatment and happy to remain the GP. Does the doctor then not have a responsibility, in the best interests of the health of the patient, to refer them to someone else who will be able to carry through that part of the treatment, because isn't the health and the wellbeing of that patient the thing that is going to override everything else here? It is not asking the doctor to be involved or making the doctor get involved in that, but surely there is an obligation for the health of the patient to pass them on to someone else who can take care of that.

Ms WONG: I guess from the perspective of that doctor, and I think it is a legitimate perspective, carrying out an abortion on that woman is not going to solve the cancer—and I am not saying you are saying that he should do it, I am saying you are asking that—

The Hon. NIALL BLAIR: No, it may prevent her—

Reverend the Hon. FRED NILE: Let her answer the questions instead of haranguing her.

The CHAIR: Order!

Reverend the Hon. FRED NILE: Let her answer the question. You are haranguing her.

The Hon. TREVOR KHAN: I do the haranguing. He is not.

The CHAIR: Order!

Reverend the Hon. FRED NILE: He wants a certain answer.

The CHAIR: Reverend Nile, you have been here long enough to know to put it through the Chair, so let us do that first of all. Secondly, I think—order! Mr Donnelly, I am adjudicating here. Mr Blair, I think you have asked your question. Do you want to answer that quickly, Ms Wong?

Ms WONG: I will quickly try to finish it off, because I know that we could talk about this for ages, but I think my understanding is that if a woman has cancer and she wants to get treatment and she is pregnant, she can do that. In that situation the life of the unborn child will be at risk, but the response has not been to directly and intentionally take that child's life, which I think is what the doctor would have an issue with and which I think is not a medical response to that particular situation.

The CHAIR: Ms Tobin, are you wishing to add something to that?

Professor TOBIN: Just very briefly just to draw the Committee and Mr Blair's attention to the second point in my submission. There is a fundamental distinction between (a) an intentional termination of the life of the foetus and (b) an intervention aimed at curing a serious pathological condition of a pregnant woman in circumstances in which the intervention cannot be safely postponed until after the baby is viable, in which circumstances the foetus's death is foreseen but not intended. Note that both of these procedures can be referred to as abortion. In my submission I use the terms "abortion" and "termination" to refer to only the former, the intentional termination, so there is an absolutely clear ethical distinction between those two acts and of course a doctor should do what is required as an emergency to look after the health of the mother in those circumstances.

The CHAIR: Thank you, Professor Tobin, for your helpful contribution. Thank you all for coming in and contributing your expertise to our deliberations. We appreciate you coming in today.

(The witnesses withdrew.)

(Short adjournment)

MARGARET MAYMAN, lecturer in theological ethics, United Theological College, sworn and examined

SIMON HANSFORD, Moderator, Synod of NSW and the ACT, Uniting Church in Australia, sworn and examined

PETER STUART, Anglican Bishop of Newcastle, sworn and examined

The CHAIR: Good afternoon. Thank you for coming today for the second day of the inquiry into the Reproductive Health Care Reform Bill 2019. This hearing is being conducted by the Standing Committee on Social Issues, of which I am the chair. I am Shayne Mallard. Thank you for coming in. Just to clarify, we have got two people from one church. Is that right?

Reverend Dr MAYMAN: Yes.

The CHAIR: But you are also a lecturer?

Reverend Dr MAYMAN: Yes.

The CHAIR: Reverend Hansford, an opening statement of up to five minutes. Thank you.

Reverend HANSFORD: Thank you for the invitation and for your time today. The decision of the Parliament of New South Wales to table and debate the decriminalisation of abortion is a critical one affecting people across our community. One of the significant advantages that the Uniting Church brings to this debate is that we have had women in leadership since our inception, offering theological, moral, pastoral and personal insight and challenge to our church, the wider church and the community beyond. This inclusion is inherent to our understanding of the Gospel and to our identity as a community of faith. Reverend Dr Margaret Mayman is one example of that leadership. The Uniting Church has been engaging in this debate for at least three decades, with a series of significant decisions dating back to the early 1990s. These decisions uniformly affirm that human life is God-given from the beginning. We believe that all human beings are made in the image of God and that we are called to respect the sacredness of life. We also believe Christians are called to respond to life with compassion and generosity.

When abortion is practised indiscriminately, it damages respect for human life. However, we live in a broken world where people face difficult decisions. Respect for the sacredness of life means advocating for the needs of women as well as every unborn child. We reject two extreme positions: that abortion should never be available, and that abortion should be regarded as simply another medical procedure. It is not possible to hold one position that can be applied in every case because people's circumstances will always be unique. We believe that abortion should not be a criminal matter but that it is of vital moral, social and health significance. The Parliament resolving that this is not a criminal matter would open the health community and the wider community to better care, better support and better options for women and unborn children.

It is important that women have the space they need to make this difficult decision after careful consideration and that they should have access to high-quality counselling, pastoral care and medical services. Women must be free to discuss their situation before they make a decision. The church needs to be a place where such discussion can happen. We can offer spiritual, moral and pastoral support without judgement to a woman at this time. Whilst we encourage our ministers to remind people of the sacredness of life, the church's role should be to offer care and support leading up to and following a decision, not to stand in judgement. Our church is also committed to support women who continue their pregnancy and help them within the community.

The Uniting Church is disturbed that recent comments could imply that women make the decision to have an abortion without proper consideration. Most women who have abortions do so only after a great deal of searching and thought and anguish. There are a range of well-informed spiritual, medical and emotional support services available to women and it is offensive to imply that these decisions are made lightly or without access to suitable consultation. The decision to have an abortion is not just a moral issue but a social one. While some aspect of the current debate attempt to pass moral judgement on the act itself, it ignores the many emotional, physical, financial and social issues that often create a situation where a woman is forced to consider an abortion. The Uniting Church asserts that abortion is a health and social issue and should not be a criminal issue.

We also are aware that not every member of the Uniting Church agrees with the church's formal position on reproductive health care. This is true of every church and faith tradition. I have had letters and emails from members of the Anglican, Roman Catholic, Presbyterian and Pentecostal churches in the last two weeks, thanking me and the Uniting Church for our statements. Similarly, I have had communication from members of our church, criticising, thanking and questioning me. The Uniting Church hopes that those engaged in this debate do not seek to further polarise what is a community concern about how we care for others in particular need, how we trust

women and trust our doctors, and know what is a health and moral issue is not continued as a criminal one. Thank you for your time.

The CHAIR: Thank you. We have just distributed your submission and also Dr Mayman's submission. You have made no other submissions, though? Just the one tendered today?

Reverend HANSFORD: Yes.

The CHAIR: Thank you. Reverend Stuart?

Reverend Dr STUART: Members of the select committee, thank you for the opportunity to engage you on the Reproductive Health Care Reform Bill 2019. I recognise the weighty responsibility on you as members of Parliament to make decisions aimed at securing the best outcomes for the citizens of New South Wales. I take this opportunity to remind you of the Anglican Way, in which Anglicans pray for parliamentarians in their work, praying that you will be led and guided in your work so that people may experience peace and justice. In speaking to you today, I acknowledge that I am speaking as a white, affluent, tertiary-educated male who is a bishop; therefore my context is different to most of the people who are affected by the bill directly. I speak on behalf of the diocese of Newcastle as a bishop: the diocese which runs from the Hawkesbury River to south of Port Macquarie, from the coast to beyond the Burning Mountain at Murrurundi.

Anglicans place significant weight on the sanctity of life. For us, all aspects of sex and pregnancy have moral dimensions. The termination of a pregnancy is amongst the most serious moral matters. In developing a response, Anglicans seek to comprehend the perspective of both the unborn life and the pregnant woman facing confronting circumstances. We regularly seek to contribute to bioethical discussions from a Christian perspective, which has involved a distinct character since 1930. Anglicans in general hold one of three main positions in relation to the status of unborn life. One position argues that a human life begins at the moment of conception. Another position says that until birth the unborn life is part of the woman, who has autonomy over her body. A third view is that the moral significance or value of an embryo/fetus accrues as it develops. No one view of when life begins is required of Anglicans; our theological formulations offer at least these three.

In preparing to write to clergy of my diocese and to write to the MPs of the Legislative Assembly for the diocese last week, I reviewed the law and the process of legal change in other jurisdictions. I noted that this bill is structured in a similar way to the laws in at least Queensland, Victoria and the United Kingdom. Those jurisdictions had processes of inquiry around legal change. In developing a response to laws in this area, Anglicans recognise that there are circumstances where a decision to terminate a pregnancy may be the best available moral outcome. This understanding is a primary justification to move the law relating to the termination of pregnancy from the criminal code. All involved should be able to exercise their discretion without fear of criminal sanction.

Anglicans have often learnt through pastoral conversation about the experience of women who, late in pregnancy, received news that devastates them: news about what is occurring within their body around a child for which they have longed. The understanding that in these circumstances a termination of that pregnancy may be the best available moral outcome means that any law regulating termination must provide a framework for those decisions. Again, such framework should be outside the criminal code. Anglicans understand that the primary decision-maker in the termination of a pregnancy is the pregnant woman. This woman will be assisted in her decision-making by others, among whom will be her medical practitioner or practitioners.

This bill provides that the weight of responsibility for that decision prior to 22 weeks rests with the woman. In the latter stages of a pregnancy, it is a woman and two medical practitioners. Commentary which presumes that those involved in making decisions about termination will not weigh their decisions carefully is worrying and misplaced. Pastoral experience indicates the significant weight that people attach to momentous decisions including profound reflection long after a course of action has been finalised. There will always be discourse around the time limits in such legislation, as evidenced by the difference between the United Kingdom and this bill.

The bill, on moving through the Assembly and to the Council, has introduced two elements: informed consent and counselling. It is evident in the wording and in the actions of the Assembly that the members were seeking to balance notional improvements with the experience of similar legislative provisions elsewhere. The bill gives a medical provider providing the termination service a responsibility to assess the need for the woman to be offered counselling and receive the informed consent.

The Parliament needs to be alert to some of the United States [US] experience where informed consent and counselling have been implemented in ways which have caused manifest distress to the woman. A consistent stance across the worldwide Anglican communion is to oppose the termination of pregnancy as a means of birth

control, family planning, sex selection, or any reason of mere convenience. Anglicans are concerned about ethical practices that deny the dignity and contribution of people born with a disability.

It is hard to conceive of a legislative framework around which the Government would then wish to allocate resources to engage in prosecution against a woman for wrongdoing in this regard. Therefore the statements in the law have the effect of naming a moral position. The responsibility falls to all agents of civil society to create circumstances where those choices are not made. Critical of the valuing and empowering of women and the affirmation of the contribution of people living with disability, society bears a collective responsibility for persuading people about the collective good, some of which is controlled by law. The Anglican Church willingly makes a contribution to these debates.

We know from many studies of the determinants of health that poverty has a major impact on a person's of their capacity to choose and on the choices that they make. We also know that many women face violence circumstances which impact their sense of autonomy and choice. Government has a critical role in addressing these determinants. All of society has a responsibility to join in that task. There is still much to be done to create a healthy society across New South Wales. Thank you.

