HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr R Molhoek MP
Mr SSJ Andrew MP (virtual)
Mr JR Martin MP
Mr TJ Smith MP

Staff present:
Dr J Rutherford—Committee Secretary
Ms R Duncan—Assistant Committee Secretary

PUBLIC BRIEFING—INQUIRY INTO THE HEALTH AND OTHER LEGISLATION AMENDMENT BILL (NO. 2) 2023

TRANSCRIPT OF PROCEEDINGS

Monday, 12 February 20244

Brisbane

MONDAY, 12 FEBRUARY 2024

The committee met at 12.01 pm.

CHAIR: I declare open this public briefing for the Health and Environment Committee's inquiry into the Health and Other Legislation Amendment Bill (No. 2) 2023. I am Aaron Harper, member for Thuringowa and chair of the committee. I would like to start by respectfully acknowledging the traditional owners of the land on which we meet today and pay our respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander peoples whose lands, winds and waters we all now share.

With me today are: Rob Molhoek, member for Southport and deputy chair; James Martin, member for Stretton; Tom Smith, member for Bundaberg, who is substituting for the member for Pumicestone; apologies from Andrew Powell; and we have online Stephen Andrew, member for Mirani. The purpose of today's briefing is to assist the committee with its examination of the Health and Other Legislation Amendment Bill (No. 2) of 2023. The bill was introduced into the parliament on 30 November 2023 by Shannon Fentiman MP, Minister for Health, Mental Health and Ambulance Services and Minister for Women, and referred to this committee for detailed consideration and report.

This briefing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Witnesses are not required to give evidence under oath, but intentionally misleading the committee is a serious offence. The proceedings are being recorded and broadcast live on the parliament's website. I remind committee members that officers are here to provide factual and technical information. Questions seeking opinion about policy should be directed to the minister or left to debate on the floor of the House. I now welcome witnesses from Queensland Health.

ALLAN, Dr John, Executive Director, Mental Health, Alcohol and Other Drugs Branch, Clinical Excellence Queensland, Queensland Health

LIDDY, Mr James, Manager, Legislative Policy Unit, Queensland Health

McDOUGALL, Dr Catherine, Chief Medical Officer, Clinical Excellence Queensland, Queensland Health

NOWLAN, Ms Shelley, Chief Nursing and Midwifery Officer, Clinical Excellence Queensland, Queensland Health

SKETCHER-BAKER, Ms Kirstine, Executive Director, Patient Safety and Quality, Clinical Excellence Queensland, Queensland Health

CHAIR: Welcome all. Would you like to make an opening statement and then we can move to any questions the committee might have?

Dr McDougall: Thank you for the opportunity to brief you on the Health and Other Legislation Amendment Bill (No. 2) 2023. I would also like to respectfully acknowledge the traditional custodians of the land on which we meet today, the Yagara and Turrbal people, and pay my respects to elders past, present and emerging. As mentioned, I am Dr Catherine McDougall. I am the Chief Medical Officer of Queensland Health. I will go through the panel so you understand their roles. I am joined today by my Queensland Health colleagues. I will keep my opening statement short so we can move to committee questions, but I would like to briefly address the key issues raised by the stakeholders at the public hearing on 1 February.

In relation to allowing nurses and midwifes to have a greater role in terminations of pregnancy, some stakeholders were concerned the bill would authorise all registered nurses and midwives to perform a medical termination of pregnancy. I can assure the committee that only those nurses and midwives with the appropriate training, qualifications, skills and approvals will be authorised to perform or assist with a medical termination of pregnancy. An important safeguard is that the bill requires practitioners to be authorised under the Medicines and Poisons Act 2019 to use a termination drug. Only those nurses and midwives who have the relevant authorisation will be involved in terminations of pregnancy. The role of the nurse or midwife will vary according to their qualifications, experience and position.

Nurse practitioners and endorsed midwives will be able to prescribe MS-2 Step as well as give a treatment dose or administer the drug. Nurse practitioners hold a master's level qualification and practise independently in clinical settings. Endorsed midwives complete a program of study approved by the Nursing and Midwifery Board of Australia which leads to an endorsement of scheduled medicines. Those registered nurses and midwives authorised to work under an extended practice authority will be permitted to give a treatment dose or administer a termination drug. For registered nurses, this will generally be those working in sexual and reproductive health and rural and isolated practice areas. These nurses hold additional qualifications relevant to their role and apply expert clinical specialty knowledge, skills and judgement in their positions.