The CHAIR: Thank you, Reverend Stuart. You have read from a prepared statement. Have you actually made a submission to the inquiry?

Reverend Dr STUART: No. I was invited by the inquiry to come.

The CHAIR: For sure. Would you mind if we just take that from you and copy it for the members, unless you have notes around it?

Reverend Dr STUART: I have notes on it. I am happy to forward it to you or to the office when I return to Newcastle.

The CHAIR: That would be helpful, but just in terms of members being able to review what you just said, that would have been helpful too. What we have agreed to are five-minute blocks of questions from members. We will see how we go with that.

The Hon. NIALL BLAIR: Thank you for coming this afternoon. Reverend Hansford, could I start with you. Having grown up in the Uniting Church, I must say it has been a while between drinks and I am not sure about the processes where the church will have come to the position that you have at the moment.

Reverend HANSFORD: Sure.

The Hon. NIALL BLAIR: You mentioned that this has been something that the church has been engaged in for 30 years.

Reverend HANSFORD: Yes—at least. Yes.

The Hon. NIALL BLAIR: Can you explain—very quickly because I have only five minutes—the structure and the processes within the church by which you can get to a point where the church can say definitively that this is its position on this matter?

Reverend HANSFORD: The church is four councils. We do not place power in a particular person. We place power in councils: congregations and presbyteries, which are regional; synods, which are State-based; and Assembly, which is national. It was at a series of Assembly and synod conversations in the early nineties and in the early two thousands in which this consideration was made. It was a lengthy and painful conversation, and this was over a long period of time. We arrived at this position. A lot of my statement was written earlier on, and this one as well, came as a result of the 1992-93 and then 2004-05, so it was a statement that was put together at those points. In terms of the Uniting Church's history, nothing that I have said here is new. It may be new to members, but it is not new in terms of our life as a church.

The Hon. NIALL BLAIR: Yes. Great. Thank you for adding some of the commentary around some of the feedback that you have had since you came out with that position in relation to this current debate.

Reverend HANSFORD: Sure.

The Hon. NIALL BLAIR: Reverend Mayman, in your submission at the bottom paragraph on page one, the first sentence states: "As long as abortion is considered a potentially criminal matter it adds a degree of pressure and anxiety that I believe inhibits the process of moral deliberation." We have had this discussion and people have been talking about morality, but I am asking you to explain: The fact to even go through this process and have a look at one's morals, the fact that you are then being asked to consider something that sits within the

Crimes Act adds another level of pressure to your own morality and that is an inhibitor for someone maybe to make an informed decision with a clear mind. Is that what you say?

Reverend Dr MAYMAN: Yes, I believe so. I think that to be a moral agent requires a degree of freedom. When you are looking at the constraints that the law places around the process of moral deliberation at the moment, a woman could feel that her back is against the wall and may make a more reactive decision than she would be able to, if she thought that this was actually her decision to make in consultation with trusted family members and friends and perhaps with spiritual advisers, perhaps with counselling. I think it is really unhelpful for understanding how people make this really significant decision in their lives, the current framework.

The Hon. NIALL BLAIR: It does not replace the moral process and thought that she must also have to go through to decide whether to still go through with the abortion or not, though, does it? That is still there.

Reverend Dr MAYMAN: Yes.

The Hon. NIALL BLAIR: This is just another pressure.

Reverend Dr MAYMAN: Yes. I think so. I mean, yes, she will engage in that process, but maybe it is going to be framed in terms of: Is this legal, or is this not legal, rather than is this the right choice for me and this pregnancy?

The Hon. NIALL BLAIR: Yes. Okay. Sorry to jump back again, Reverend Hansford. Again I was drawn to your opening statement where you say that this is not just about the two extremes.

Reverend HANSFORD: Yes.

The Hon. NIALL BLAIR: There are so many different circumstances and therefore it is an individual case-by-case and individual-by-individual decision and the church is, I guess, providing assistance to go through that journey with parishioners.

Reverend HANSFORD: Our understanding of the Gospel, of Scripture, or our faith, is that it places us in the middle of the world. We are not in some secluded sacred space off to the side. We are engaged in the middle of the world and so people's lives are part of that and the community is part of that. To make some blanket assumption about how people are going to respond or feel or want to make choices is to misunderstand the human condition. We want to say very clearly that we think in this debate too one of the worst parts of it has been this desire to make a polarising comment: You are either this or you are this, and there is no middle ground at all. We want to say very clearly we think there is a whole range of middle ground space, usually populated by people in struggle or difficulty or concern or illness or facing possibly hard choices rather than simply to say you are either for this or you are against this and there is no other space to be in at all.

The Hon. NIALL BLAIR: In fact, you described it not just as a world but a damaged world.

Reverend HANSFORD: Yes, absolutely. I mean, one of the inherent parts of our understanding of faith would be to say that the world battles with issues that are a sign of brokenness in the world. Some people would use the word "sin" and I find that language quite difficult sometimes because it carries so much baggage to it. But to say there is brokenness in the world—people fall ill, people have struggles with their lives, things do not work, people have difficulty with pregnancy or health or their relationships or justice or hope in the world—and part of the challenge of faith is to speak into that and to offer, not judgement, but to offer care and support and wisdom and nurturing in those spaces.

The Hon. NIALL BLAIR: My time has run out. Maybe I should come back and have a chat one day.

Reverend HANSFORD: We are not fussy. That would be all right.

The Hon. NIALL BLAIR: That was interesting. Thank you.

The CHAIR: We may have some time at the end to ask some extra questions.

The Hon. NIALL BLAIR: No, I am talking about on a Sunday!

Reverend HANSFORD: I cannot see that.

Ms ABIGAIL BOYD: Thank you all very much for coming today. It is really great to see you here. Yesterday we heard from a number of church leaders. The impression that you may have got from that would have been that religious institutions were synonymous with anti-choice attitudes. I am really grateful to see you come here and put forward a different view. Would you say that within any particular religious institution it is possible to say, as the leader, you would be representative of most of the people within that institution?

Reverend HANSFORD: One of the points of great hope and pride we have in the Uniting Church is its diversity. Part of that diversity is people who are new to the life of the church and faith and people who have been there all their lives. To try to make a blanket statement about any particular issue would be very difficult. For example, I think we would find the full spectrum of responses to this issue in the Tamworth congregation where I was most recently involved. People would work in terms of respect, of listening to each other. As the leader of that congregation—or in this case, the church—I would say it is a highly fraught conversation to be saying as the leader of any church—there is an old hymn that says "now we all speak and think the same and cordially agree". I think the hymn was written tongue-in-cheek. I do not think one could say that easily. I think one might say that we respect the leadership and what it is seeking to achieve and to say about the Gospel. However, my experience is that unanimity would be unlikely, especially on significant moral and social issues like this one.

Reverend Dr STUART: I think that would be true also from within the Anglican church, the Anglican communion. In our polity we anticipate that the bishop would represent the diocese in public domains but we also would have a variety of voices within the life of the church. When we speak publicly we also recognise there is often a difference between those who are churchgoing members and those who would affiliate with the church in some way. The Census statistics have a much higher number of people who call themselves "Anglican" than who are in church each week. My own experience is of people stopping me in the street since last week to indicate to me support for a more open sort of stance. This was in part around the way it was written, which was to invite people to think of their own perspective. I think within every Anglican diocese in Australia there are people who come from a variety of perspectives on this matter.

Reverend Dr MAYMAN: I think that the ethical process for churches is not just about having a declaratory statement that speaks for everybody, but inviting people into a process of ethical reflection and drawing on the resources available to us in scripture, tradition, reason and experience. Because all of those things contribute to the process of moral deliberation we might end up in different places. One of the things I value about our tradition is that women's experience is part of that experience that is taken seriously. People may end up with different views about the decision that they may take for themselves. However, I think there is a general respect in our church that this moral decision does not belong in the criminal law. There is respect that there ought to be space for an ethical reflection and that it is perfectly acceptable that somebody may come to the conclusion that it is morally wrong, but that does not mean they would expect that that would be enacted in a public law that has to be applicable to people who have diverse religious and ethical beliefs—a legal system in which everybody should be treated with respect and equality.

Ms ABIGAIL BOYD: An important part of your roles is providing that pastoral care, that guidance and support for people who come to you. Do you think that the criminalisation of abortion makes people less likely to come and talk to you about abortion?

Reverend Dr MAYMAN: I think that was the point that was being made, that it frames it in an unhelpful way for serious moral deliberation. Yes, I think it is restrictive. I am aware of a pastoral situation that I have come in contact with quite recently where it is clear that the pregnancy will not be able to come to full term because of fetal abnormality—the fetus is severely compromised. The woman I was speaking to had to be advised by her doctor about the legal issues in relation to termination of that pregnancy. She felt that it was just part of the conversation that should not be happening. This pregnancy that she was longing for—a second child—was not going to happen and she was having to hear about the possible criminality of having an abortion at that point.

Reverend Dr STUART: My experience in some of this is in the area of shame. Often my pastoral experience has been to hear from women long after they have had an abortion and for some reason they have moved to a place of being able to speak to me in a space of trust—often about some other things—and they want to tell their full story. There is a shame dimension to the experience of abortion. That means that at the time they are reaching out to make those decisions they are unlikely to go to a wide circle of people. I think criminalisation actually makes that circle of people much, much smaller. If we want to enable women to make the best possible choices in these circumstances then for them to be able to openly seek advice this needs to be outside the criminal code.

Reverend HANSFORD: Often as church leaders we might be viewed as being absent from the moral everyday conversations and we simply are not. Most of us have been in congregations for much longer than we have been in leadership. We are engaging with people's lives everyday on issues just like this one. It is a real consideration rather than a theoretical one for us.

The Hon. TREVOR KHAN: I am inviting each of you to comment. I know we have talked about criminalisation as being in a sense one of the issues. However, I just want to take you to the penultimate paragraph of what I suppose we would call Reverend Mayman's submission. It reads:

The current law is unjust. It denies women's capacity for moral agency. It requires that women justify to a doctor their reasons for seeking what is, in legal terms, a health procedure. It implies that women can't be trusted [to make this significant moral decision].

It struck me in reading those words that whilst we talk about the current law being criminal, one of the problems that exists with it is that the decision-maker is actually not the woman; it is a third party, historically so often a male, to whom the woman has to justify the reasons for her decision. Do you want to comment on that? We are not quite looking at the issue of the criminality but actually the procedural dynamic involved in the current law's way of getting to the point of a termination.

Reverend Dr MAYMAN: That is the point I want to make. I think that in the end—

The Hon. TREVOR KHAN: I am glad I picked it up.

Reverend Dr MAYMAN: —women do engage in an ethical process and come to the conclusion that they want to proceed with a termination and then they have to justify that to another person. I think that is about not taking seriously their capacity for moral agency. In terms of linking it to the current law, it goes back to a time when women not only had no moral agency but had no legal agency. Women's lives and sexuality were regulated and that was accepted. We are in a different context now. It seems anachronistic that the woman engages in this ethical process but then still has to seek permission.

Reverend Dr STUART: I think the fine-tuning of this area of law is really important. The most significant debate in the Legislative Assembly was around sex selection. Part of the issue of sex selection is to do with the denial of birth to a girl child who will become a woman. I think one of the most important responses we can make a society is a proper affirmation and empowerment of women around women's agency and women's choice. I think the bill in its current form seeks to strike the balance between the right of women to exercise choice and—as it becomes a weightier matter because of the length of the pregnancy—that it is a shared decision-making approach.

The Hon. TREVOR KHAN: Just before Reverend Hansford comments—I will come to him in a second—I have been troubled all the way through, notwithstanding that I am obviously a proponent of this bill, that there is this concept of choice. It is not actually "choice" but decision-making, isn't it, and the framework that each woman hopefully is going through making that ethical decision?

Reverend Dr STUART: That's right.

The Hon. TREVOR KHAN: In a sense using the term "choice" under sells the moral conflict that any person having to make a decision such as this must necessarily go through.

Reverend Dr STUART: My pastoral experience is that people weigh significant decisions with great magnitude and this is one of the most serious decisions that a person makes—in this case, that a woman makes.

The Hon. TREVOR KHAN: Before Reverend Hansford comments: He buried my father-in-law with grace and dignity was a great help to the family. I thank him publicly.

Reverend HANSFORD: Thank you, Trevor. Reverend Stuart pointed out in his presentation—one of the gifts of having Reverend Mayman here—this predilection often in the church to have men speaking for women. In my role as leader of the church—and a middle-aged white male—I am very conscious that that voice is being heard. This tendency for the church to want to speak on behalf of women or to treat them as a secondary citizen in the conversation is something we are stringently trying to avoid in this conversation and certainly in the Uniting Church. Women have their own agency, their own decision-making processes and their own ability to consult and decide. We want to strongly affirm that. To be heard in any way to be saying that we are speaking on their behalf or for them would be a great mistake and we would want to avoid that at all costs.

The Hon. TREVOR KHAN: Do I take it—and I not being trivial when I say this—that you are not coming here to, in a sense, promote termination of pregnancies; you are coming here to promote that women make a choice and have agency for making that choice and take a whole series of ethical criteria around the making of that choice? Is that how you would define your role?

Reverend Dr STUART: That is correct.

Reverend HANSFORD: And to be present in that space.

Reverend Dr MAYMAN: Just to pick up on your point about choice, the way it has been expressed in the public debate is the pitting the rights of women against the rights of the fetus. But when you look at the way that women make ethical decisions around this—and there is research about the process that women go through—it is generally not made in those terms. It is made in terms of an ethic of care and responsibility within which they are balancing calls on them in terms of responsibility to other family members, to themselves and their own bodies and to their partner, who is the other parent of the child.

It is much more complex than a pitting of rights against one another. They are thinking about issues of health—physical and mental—but also about their ability to parent and being prepared to parent and all sorts of other reasons. It is a complex network of decisions and factors that women engage in. It is not a declaration, generally—and the research would support this—that, "It's my right to do with my body what I like." I can see that that is a valid statement in a public space, but the way that ethical decision making happens is usually much more relational than that.

The Hon. TREVOR KHAN: And much more nuanced too.

The Hon. NATASHA MACLAREN-JONES: Thank you very much. There is one thing I just want to clarify that Reverend Dr Stuart said in his opening statement—about three quarters of the way through—about concerns around disability. I was not sure if that was about access for a person with disability? I just wanted to clarify.

Reverend Dr STUART: In the whole area of the termination of pregnancy debate one of the questions that has not come up so much on this occasion is that there is a whole range of terminations that occur because of an identified disability of a fetus. Anglicans generally hold some question about the nature of termination on the basis of disability and we want to affirm the contribution of people with disability to the community. Therefore, perhaps, we would want to discourage some people from pursuing a termination in those circumstances. That is where that comes from.

The Hon. NATASHA MACLAREN-JONES: Thank you very much. I am interested to hear from you about the legislation that is currently before us that has been amended. Obviously there were a number of amendments put forward in the Legislative Assembly. Over the past two days we have had a lot of discussion around a range of topics, including counselling, coercion and so on. I would like to hear your views in relation to the legislation as it stands and whether you support it as it stands or if there are areas for improvement or clarification?

Reverend Dr STUART: I have alerted to some warning around the areas of informed choice and counselling. My concern is not with how the bill is drafted but comes from the experience in the United States. Any web search on informed choice reveals a range of material that is present to a woman who is going to her medical practitioner to seek termination or to even explore termination that I think in the Australia context we would find very confronting. I suppose I have some caution about how that might evolve. In the drafting of the bill I saw that the primary responsibility for counselling and informed choice sits with the medical practitioner. My worry was somewhat allayed in terms of what the experience would be like for the women. Overall I thought that there were some improvements made in the process within the lower House which have been reflected in the bill.

Reverend Dr MAYMAN: I would like to support it without further amendment. I think considerations of counselling and the requirement for any particular steps, if they were put back into criminal law, would defeat the purpose of what we are trying to do here. To legislate that in great detail would mean that people are not able to make the right choice for themselves. I share concerns about the direction in which informed counselling has gone in American jurisdictions, up to the point of requiring women to watch ultrasounds of their fetuses. They are things that we do not want to be seeing in Australian society. The whole idea about coercion is absolutely an anathema.

Reverend the Hon. FRED NILE: Thank you very much for appearing before our inquiry. You probably know that I moved the motion to have the inquiry, because I felt the bill was not being properly discussed and the public were not getting the opportunity to be involved in.

The Hon. TREVOR KHAN: Sorry, Fred, I think it was both you and I who moved the motion.

The CHAIR: Let us move on to the questioning.

Reverend the Hon. FRED NILE: I put the proposition first.

The Hon. TREVOR KHAN: Fair enough, Fred.

Reverend the Hon. FRED NILE: I would just like to read to you something that you would know off by heart. In Jeremiah 1: 4-5 it says, "The word of the Lord unto me saying, "Before I formed you in the womb I knew you, before you were born I set you apart; I appointed you as a prophet to the nations." How do those words govern your response to this extension of abortion in New South Wales to 22 weeks?

Reverend HANSFORD: My first response to that question is that this is a question that we are seeking to understand in terms of not only an unborn child, but also women in a range of circumstances, almost all of which we understand are not of their own choosing. The debate we are engaging in here is firstly an issue about criminality, which I think is a significantly important consideration. It is an issue of justice in that sense. Also, part of our concern is that we understand the place of women in this conversation. When people simply quote that verse and none other it excludes women from the conversation entirely. It misreads scripture, it misreads the purpose of scripture and it misreads the place of human beings in the larger conversation.

Speaking as a somewhat biblical theologian I would question simply pulling a bible verse out of Jeremiah, which is talking about a young man and prophesy, to be an argument for or against abortion. I would question that. The larger questions we are talking about here, as far as we are concerned, are about criminality—which is critical in this conversation—and about not just an unborn child but also a woman, who is usually under some kind of duress, whether it is through circumstance or through the situation she is in.

Reverend Dr STUART: I find any engagement with the scripture to be a profound opportunity to try to understand. That particular passage is a wonderful piece of poetry and writing to try to understand the sanctity and beginnings of life in order that the work of the prophet could be fully comprehended—they were fully called by God to do this particular piece of work. But I tend to see it in terms of a theological reflection, rather than a prescription for how the world was made. In fact, if we look at the whole of scripture, the *Bible* is a complex book and there are moment where what we understand as the sanctity of life is not reflected in the Old Testament at all. There are aspects of death and destruction and there are instances of the treatment of other people that are really quite confronting in the Old Testament.

Reverend the Hon. FRED NILE: That is why we have the New Testament.

Reverend Dr STUART: That is right. But as a Christian writer and thinker what I seek to do is try to weave together our understanding of how we respond to God in this age in relation to those scriptures, which remain authoritative and informative of our own understanding.

Reverend Dr MAYMAN: I agree that scripture is one of the resources that we turn to, but we do not turn to it in terms of uplifting one particular verse that we think might solve the problem that we are facing. We engage with the broad arc of scripture. And, as Reverend Dr Stuart has said, there are some very concerning aspects. I am thinking of Number 5, which suggests that a man who thinks that his wife may have been unfaithful should take her to the priest for the admission of some kind of drink with bitter herbs in it that will produce an abortion. In that case it appears that Yahweh is advocating for abortion. We cannot rely on particular versus of scripture for our model and ethical view in total. We have to look at the broad story of the actions of God, the people of God in ancient Israel and the life of Jesus. In particular we should look to the life of Jesus, who is the lens of interpretation for the whole of scripture, and the stories of the New Testament and the early church communities. That is why I am saying that we have to engage in an ethical reflection which is Scripture, reason, experience and tradition. All of those play a part.

Reverend the Hon. FRED NILE: Looking at your submission, you emphasise as a Christian who holds a sacredness of human life as a primary value—how does that value, that belief, influence this legislation?

Reverend Dr MAYMAN: I think that a distinction needs to be made between human life in the early stages of pregnancy and human personhood. Our tradition has wrestled with that throughout history. There have been many religious teachers who are significant, like Aquinas and Augustine and others, who have actually believed that human personhood began at birth—at the beginning of taking a breath. There is another part of our tradition that sees that happening at the point at which the fetus is quickened. So we are talking about human life because it is a potential human being in the womb, but the status of that as a human person, we believe, evolves through the pregnancy and needs to be considered in that light.

Reverend the Hon. FRED NILE: A moment ago—just reminded me—when Prince Harry and Meghan found that she was pregnant, they announced excitedly, "We're having a baby!" They did not say, "We are having a fetus." "The fetus" is a term you have used in your presentation. I am just wondering why you do not use the term "baby" instead of "fetus". "Fetus" seems to be a non-person.

Reverend Dr MAYMAN: I would be honouring the capacity for human life—potential capacity—that exists in the fetus. But I think, in this context, we are having a discussion in a legal framework and so I am just using the language that seems appropriate. And the longed-for child that will emerge from a pregnancy—of course people refer to that as the baby. That is why severe fetal abnormality and the loss of a baby is a terrible thing. But it depends on the relationship of the pregnant person to the fetus.

The Hon. GREG DONNELLY: I just need to start by asking you a question each. I want to do it in the most respectful way and I do not want you to misinterpret what I am about to say.

Reverend Dr STUART: That is worrying, the way you put that.

The Hon. GREG DONNELLY: So you cannot say you could not see it coming. We had a number of faith leaders here yesterday morning; you are aware of who they are so I will not go through that. They expressed—or certainly they introduced themselves and their standing within—when I say "standing", I do not mean any sort of way of reflecting up or down, but their position within their respective church or faith traditions. They made clear and unequivocal positions with respect to their faith: positions in regard to matters to do with life and when life commences—mainly at conception—and their thoughts of how that then translates into consideration of the position that they take as a church leader in regard to the bill. Perhaps just going through this, then, with respect to yourself, Reverend Mayman, who are you speaking for today? Who are you representing today?

Reverend Dr MAYMAN: I am here as the minister of Pitt Street Uniting Church and somebody who has been trusted to teach theological ethics to theological students within the Uniting Church.

The Hon. GREG DONNELLY: So you are representing a church, a particular church on Pitt Street. I understand from the top of the page you have got a standing in terms of your teaching. With respect to Reverend Hansford, who are you representing here today?

Reverend HANSFORD: I am here on behalf of the New South Wales synod of the Uniting Church. I want it to be very clear that the documentation I am bringing is part of the whole United Church. This is not something I have wrote recently.

The Hon. GREG DONNELLY: That is fine. I am just trying to get this very clear. There is no trick here; I am just trying to get it clear.

Reverend Dr STUART: There are 23 autonomous dioceses of the Anglican Church of Australia. There are seven in New South Wales and I am the bishop of one of those. So I speak in my capacity as the Anglican Bishop of Newcastle.

The Hon. GREG DONNELLY: For and on behalf of those members of the Anglican Church in Newcastle? Is that how it operates within the Anglican Church?

Reverend Dr STUART: I am elected by them to be their bishop. It is a bit like when you speak for and on behalf of the citizens of New South Wales; you have got all those who agree with you and those who do not.

The Hon. GREG DONNELLY: I understand that. Thank you for making that clear, because it really is quite important. The other faith leaders just essentially—whilst not asked that direct question, it was implicit from the way they introduced themselves what their respective standing was.

The Hon. TREVOR KHAN: Or their perception of their respective standing.

The Hon. GREG DONNELLY: No, they hold those positions within their church. Not perceptions; they hold those positions. The reason I say that is, once again, not to reflect. But we, when we deliberate on this report to produce the report, will have to place weight on what is the evidence from the church leaders from yesterday and what they said with respect to matters to do with the question of when life commences and the matter of termination and the reflections on the bill, and equally those same questions with respect to yourself. We have got to work that weighting. With respect to this matter, then, is it the position of the Uniting Church—once again, it is not a trick question—that human life commences at conception?

Reverend HANSFORD: I do not know that we have that formal position on it.

The Hon. GREG DONNELLY: That is fine. To be very clear about this, I will ask the question again. Does the Uniting Church, as a faith tradition in Australia—and I will welcome the reverend to comment as well—have a position or accept or adopt the position that human life commences at conception? I ask that not as a theological question, but as a scientific question: that a unique human being—that is, with unique DNA—is

created at the point of conception. So human life commences at conception—my simple question is does the Uniting Church accept that proposition or not?

Reverend HANSFORD: I do not know we would have made a definitive statement on that in that way.

Reverend Dr MAYMAN: I would—

The Hon. GREG DONNELLY: No, I have got limited time.

The Hon. TREVOR KHAN: I think we can probably allow you extra time.

The CHAIR: Dr Mayman is a theologian.

The Hon. NIALL BLAIR: The witness wants to give an answer.

The Hon. GREG DONNELLY: As long as I have got the time to keep going.

Reverend Dr MAYMAN: I just wanted to observe that your question had both a theological and a scientific aspect to it.

The Hon. GREG DONNELLY: I withdraw that, then. Mine was very clear. This is not from a religious position at all. This is a statement of what is medical fact. Does human life commence at the point of conception—namely, the combination of the two gametes, male and female, to create a unique DNA which is a new human life? It is a question of medical science. It is not a theological question. That is a creation; at that point there is a new human life, albeit potential—and you mentioned potential in, I think, one of your earlier answers. Putting aside the issue of what potential means, I am talking about that, scientifically, the fact is that a human life—a new entity called a human being, albeit potential—is created at the point of conception. I want to know, does the Uniting Church accept that proposition or not?

The Hon. NIALL BLAIR: Are you asking medical or legal? I just want to clarify.

Reverend HANSFORD: I want to stand with Reverend Dr Mayman and say I think you are actually confusing theology and science in the one conversation, because naming it as a creation suddenly becomes a different space.

The Hon. GREG DONNELLY: I am not trying to do that.

Reverend HANSFORD: No, but it sounds like you are. The difficulty is that it may well be that in our statements we have assumed that, but I do not recall any statement that actually names that out aloud scientifically, because we do not want to comment theologically about that. I cannot speak for the Anglicans, of course.

Reverend Dr STUART: I quoted to you from a submission from the Anglican diocese of Melbourne to the abortion law reform inquiry in Victoria. I identified, as they did, that there are at least three positions about what we would call human life, which is at conception, and that there is that the unborn life remains a part of the woman until birth, and basically a graded approach in between in which the life takes on particular significance. The General Synod of the Anglican Church of Australia has made very few resolutions in relation to termination of pregnancy and abortion.

I am not able to state a definitive position for the Anglican Church of Australia. What I am able to do, which I think is why the Committee invited me and probably invited Simon as well, which was a recognition that within religious traditions there is a diversity of views and that this Committee actually wanted to hear from the diversity of views, but it does mean that when you are putting weight on statements you have to weigh the particular traditional formation. So for a Catholic, as they speak, they speak with a magisterium, they speak from a particular place, whereas the Anglicans and the Uniting Church come from different places.

The Hon. GREG DONNELLY: I accept that.

Reverend Dr STUART: But you asked the question about how you apply weight.

The Hon. GREG DONNELLY: No, I did not ask you that.

Reverend Dr STUART: Yes, you did, you said how do you weigh our submissions in relation to the people from yesterday.

The Hon. GREG DONNELLY: No, I did not. With due respect, I was not asking you to give me a view about your thoughts on weighting, I said that this is what we will have to do. My question was trying to get to this point, so let us forget theological, just a statement of medical fact—

Reverend Dr STUART: I cannot answer that because I am not a medical practitioner.

The Hon. GREG DONNELLY: Is it the position then of the Uniting Church, represented by those here today, that it is not possible to state as a medical fact that life commences at the point of conception? You cannot say that.

The Hon. TREVOR KHAN: Point of order: You are asking two people from the Uniting Church to assert something on behalf of the Uniting Church about what you say is a medical fact. They might have many skills, but medicine may not be one of them.

The CHAIR: I accept that. They can choose to answer as they feel, although I think they have answered.

Reverend Dr MAYMAN: I just want to say that it is loaded with moral significance. You can say a scientific fact, but then as a human being with moral capacity you have to reflect on the meaning of the science.

The Hon. GREG DONNELLY: I take the Reverend's comment that within your tradition—and it was in your opening statement—there are three possibilities. In fact you said there are at least three. You did say that.

Reverend Dr STUART: Yes.

The Hon. GREG DONNELLY: Can I move then to the Anglican Church and specifically the Newcastle diocese. As the Bishop of Newcastle, do you agree with the proposition—this is a question to you and, if you cannot answer it, just say so—that as a matter of medical science, medicine, at the point of conception, the combination of male and female gametes and the creation of a unique DNA that flows from that, life has commenced? Are you able to agree with that proposal or not?

Reverend Dr STUART: Are you asking me in a personal capacity or in my capacity as the Bishop of Newcastle?

The Hon. GREG DONNELLY: As the Bishop of Newcastle.

Reverend Dr STUART: I think there would be a diversity of views.

The Hon. GREG DONNELLY: Thank you for that. Just so that we are clear, the position is that with respect to the faith traditions represented here this afternoon we are not able to reach, dare I say, an agreement on the point of when life commences. Is that a fair summary of where we are?

Reverend Dr STUART: I think we are reaching agreement on the principle that developing a theological understanding has nuance and diversity and that, as we speak to this debate around this bill, we are actually not trying to answer some of those questions. Our focus is around criminalisation and the care of women.

The Hon. GREG DONNELLY: This is the point: You are not reflecting on a position as a matter of what has actually happened on the issue of the creation of human life, but rather trying to enrich a discussion around the matter of theological reflection. Is that fairly what you are trying to do?

Reverend HANSFORD: No.

The Hon. GREG DONNELLY: Okay, so what are you doing?

Reverend HANSFORD: We are making a comment about criminalisation of abortion, we are seeking to make a comment about that, and we are making it very clear that we have no authority to comment on medical or scientific issues.

The Hon. GREG DONNELLY: That is fine.

The CHAIR: That is 10 minutes.

The Hon. GREG DONNELLY: This is really important.

Ms ABIGAIL BOYD: Point of order: It has been five extra minutes—again.

The CHAIR: Yes.

The Hon. GREG DONNELLY: This is a submission from the Anglican Church.

Reverend Dr STUART: From the diocese of Sydney?

The Hon. GREG DONNELLY: Yes, but it relates directly to your point about this issue of removal from the Crimes Act. You are aware that the Archbishop of Sydney made the submission yesterday?

Reverend Dr STUART: Yes, I am, and I think he agreed that there are some circumstances where decriminalisation is the right way forward.

The Hon. GREG DONNELLY: More than that. That is why I want to take you to this point. He is in almost furious agreement with you on this particular point. Let me take you to the last page of his submission.

Reverend Dr STUART: Yes.

The Hon. GREG DONNELLY: It states:

If the NSW Parliament had merely considered a Bill which enshrined in legislation the current practice, arising from the Levine Judgment and other subsequent judgments, then the outcry—

That is, the sort of response we have seen publicly—

—would not have been as fierce or as widespread. If abortion was legislated for reasons of health, then the average citizen, even if they held strong beliefs to the contrary, would have accepted the normalisation, by way of statute of a practice that has been in operation for 50 years.

That is, taking abortion out of the Crimes Act. He is agreeing with the proposition that taking it out of the Crimes Act, on the face of it, may have general acceptance within the community.

Reverend Dr STUART: I understand that is the Archbishop's view, yes.

The Hon. GREG DONNELLY: Do you agree with that position?

Reverend Dr STUART: Well, I am urging that it be taken out of the Crimes Act—strongly.

The Hon. GREG DONNELLY: Indeed, but we are creating a statute law which is going to regulate abortion in New South Wales, so the question is what should be in that statute. If you cannot answer that—

Reverend Dr STUART: No, I think in my opening statement I affirmed the movement of the bill from the Assembly to the Council and some of the things that are in there with some caution, and I identified that there was always going to be debate around, for example, 22 weeks. People are going to move that for a whole variety of good reasons one way or another—for example, the United Kingdom and New South Wales in a different place—and I highlighted that the experience of distress late in pregnancy which leads to consideration of what has been named as late-term abortion requires some regulation, so therefore the bill has to cover the spread of issues that it covers in order to properly regulate in this space, to make sure there is a balance of choice between women and medical professionals and to try to reflect the breadth of views, so I think on balance the bill does what it seeks to do without necessarily requiring a person like myself to move to the point of what is my own personal view or place in relation to this. This is around what should be the law in New South Wales. While it causes regret to some people, it seems to be a just and fair law if it is passed in terms of actually ensuring appropriate protections.

The Hon. GREG DONNELLY: In your eyes.

Reverend Dr STUART: Well, you asked for my opinion.

The Hon. GREG DONNELLY: Your opinion, yes.

The CHAIR: I am going to ask a couple of quick questions as the Chair. I think your presentation and evidence this afternoon has awoken me to this: It is polarised, there is anti-abortion and pro-abortion, and that is it, head to head. You have presented an argument that if we take it out of the Criminal Code then we can deal with the moral issues—which I am not expert in; that is your area—with the person involved. I think Reverend Hansford made reference to middle ground space.

Reverend HANSFORD: Yes.

The CHAIR: Would that be an accurate point to make? You want it out of the Criminal Code because I think one of you referred to it being an inhibition for dealing with the moral issue, and then people of the cloth, the clergy, and others such as counsellors would deal with the moral discussion that may or may not be necessary.

Reverend HANSFORD: I think it is too simplistic to say it is either this or it is that. The reality is that the world occurs in the middle. People's lives, tragedies, struggles, difficulties and needs are in the middle, and that is where our faith calls us to be. It places us squarely in the middle of people's lives. Our task is not to pass judgement but to provide care, wisdom and support, especially in a considerable issue like this, and offer support in this case to women particularly who are in need of support and nurture through a difficult process. That is where our faith calls us to be.

Reverend Dr STUART: I think the criminal code should reflect the crimes which the New South Wales Parliament and therefore the Government is prepared to resource to enforce. Our criminal code needs to be carefully structured around those things which we weight very highly in society and we want our police and others

to investigate. The view that is being presented today is that is not a matter for that sort of resourcing and that sort of oversight. It is an issue that requires careful regulation and therefore careful review, which the bill seeks to do. That does create a different sort of space for a different sort of engagement. The point that we have been trying to reflect is that Christians, other faith traditions and people of no faith tradition have a variety of views on this matter, not just at one end or the other, which I think you correctly picked up.

Reverend Dr MAYMAN: I would not want our view to be misunderstood in terms of saying that it should be shifted from law to clergy in particular. What we are saying is that women do engage in moral decision making, moral deliberation and we want to respect that. For women of faith who have a relationship with a faith tradition or with a spiritual leader in some way, that may be part of the resource they access. But there will be many women in our society who operated within a secular framework of ethical belief, they will engage in moral deliberation too. I think that their agency needs to be respected by both the church and the State.

The CHAIR: Dr Mayman, your submission in the context of the 1900 legislation. There was an interjection earlier today from the Hon. Trevor Khan that the anti-abortion law predates the 1900 Crimes Act. There was a recent issue of vending machines for the pill, for a contraceptive for women. There is debate that they should go to the doctor. I looked at who was saying that and predominantly churches and men historically. You have put in your submission talk about the context of Australia in 1900 when abortion was put into the criminal code?

The Hon. GREG DONNELLY: Point of order: Are we extending the time for these witnesses?

The Hon. TREVOR KHAN: You are taking a point of order as to time?

The Hon. GREG DONNELLY: I will take a point of order on the Chair.

The CHAIR: Which is unusual.

The Hon. GREG DONNELLY: I have taken a point of order. We have time for witnesses. Have we reached their time? Have we?

The Hon. TREVOR KHAN: Mr Donnelly, you have been over time virtually every time you have asked a question. That is outrageous.

Ms ABIGAIL BOYD: That is absolutely outrageous.

The Hon. GREG DONNELLY: No. Point of order: There is time for these witnesses, their time has completed. We move on or we provide extra additional time to the next set of witnesses.

The Hon. TREVOR KHAN: You can be held to you time because you take five minutes to ask a question and then we have to give you extra time.

The CHAIR: Order! First, it is unusual to have a point of order against the Chair. Secondly, I have been extremely generous in terms of time for the Hon. Greg Donnelly.

Reverend the Hon. FRED NILE: I move:

The Chair be able to ask the question.

The CHAIR: I was going to rely upon the Committee to support me. I wanted to have the evidence. It is extraordinary.

The Hon. NIALL BLAIR: To the point of order: The Chair has not asked many questions in the last two days.

The CHAIR: I forfeited time so that we would be on time.

The Hon. NIALL BLAIR: If it was against me I would take that, but he has not been flouting the time rule. I have probably been the one you should have taken the point of order with earlier because I have chewed a bit of time. We have both been guilty of going over.

The Hon. GREG DONNELLY: I apologise then.

Ms ABIGAIL BOYD: You have already wasted the time.

The CHAIR: Do you withdraw the point of order?

The Hon. GREG DONNELLY: Only in that one person answers one question.

The CHAIR: I will Chair it.

The Hon. NIALL BLAIR: You can have my time with the next witness, how is that?

The Hon. GREG DONNELLY: Let's be clear, if there is one person answering—

The Hon. TREVOR KHAN: We have attempted to give you every opportunity to ask witnesses.

The CHAIR: Indeed.

The Hon. TREVOR KHAN: We have been very careful to ensure you get full rein.

The Hon. GREG DONNELLY: Yes.

The Hon. TREVOR KHAN: So the complaint cannot be made that you are being shut down. You are demonstrating precisely that at the moment.

The CHAIR: Order!

The Hon. GREG DONNELLY: You can reflect on me mate, but it is a day.

The CHAIR: Order! The Reverend Nile has moved to extend the time so my question can be asked.

Motion agreed to.

Reverend Dr MAYMAN: I do not think it will take me that long to respond to your question. I did say in my statement that I think it is an anachronism, that we need to be aware that the anachronism of locating abortion within the criminal code relates to a time when women's bodies and women's sexuality, it was considered appropriate that they be controlled by patriarchal power that was found in government and medicine religion and family.

The CHAIR: It was 1900.

Reverend Dr MAYMAN: Also what was happening at that time was the rise of the eugenics movement and a concern about decreasing fertility among white women and a desire to regulate that. That is a shameful part of our history. That needs to be understood in how this legislation came about. There are some religious bodies that still discriminate against women, including the voices of those heard yesterday, but that is not the view that we want to hold within Australian society when we do regard equality on the basis of gender as core to who we are as a people.

The CHAIR: I thank you for your evidence and submissions.

The Hon. GREG DONNELLY: Before you leave I want to make a personal statement. I was bursting to go to the toilet, I went to the toilet, I came back. I was not aware, Chair, that you were asking the question. I honestly did not know that. I thought it was a continuation on past the cut-off time. That is what I thought was going on. That is why I did what I did. We have been very deliberative and collegial in the way we have conducted this hearing. I would not have taken that point of order on you to shut you down. I think you would appreciate that point. There has been a misunderstanding, I withdraw that.

The CHAIR: That is accepted and it is on the record.

(The witnesses withdrew)

SIMON MCCAFFREY, Obstetrician and Gynaecologist, sworn and examined

JOHN WHITEHALL, President, Christian Medical and Dental Fellowship, sworn and examined

The CHAIR: I thank you for attending the Inquiry into the Reproductive Health Care Reform Bill 2019. It is being conducted by the Standing Committee on Social Issues. I am the Chair.

Dr WHITEHALL: I am a paediatrician. I am professor of paediatrics and child health at Western Sydney University. I make it quite plain that I do not represent that university. I am here in my own right.

The CHAIR: We have you as the president of the Christian Medical and Dental Fellowship.

Dr WHITEHALL: Yes, I am that too.

The CHAIR: Is that correct?

Dr WHITEHALL: Yes, I am the national chairman of that.

The CHAIR: I invite you to make an opening statement for up to five minutes.

Dr WHITEHALL: May I table this article I wrote in the Medical Journal of Australia?

The CHAIR: Of course.

Dr WHITEHALL: I thank you for inviting me, it is a privilege. I oppose the bill because I am a paediatrician and for much of my time I have been a neonatologist. I was director of the neonatal intensive care ward in North Queensland for 15 years. I was very involved with fetal abnormalities, fetal pain, looking after sick newborn babies and I was on the panel that looked at fetal abnormalities as to what might happen to them. It is not foreign to my experience. On the basis of that experience I oppose the bill. Why would I do that? Because I think that inevitably it will lead to late-term abortions. I think that that is a contradiction in the public health system that is schizophrenic at best.

You have one team of people, for example in Townsville who are very committed, very skilled in caring for the baby. They hear a baby's cry as a demand for something to be looked after and cared for. They train for that. And on the other hand, in the birthing suite next door there can be a baby who is left to succumb, not yet dead from the process of abortion. That is one cry they will not be allowed to respond to. And that, in any terms, will be a contradiction which I think will reflect badly on the morale of the hospital system and all the people in it. Not just medical students or specialists or whatever, but even cleaners who one way or another have to dispose of the remains of this business. I think that it is contradictory.

As well is that it is not just about looking after the baby. If we saw a baby there that was going to die we would wrap the baby, we would warm the baby, we would give baby to the mother and the family, and the baby would succumb. And here the baby, we understand, is just going to be left to pass away. We think that is an anomaly with regard to pain also. Although a lot of evidence that I see and other people are saying is based on the American Journal of Obstetrics & Gynecology resume on when does a fetus feel pain, and they say that the fetus does not feel pain until 30 weeks of gestation, I can attest, looking after 23-weekers, that they feel pain.

It reminds me of the old Limerick: "There was a young lady from Theale, who said, 'Although pain is not real, if I sit on this pin and it punctures my skin I dislike what I fancy a feel'." And with regard to terminations, where it is allegedly not painful to the baby, this is the baby saying, "You may say that I do not feel pain but I dislike what you fancy I do not feel." So there is pain involved in this, it is minimised. It is an inherent part of the dilatation and evacuation process where the baby is moved into a position and then pulled out, even dismembered. Will you say that a baby does not feel that? I suppose that the end would be quicker when you put in an instrument and pierce the skull, but the baby is still going to feel that. I think in the public debate this is not brought out. And I think that these things would become second nature to us if we just pass this bill and continue on in this way.

Furthermore, with regarding to the indications for termination I have noticed a wonderful thing that keeps the human being going. I have noticed that a mother, in the darkened room of an ultrasound office, can have a black-and-white image pointed out to her and appears like the end of the earth. But when the baby is born, it is the light of day, it is the wonderful miracle of motherhood, things change. I will give you an example of that. There was a mother who was encouraged to have a termination around about 34 weeks because it was thought that she was emotionally unstable and unlikely to be able to handle this with aplomb. They went ahead with the termination.

The reason for the termination was that the child, a male child, had a cleft lip—that was it. So when the baby was born, I swear to you, I do not believe the mother noticed that cleft in the five days it took for her to say goodbye. There was a little blue cap, a little blue dress, a little blue shawl—in and out of the refrigerator—for five days. This is an emotional story. Why am I telling it? Because I think that there is a cold black loneliness of diagnosis in the ultrasound office which changes, and a lot of things are not as bad afterwards, especially with medical care. I have also seen things that have been diagnosed as irreparable before birth that have in fact gotten better with the passage of time.

We know the cystic adenomatoid malformation of the lung, where the lung is thickened and does not work very well and it looks as if it is not going to allow the baby to live. And the number of babies we have terminated on that basis, we now know that if you wait it is likely to result by itself. There are indications with dilatation of the renal pelvis, that is to say the collecting system in the kidney, that gets better with the passage of time. All sorts of things. There is the ability for it getting better. Then there is the next issue of, I know, I have had this in my own family and it is to do with that article that I put out, I understand the pain of a child who is sick and not made properly. The question is: is it better for the mother to be relieved of that pain or is there something that can grow and turn into a positive thing through the passage of life.

I remember one child who had heart disease and there was nothing we could do and that lingered for about two years and I went and saw the parents afterward and I said, "Look, this has been a terrible business. The baby has died. What has it meant to you?" And they explained to me, very clearly, how this tragic process, this process of suffering was in fact, unexpectedly to me because I was a young and inexperienced paediatrician, unexpectedly to me it turned out to be a very positive experience. In the cold hard light of day, or night, or the darkened ultrasound office, what worries me is this bill is going to just allow that kind of decision making, in the best interest of the mother as everyone thinks, but it will not ultimately be in the best interest of the mother. That is why I am worried about this bill. It leads on, therefore, to injudicious, hasty, ill-advised decisions that are of life consequence.

There was an organisation in New South Wales, a society for after fetal death, and the people who were in it were fielding the loneliness and the sadness of having the terminations and so forth, which were given with the best intentions earlier on. My argument is this bill is a hasty bill and this bill will push it through and will get around the necessity for having two specialists involved. A learned discussion. You have seen the RANZCOG business which ultimately favours this but they are saying that this decision should be made by two specialists and other people, even a neonatologist for what we are worth, but social workers and counsellors.

This is a major, grave decision that should not be just left to the quiet processes of a multinational profit-seeking organisation. This should be brought into the public system and done in a slow and measured and careful way. And all of the aspects should be explained to the mother including, quite frankly, the issue of fetal pain because if we do not explain before she is going to learn later on and that will probably add up to the guilt that she may well feel. We need to prepare and look after these people before and after. Informed consent, call it counselling or whatever you want, we should be explaining to the parents the whole issue and including the fact that there will be fetal pain.

The CHAIR: I thank you for that opening statement. I think those issues will be come back to in questions.

Dr McCaffrey: Thank you very much. I have been practising obstetrics and gynaecology now for 40 years. I believe that abortion services will provide less duty of care to women if the Reproductive Health Care Reform Bill 2019 is passed, primarily on the basis that the bill stipulates that only pregnancies terminated after 22 weeks require specialist care. To me, pregnancies terminated without specialist oversight between 14 to 22 weeks abrogates our duty of care to women and this bill will ensure that that is exactly what will happen. Thank you.

The CHAIR: Thank you. Some of the members had to tend to other duties this afternoon now so apologies on their behalf. We have a rotation of the members of five minutes per member.

The Hon. TREVOR KHAN: Dr McCaffrey, do you any positions with any organisations apart from being an obstetrician?

Dr McCaffrey: Mr Khan, I have presented myself today as a practicing obstetrician and gynaecologist.

The Hon. TREVOR KHAN: I know that.

Dr McCaffrey: If it is all right, if I could please finish. I presented a submission which I was hoping I would be referred to and I could talk to, and hence I am not sure—going through the Chair—whether you want me to run through the myriad of organisations I have been involved in or have any association with over the past 40 years, but it could take quite some time. So I am happy to address my submission and I am happy to be asked my questions on the basis of my submission.

The CHAIR: Thank you. Mr Khan might ask a more specific question.

The Hon. TREVOR KHAN: Dr McCaffrey, have you been an office holder in an organisation such as the Right to Life?

Dr McCaffrey: Yes.

The Hon. TREVOR KHAN: Are you still an office holder in the Right to Life?

Dr McCaffrey: In relation to my submission, is this relevant?

The Hon. TREVOR KHAN: Just answer the question, Doctor.

Dr McCaffrey: Yes. And if, possibly, you could point out from my submission—I am not sure if you have read it, Mr Khan—but from my submission where anything in my submission in any way refers to the position I hold in that organisation? I am more than happy—

The Hon. TREVOR KHAN: Dr McCaffrey—

Reverend the Hon. FRED NILE: You are not representing them here today?

Dr McCaffrey: I am certainly not, Reverend Nile.

The CHAIR: Order. I think we have established the point there. We will move onto the submission.

The Hon. TREVOR KHAN: No, we will move onto the bill. How about we do that?

The CHAIR: The bigger part. We will move onto the bill, yes.

The Hon. TREVOR KHAN: Dr McCaffrey, do you know that the law in New South Wales with regard to terminations was in a sense first defined by the Levine decision of *R v Wald*?

Dr McCaffrey: Yes.

The Hon. TREVOR KHAN: And for instance, that requires a doctor to go through a variety of criteria before undertaking a termination?

The Hon. GREG DONNELLY: Could I just take a point of order? I think it is important. You are cross-examining and that is fine, but I think you need to put a question and allow the witness—it is just like a hearing the other day—and allow him to answer the question in that order, okay?

The Hon. TREVOR KHAN: I do understand the question and I have asked the question and I am waiting for the witness to answer.

The Hon. GREG DONNELLY: And we are dealing with laypeople who need to be able to—

Ms ABIGAIL BOYD: To the point of order, what the Hon. Trevor Khan is doing is in no way different to anything anyone else has done. If we could just let him ask his question.

The CHAIR: I do not uphold the point of order. Let us get on with the questions.

The Hon. GREG DONNELLY: Question followed by an answer, followed by a question.

Dr McCaffrey: If it is okay, I will try and answer that question. It is my impression, again as a practicing obstetrician and having sought legal opinion as a practicing obstetrician, that presently abortion services are legal in New South Wales if the woman feels it is of necessity. Women do not terminate their pregnancies unless they feel it is of necessity. If that is the case, they are legally entitled to terminate their pregnancies. And it is on that basis that myself and other obstetricians practice that abortion is legal in New South Wales when performed of necessity, and that the woman decides when it is of necessity. That is the best I can put it, Mr Khan.

The Hon. TREVOR KHAN: Let us suppose, Dr McCaffrey, that that understanding of the law is wrong—that it is actually the doctor's assessment of necessity, not the woman's?

Dr McCaffrey: My legal opinion is to the contrary, that the woman decides when it is of necessity. I am not a lawyer and I guess if you are a lawyer I must defer—

The Hon. TREVOR KHAN: Just at traffic court.

Dr McCaffrey: Yes. If you are a lawyer, I must defer to you.

The Hon. GREG DONNELLY: Do not do that. Point of order. He is a traffic court lawyer.

Dr McCaffrey: The respected legal opinions which I have sought on numerous occasions in the past have reassured me that when the woman decides it is of necessity, it is of necessity.

The Hon. TREVOR KHAN: Well, let us get to this point. Under the current—

Dr McCaffrey: Sorry, may I add that after this 40 years of obstetric practice with close to 25,000 terminations being performed in New South Wales every year, it is not my experience that women are being prosecuted in this State when a doctor may think that it is not of necessity and the woman think s it is of necessity. The fact that women are not prosecuted, to me, is more than enough evidence that the woman decides when it is of necessity, not the doctor.

The CHAIR: We will move on, because we may have some time at the end for extra questions.

The Hon. TREVOR KHAN: No, no. I think I am all right.

The Hon. NATASHA MACLAREN-JONES: I might begin with a question to Dr McCaffrey in relation to your submission. Point 9, you said, "Accordingly, the need for a specialist medical practitioner to perform an abortion only after 22 weeks is a dangerous proposition. At the very least, a specialist medical practitioner should be involved in any termination from 16 weeks onwards." In your opinion, why are you suggesting that?

Dr McCaffrey: I am not really sure many reasons. The first is that most terminations performed after 14 to 16 weeks are done for fetal anomalies. The fetomaternal specialists are regularly in discussion and dispute over the prognosis and outcome of fetal anomalies detected after 16 weeks. There is an enormous amount of expertise and experience and discussion with colleagues, including overseas discussion, before they can agree on what the fetal anomaly constitutes for the outcome for the baby and the impact on the woman. To abrogate that amount of expertise and responsibility to non-specialist medical practitioners, I believe abrogates our duty of care to women. Women are entitled to—it is such a life-defining decision that they are entitled to specialist knowledge and opinion based on experience. And non-specialist medical practitioners simply cannot provide that.

I cannot understand why the cut-off is 22 weeks. My fetomaternal specialist colleagues also cannot understand why the cut-off is 22 weeks. The complexity of a termination performed at 23 weeks is no different to 21 weeks. If we require specialist oversight at 23 weeks, we require specialist oversight at 21 weeks because they are very similar conditions. And terminating a pregnancy at 23 weeks is very similar to terminating one at 21 weeks. The complications are the same. The cut-off makes no medical sense and I believe it leaves women with less duty of care. That is why I have the problems I do with the bill.

The Hon. NATASHA MACLAREN-JONES: I might move on to counselling. There has been a lot of discussion and evidence presented in relation—or views, and we saw amendments in the lower House also in relation to counselling before a procedure, so when presenting at the GP or at the clinic. I am interested in your comments around counselling post-termination, but also counselling of staff and what is current practice in relation to support given to staff.

Dr WHITEHALL: To me?

The Hon. NATASHA MACLAREN-JONES: To both.

Dr WHITEHALL: Well, in general terms there is no counselling of the staff who serve in a neonatal intensive care ward before the event. But in the ideal situation, you would have a number of people talking with the mother, including a neonatologist, a social worker, maybe a psychologist if you have got one, and one or two obstetricians so that the counselling there is up-to-date. They have a responsibility to bring in and look at the new knowledge and so forth and impart that to the mother so that she knows what is happening now and what might be happening in the future. For example, fetal operations went out of fashion but are now coming back. And miraculous things are being done, for example, even to diaphragmatic hernias or other things. These things need to be brought to the mother so that she understands this—and the man who is involved and the family, and make it a family decision.

Now, all that happens in a way in a neonatal intensive care ward, but we do not bring the nurses in because they are out looking after the babies. That sort of counselling is not going to happen in a busy international organisation that has a certain number of babies to be terminated throughout the day, very limited resources and

no-one there after dark. What I am saying is that the gravity of the situation demands counselling in its fullest form, which includes imparting sympathetic, up-to-date, conservative knowledge to the mother. That is what counselling is before it happens. That is not going to happen outside the public system. I am therefore saying that this should be a reasoned and very, very serious thing within the public system, where there is more time, quite frankly, to take these things to a greater depth.

The Hon. NATASHA MACLAREN-JONES: My final question is in relation to data. One of the amendments that was put through the Legislative Assembly was that a review be done of the Act and of sex selection. We have heard a lot of evidence that data is not collected accurately around current terminations. How should data be collected moving forward?

Dr WHITEHALL: It should become very stringent in terms of why you are doing it, as with all other medical issues. This is public health issue. In north Queensland, for example, we were involved with gastroschisis, which is where there is a hole and the intestines hangs out. No-one knew what the prevalence was throughout the State and whether it had a relationship to Indigenous babies. In the end we thought it was and that allowed us to look more closely at what was causing it. We were limited in data because it was not collected in Queensland. We had to go to Adelaide. There should be nation-wide collecting of the reasons for these fetal abnormalities, for example. With regard to sex discrimination—

The Hon. GREG DONNELLY: Selection.

Dr WHITEHALL: Yes, well, I call it discrimination, quite frankly. I have a couple of articles. RANZCOG and the other organisations minimise the issue but there is evidence, for example, that in Canada second-generation migrants had a boy to girl discrepancy of something like 1.5 to almost two. Sex selection is occurring in Canada, where you do not starve to death and where the system looks after people. Why would that not happen here? It is a horrible business. I am a feminist in relation to this issue. Why should girls be done in before they have a chance to breathe? You cannot say it is not going to happen here; that is wishful thinking.

Dr McCaffrey: I would like to answer as well. You asked about counselling. I have been involved in a lot of counselling and consent. To me the basis is knowledge. I give the woman as much knowledge as I practically can. I give her every possible bit of knowledge I have about her situation, the condition and the outcome she is entitled to. At the end of it I would hope that she has no idea about my personal feelings about abortions or anything else. It has no place in counselling and consent. The woman wants knowledge because she is perfectly capable of making up her own mind on the basis of that knowledge. That is my approach to both counselling and consent.

Dr WHITEHALL: Can I just add that was my approach as well. As a neonatal opinion coming in I was disinterested in that sense. I saw it as my responsibility to give all the current knowledge and future possibilities to the parents and I kept my own feelings out of it.

Reverend the Hon. FRED NILE: Thank you very much for appearing before our inquiry. I appreciate it. I have lots of questions on your submission. What is your opinion on this bill? Should we vote it down? Next week we have choice to vote for or against it. That is the first question. The second question is: Do you have amendments that would mean it could survive?

Dr WHITEHALL: I think you should vote it down because although the word "criminalising" is not popular and is politically incorrect in a way, it is the choking of the entry to the whole process by means of the criminalisation that will direct this process into the public hospitals, where there is ample opportunity for broader and deeper investigation, counselling and support. That, as I see it, is the good result of the criminalisation. This should not go out into those multinational organisations that are making money out of terminating people with very little counselling, not to mention that they stop work at 5 o'clock in the afternoon. The main role for maintaining the criminalising business is to direct this into the public hospital system, with all the advantages that can and should be employed. The Government should understand that this is a major issue and all our resources should be put to it, not just in a private situation. That is the advantage and that is why I think the bill should be voted against.

Dr McCaffrey: I have never viewed a woman who has accessed termination services as a criminal—never. I would never want her prosecuted in any shape or form. But at least with the previous Act—the Crimes Act—medical practitioners who did not have the necessary expertise and experience to terminate pregnancies between 16 and 22 weeks had a disincentive to get involved in those practices because they knew there was an Act that could come and get them if they harmed women. If this reform bill was only interested in removing criminal sanctions against women I would jump at it because none of us would ever want to see a woman go to jail for having a termination. It is a terrible thought.

But this reform bill allows doctors who do not have the expertise and experience to care for women who feel they may need a termination between 16 and 22 weeks. It simply gives them a licence to terminate pregnancies that they are not qualified to terminate. That is a disservice to women. That is why I do not believe this reform bill should go ahead. If women view the Crimes Act as a disgrace to their autonomy and their dignity by all means we should get rid of the part that makes them feel that way. But at the same time we should make sure that the duty of care that we owe women is always there.

Reverend the Hon. FRED NILE: Dr McCaffrey, in your submission you made a strong point that there should be four specialists involved in an abortion from 22 weeks.

Dr McCAFFREY: Yes, I did. At the moment medical practice in terms of fetal anomalies changes every month. We are discovery aspects of fetal development that we never knew in the past. A lot of ultrasounds, scans and radiological investigations are open to interpretation. Fetal conditions can stabilise and can often regress. Because of the fact that even two or three fetomaternal specialists can disagree on prognosis and outcomes, it gets back to knowledge and providing women with knowledge. The more knowledge we can provide them with to help them make their own decision the better. That is what it is all about. Fetomaternal medicine is such a vexed area and four fetomaternal specialists are going to provide that extra surety that the decision they are going to make is based on what is best for their infant. That is why I would like to see any framing of the bill include that.

Reverend the Hon. FRED NILE: And any amendments—you could send them to us or to me later—that you would like to see introduced.

Dr WHITEHALL: My worry about amendments is that when I was reviewing other submissions, unfortunately I discovered that the Family Planning association's submission recommended to NSW Health that we define requirements for "specialist medical practitioners"—be interpreted broadly. This worries me because it reinforces my impression that the reform bill is compromising the necessary expertise which women are entitled to before making this decision. Once a reputable, esteemed body like the Family Planning association seems to want to broadly interpret "specialist medical practitioner" definitions, it is of concern to me, because rather than interpreting it broadly, I would be insisting that fetomaternal specialists—a strict definition be entitled to give women the knowledge, the expertise they are entitled to. And the more we broaden our interpretation of what constitutes a specialist medical practitioner to decide when a termination can be performed, to me it compromises the bill possibly beyond comprehension. It is fetomaternal specialists. It is their knowledge which women are entitled to.

Dr WHITEHALL: You asked me for amendments?

Reverend the Hon. FRED NILE: Yes.

Dr WHITEHALL: I would get rid of the whole business about forcing people to have to refer. This is a conscience matter, and to oblige a doctor to have anything to do with this is punitive. There are people who would find their conscience very, very stricken if they had to refer. They would rather say, "Look, I do not believe in this. I do not want anything to do with it, and my involvement in referring you would be as much"—and people do not like analogies with the Second World War—"a bit like saying, 'Sorry, you know, I know you are Jewish. I just have to write this down and I am not responsible for what happens next. Here, take this letter to the authority'."

A lot of people would rather have absolutely nothing to do with this as a matter of their definition of the values in life. They are not critical of the mother, they are not hounding the mother, but it is a matter of intense personal conscience, and that must be reflected. I would throw all of that out. Not just amendment. I would throw the whole business out. There must be, within the medical profession, the right not to be involved with something that you think is even partially wrong. How do we then maintain standards if we haven't got people who can stand up and say, "This is what I believe"?

The Hon. GREG DONNELLY: I thank you gentlemen for coming along this afternoon. I will begin with this preliminary statement just so you are very clear. Chair, I draw your attention to what I am about to say, so you do not misinterpret it in the wrong way.

The CHAIR: I will listen.

The Hon. TREVOR KHAN: I will listen, too, Greg.

The Hon. GREG DONNELLY: We have before us what is an utterly morally and intellectually bankrupt process happening here in New South Wales—

The Hon. TREVOR KHAN: That is a bit harsh.

The Hon. GREG DONNELLY: —with respect to the consideration of this legislation. We are being forced to deal with an inquiry over a very short matter of days.

The Hon. TREVOR KHAN: Point of order: The member is entitled to ask a question. He is not entitled, at this stage, to make what is self-evidently a speech.

The CHAIR: I think the member is leading to a question.

The Hon. TREVOR KHAN: Some of his leads have been fine. He is now making disparaging assertions, including about me.

The CHAIR: Order.

The Hon. GREG DONNELLY: I have not mentioned your name.

The CHAIR: There was no mention.

The Hon. TREVOR KHAN: I know what you are doing.

The Hon. GREG DONNELLY: If I am going to punch you in the nose, I will straight up, mate. Don't worry.

The CHAIR: I don't know that we want to have threats of assault in *Hansard*.

The Hon. GREG DONNELLY: I withdraw that.

The CHAIR: Thank you. Let us get to that question. Go where you are going.

The Hon. GREG DONNELLY: I have got very limited time as the result of this process. This bill has gone through the Assembly. It is a short, sharp—we call them "quick and dirties", an inquiry that takes one week and we are in fact next week going to be deliberating in the Legislative Council on this bill. And the plan is it will commence on Tuesday afternoon and be through the council by the end of next week. So from the going in at 1 August to the 20th, the debate in the council, we are talking about a 20-day period. I just want to make that point that there is great pressure on everyone to deliberate over this as best they can in most difficult circumstances. That is why we are sort of having to sort of push through this very hard. I think it is just a great, great pity that there is not more opportunity to hear more detailed evidence from people like yourselves.

The next thing I wanted to ask is to Mr McCaffrey, this will need to be clarified for the purposes of a meeting which is going to finalise this report, which you will have nothing to do about, next Monday. Mr Khan, rather, led with his chin by wanting to sort of go down a particular line of questioning about your position either current—and I do not know whether it is current—or at least past association with Right to Life NSW, of which you acknowledged at least association with that and many other organisations. Setting that aside or acknowledging that point, are you here today as Dr Simon McCaffrey with your submission representing Right to Life NSW or are you representing Dr Simon McCaffrey?

The Hon. TREVOR KHAN: That is what you call a Dixer.

Dr McCAFFREY: I am only representing Dr Simon McCaffrey, an obstetrician and gynaecologist who has practised for 40 years in the public and private sector and overseen an enormous amount of obstetric practice, and it is only on that basis that I appear today, because I honestly believe this reform bill is flawed because it does not provide women with adequate duty of care from abortion services as proposed by the reform bill. And with all due respect, Right to Life has nothing to do with that. It is simply a medical opinion and it is not only mine, it is fetomaternal specialists who cannot believe that medical practitioners will be able to oversee abortion services up to 22 weeks.

The Hon. GREG DONNELLY: Thank you for that. I almost interrupted you because you were actually taking up my time with that answer, but it was a very good answer.

Dr McCAFFREY: I do apologise.

The Hon. GREG DONNELLY: Moving on.

The Hon. TREVOR KHAN: You took up your time with your question to that answer.

The Hon. GREG DONNELLY: Moving on, this is a very important point which we need to in fact be very clear about. This is where I will ask the gentlemen at the table to give me their expert opinion based on their training—their science training and medical training—and that is this: With respect to the commencement of human life, and that is the creation of a new entity, a human being at the point of conception where you have a

uniquely created or unique emerging of a new entity of a human being which is discrete and with DNA that is unique to that person, is that the commencement of human life as science understands it?

Dr McCaffrey: Absolutely. It is beyond dispute amongst medical scientists and reproductive physicians. Human life begins at syngamy conception and proceeds from there.

The Hon. GREG DONNELLY: And that would be fair to say that that probably was taught in your early years at medical school?

Dr McCaffrey: It has never stopped.

The Hon. GREG DONNELLY: Right. Perhaps we will have a yak with the Uniting Church a bit later over a beer. Moving on, with respect to the matter of—and this is now to Dr Whitehall—disabilities and termination for disabilities. I have got a document which, might I say, makes up one of my annexures to my submission to this inquiry, okay? So it is a public document. I have two copies for the gentlemen. Perhaps if I just—why don't we swap here? And you will see my time has been cut off already, so it is a very—

The CHAIR: You can ask the question and they can answer the question.

Reverend the Hon. FRED NILE: What is the title of the document?

The Hon. GREG DONNELLY: It is called—

Reverend the Hon. FRED NILE: Just the title.

The Hon. GREG DONNELLY: Okay. Let me—

Reverend the Hon. FRED NILE: Just the title.

The Hon. GREG DONNELLY: Fred, let me bloody—

The CHAIR: Order.

The Hon. GREG DONNELLY: The document I have placed before you is something you have probably not seen before. It is the Journal of Policy and Practice in Intellectual Disabilities. It is volume 16, No 2, June 2019. It is actually not a subscription document for myself, but it was provided to me in the preparation for this inquiry. One of the editors is Rhonda Faragher, PhD, who happens to be a member of the governing body of Down Syndrome Australia. She has overseen, as the editor of this particular edition of the journal, a series of articles to do with the—and she calls it as it is, or at least the articles do—the eugenic practices that exist with the termination of the unborn with, dare I say, less than perfect features as human beings, be they physical or intellectual.

My question to you, Dr Whitehall, is this—and perhaps Dr McCaffrey can jump in as well: We are voting on, probably next week, a piece of legislation that for the first time is going to statutorily regulate the practice of the termination of life in utero here in New South Wales. That will become law on and from when it is proclaimed by the State of New South Wales and will run into the future as far as we can see. I do not expect that abortion is going to be, as a debate, returned anytime soon to this Parliament.

Do you believe that, in light of that, if we as legislators are looking into the future and we are clearly able to see what is happening in terms of with respect to the use of ultrasound and genetic testing and a range of other things, which are actually happening right now—it is not a case of looking into the future—which may shape decision-making over the way in which judgements are made over legitimacy of the unborn, that it is quite proper that these considerations be part of a consideration in terms of a piece of legislation that would regulate abortion in New South Wales? In other words, ought we be discussing this in the context of regulating abortion in New South Wales?

Dr WHITEHALL: Mr Donnelly, you flatter me that I can actually compress that into a quick answer. I am not for one second minimising disabilities in children; I deal with that all day long and I see the pain. As a crass young paediatrician I thought that to have a child with a disability would be a horrific thing. With the experience of time, I do not minimise the pain but I have realised the contribution that these children can make to love, whatever love is, and to family solidarity, a diminishing quality these days. I have seen the contribution that disabled children can unexpectedly make and therefore I do not submit to the concept that just because they seem in black and white a bit different from everyone else, we should do them in.

The Hon. GREG DONNELLY: You may have misunderstood me, because I was talking so fast. I was not reflecting on your position, but rather making a comment on this: We are setting up what is the statutory regulation for abortion in New South Wales. We have significant intellectual discussion going on about the matter

of what is happening with respect to the termination, essentially, of people with disability in utero because of genetic conditions, for example. My question to you is: This is a live issue now, so if we are thinking about creating new legislation, there should be some consideration at least about, should such legislation permit, for example, the termination of perhaps a person, dare I say, with disability or perhaps the choice of a colour of eyes or some matter that we might look at in the future? Are these matters we should be looking at now, or should we just simply say let us put these aside and just look at the bill before us?

The CHAIR: I think that you have clarified the question and so I will allow the witnesses to take their time to answer.

The Hon. GREG DONNELLY: If my question is not clear then I will have to—

Dr McCaffrey: I will try to answer it. As I read it, I take that you mean that, as politicians, you will be creating and enacting laws which will affect social policy to such an extent that it will reflect what our society is going to look like in 10, 20, 30 years' time—in other words, our children and our children's children, what sort of society they are going to be born into. You have an enormous responsibility and it is why we respect your position and your vocation to create social policies which will produce better societies. I would worry that a society which does not understand that disabled people actually make our society better, disabled people help us understand our vulnerabilities. Their vulnerabilities are no different to our vulnerabilities. If we remove them from our society, we will be poorer for it. The same applies to termination.

If a woman feels that her child is not going to be loved and cared for in our society then it is going to be a very, very dark place to live. Children are unique. They are beautiful beyond description and they are irreplaceable—they are simply irreplaceable. You can never replace human life as we know it; we can never replace a child who is taken away from us. Parents know that and women want our society to welcome their children as much as they should be allowed to. That applies to disabilities as well. Every single human being has the right to breathe the air which they are entitled to. As politicians, you have an obligation, a responsibility, to create a society for our children where that is the way life will be accepted and embraced.

Reverend the Hon. FRED NILE: Hear, hear.

The CHAIR: Dr Whitehall, do you want add to that?

Dr WHITEHALL: I cannot improve on that answer. I have nothing to add.

The CHAIR: Do you agree with that statement?

Dr WHITEHALL: Yes.

Ms ABIGAIL BOYD: Thank you both for coming here and sharing your views. I want to start with Dr McCaffrey. You will be aware that earlier today we heard from Dr Roach, who is the President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. In the evidence that was presented, Dr Roach explained that, as is the case in any organisation, there are differing views within his organisation and that there are provisions made in regulation and also within the professional comradeship of obstetricians and gynaecologists that would allow people to exercise their own conscience. That is an absolutely valid thing for you to be able to do. I understand that you are—and please correct me if this is wrong—against abortion in any circumstances, except perhaps for ectopic pregnancy.

The Hon. GREG DONNELLY: Point of order—

Ms ABIGAIL BOYD: I am asking questions and these are valid questions.

The CHAIR: There is no point of order.

Dr McCaffrey: It is a very valid question and I am very comfortable with you finishing the question and me answering it to the best of my ability.

The CHAIR: Thank you.

Ms ABIGAIL BOYD: Thank you. I certainly do not mean any offence by asking you your views.

Dr McCaffrey: No offence taken.

Ms ABIGAIL BOYD: You are here as a dissenting member of the college of obstetricians and gynaecologists—one of, as I am sure there are many who have the same views as you. I am trying to get to the basis of the evidence that you are giving and in what capacity. I understand you are not here as the president of Right to Life.

Dr McCaffrey: Certainly not.

Ms ABIGAIL BOYD: But that position leads me to imply that you are—I will ask you straight: Am I correct in thinking that you do not agree with abortion in any circumstances

Dr McCaffrey: I probably represent maybe 20 to 30 per cent of women who believe that human life is so precious that it cannot be taken away from them. To some extent, that 20 to 30 per cent of women do find it comfortable seeking out an obstetrician who does not do abortions. To some extent, the way events have panned out over the last 40 years, because I believe the unborn child from the moment of conception is human life, with all due respects I simply cannot take that human life, just as I am against capital punishment. Innocent life is innocent life and I cannot personally do anything harmful to it.

That opinion, that belief, many women in our society find comforting and a lot of women come to me because of that opinion. Therefore, to some extent I am providing a service to those women, as my colleagues like Vijay Roach and many obstetricians like him, who I have immense respect for, have a different approach and women can access their services because they believe differently as well.

To me, there is no problem at the moment in the way obstetric services are provided in New South Wales. Women who want to access abortion services can easily find doctors who will provide that service. There are many women who seek out one of the obstetricians who actually do not perform abortions. That is the way they want to be cared for. Myself and other doctors like me provide that service—in other words, if anything, I would argue we are giving, between all of us, an even better service to women in this State than if all doctors did the same thing or were forced to do the same thing.

Ms ABIGAIL BOYD: I absolutely would defend your right to exercise that conscientious objection, if there was ever a law to require you to conduct an abortion. I would be one of the first people on the streets protesting because I do not agree with that.

The Hon. GREG DONNELLY: What about referring?

Ms ABIGAIL BOYD: When we are looking at the value of your evidence from a medical perspective, I do not believe that that is tainted by your views in any way. But we have to value that against Dr Roach's evidence as well.

Dr McCaffrey: It is a good point—in other words, you have the president of my college, Vijay Roach, a very reputable and respected obstetrician, arguing for this bill. Everything he has told you is his considered, professional opinion and I respect that. The evidence I have given you today, in all honesty, is not based on my personal attitude to abortion services or my belief in when human life begins. It is on the basis that whatever decision a woman makes, she is entitled to the absolute best quality of care and that allowing non-specialist medical practitioners to perform terminations and to consent for terminations up to 22 weeks is a disservice to women. I have also spoken to fetomaternal specialists—Vijay is not a fetomaternal specialist; he is a specialist obstetrician and a very good one—but I am talking about fetomaternal specialists here. I have spoken to them and they have concerns about this bill as well—that is, terminations between 16 and 22 weeks, as the bill encapsulates it, will not necessarily get the most expert and experienced knowledge from the fetomaternal specialist.

Until somebody can convince me that allowing a non-specialist medical practitioner to oversee a termination at 20 weeks, when they cannot at 23 weeks, I find that illogical because there is virtually no difference between terminating a pregnancy at 21 weeks and 23 weeks. Yet the bill insists that in fact at 22 weeks a woman must have oversight from a specialist, which does not necessarily happen at 21 weeks. That, with all due respects, does not provide quality of due care to a woman. In all honesty, every single fetomaternal specialist I have spoken to and even specialist obstetricians still have not been able to tell me why what is permissible at 21 weeks is not permissible at 23 weeks.

Ms ABIGAIL BOYD: But you acknowledge that that view is different to the college at large?

Dr McCaffrey: Absolutely. The RANZCOG submission argued that it recognised that the complexities after 22 weeks required a multidisciplinary team including mental health specialists—in other words, Dr Roach and college members felt that a termination at 22½ weeks required maximum specialist oversight with even mental health specialists. Yet, for some reason at 21½ weeks that was not necessary. That is not good obstetric practice. If the cut-off was made simply because a cut-off had to be made somewhere, in this case 22 weeks—viability? The child is not going to survive the process, therefore viability, to me, becomes irrelevant.

Ms ABIGAIL BOYD: Are you suggesting then that a doctor at 21 weeks, who viewed a woman as requiring mental health assistance, would not seek that out for the woman as part of the duty of care?

Dr McCAFFREY: You would hope so, but what I am saying is that the RANZCOG guidelines pointed out that after 22 weeks they would include mental health specialists in the multidisciplinary team which oversees terminations at 22 weeks. That is in the RANZCOG submission. They might suggest that that would be a good thing at 21½ weeks, but the bill does not stipulate that. The bill stipulates that only medical practitioners need be necessary to oversee terminations.

Ms ABIGAIL BOYD: Does it need to state that, though? Would that not be the case anyway?

Dr McCAFFREY: Definitely not, I am sorry to say. I wish I could say that medical practice always provides the best duty of care to women, but unless terminations of pregnancy after 16 weeks are performed in public hospitals and by specialist medical practitioners, there is always the potential—the very real possibility—that women will not get the duty of care which they are entitled to. The private system struggles to provide the same duty of care, oversight, facilities, ancillary services—all of those things. Unfortunately, there will always be a financial incentive in private hospitals, which does not exist in public hospitals. For termination of pregnancy, abortion services, financial incentives should never ever play even the remotest part in these life-defining decisions which are of such paramount importance to women.

The CHAIR: As Chair, I need to bring proceedings to a conclusion. We have gone almost 15 minutes over time, which makes up for the late start.

The Hon. GREG DONNELLY: I have some more questions.

The CHAIR: You can certainly ask them privately. I thank both witnesses, who are no doubt very busy men, for coming in this afternoon to give evidence to the inquiry. We appreciate that. That concludes the inquiry for today. The transcript of today's proceedings will be on the website late tomorrow. For those who are interested, the transcript of yesterday's proceedings is now on the Committee's website. We have a hearing tomorrow morning.

Dr WHITEHALL: May I make a very quick comment on the RANZCOG stuff to do with conscientious objection?

The CHAIR: I have closed the meeting, but thank you.

(The witnesses withdrew.)

The Committee adjourned at 17:30