The use of the extended practice authority for registered nurses must be approved at health service or facility level through the approval of a health management protocol by the relevant chief executive. The protocol must be endorsed by an interdisciplinary health team comprising at a minimum medical, nursing and pharmacy professionals. The review by an interdisciplinary team ensures the arrangements for using a medication at a particular service or facility has the relevant clinical oversight, approvals and escalation pathways.

For completeness, I will also mention that nurses and midwives are already permitted to assist in medical terminations of pregnancy by administering a termination drug on a prescription from an authorised provider, such as a doctor. Under the bill, nurses and midwives will also be able to administer the drug on prescription from a nurse practitioner and an endorsed midwife who will be authorised to prescribe the drug. This is the same process that applies to other schedule 4 medicines.

At the public hearing some stakeholders also asked about care for patients experiencing complications from a termination of pregnancy. The health system already deals with these issues and patient safety and care will continue to be an important priority. Patients given a termination drug will be advised about normal side effects of the medication and any side effects or complications that may require additional care, escalation or a follow-up appointment. Advice will also be available through 13HEALTH, sexual health clinics and community health settings. In the rare cases where an emergency arises, which is a rate less than one in 1,000 as per the evidence, patients would be able to attend their local hospital, multipurpose health service or primary health care centre.

As Chief Medical Officer for Queensland Health with my colleagues in the Clinical Excellence Division I can reassure the committee that we will have the relevant training, referral processes, escalation pathways and clinical oversight in place to ensure termination of pregnancy can be provided safely.

In relation to amendments to the Hospital and Health Boards Act 2011, the Health Ombudsman suggested expanding information sharing by quality assurance committees to include unregistered health practitioners. Queensland Health recognises the vital importance of ensuring appropriate reporting to the Health Ombudsman of risks in relation to all health practitioners, including unregistered practitioners. However, the department considers this issue should be addressed in a future bill as it requires significant policy work and consultation with affected stakeholders. Under the Hospital and Health Boards Act, reporting of certain conduct already occurs for registered practitioners. In contrast, the act does not currently contemplate a quality assurance committee sharing information about unregistered health practitioners in any circumstances.

The inclusion of unregistered health practitioners requires a detailed review of existing provisions for both registered and unregistered practitioners to improve consistency and ensure reporting of all appropriate levels of risk. One of the difficulties in applying the existing regime is there are no currently accepted thresholds in which reports should be made about an unregistered health practitioner. In contrast, registered practitioners are subject to mandatory reporting for certain conduct at a specified threshold level. Queensland Health is committed to making improvements to these provisions, but it needs to be done as part of a longer term, more detailed review. Queensland Health will engage with the Health Ombudsman about these issues and seek to make these changes in a future bill.

At the public hearing some stakeholders, including the Public Advocate, queried whether the expanded use of expert reports and transcripts from Mental Health Court proceedings should require the person the subject of the report to consent or not object to their use in other criminal proceedings. The department does not consider this necessary or appropriate as other safeguards and considerations apply. Firstly, leave of the Mental Health Court is required before any release or use of an expert report or transcript in a criminal proceeding. This process ensures all parties, including the person the subject of the report, can make submissions about whether the report should be able to be used and to suggest conditions the Mental Health Court should place on the use of the material.

Secondly, criminal courts will have discretion about whether to admit the material into evidence. Again, the defendant would be able to make submissions to the court about whether the material should be admissible. The criminal court would need to consider the relevance of the clinical opinions, including how recently the report was prepared and its relevance to proceedings. Thirdly, if material is admitted into evidence, a criminal court may only use it to consider a person's unsoundness of mind, fitness for trial or in sentencing. Evidence of a person's mental illness or intellectual disability may be considered relevant as a mitigating factor in a criminal case; for example, it may reduce the severity of a person's sentence.

Under the current provisions the use of the expert reports or transcripts by prosecutors in criminal proceedings is exceptionally rare and it is expected this will continue to be the case. However, it is the prosecutor's role to act in the interests of justice, so it is important to have a legislative mechanism available to ensure criminal courts have all relevant information available to decide a matter. Ultimately, the criminal court will have discretion about whether to admit the material and the weight given to it. The defendant's ability to make submissions about both the admissibility of the evidence and how it is used in the proceedings is considered a sufficient safeguard to appropriately balance the interests of justice for all parties. I am happy to take questions and may refer questions to my colleagues.

CHAIR: I will start with getting clarification around the OHO expanding information sharing, which you talked about. Just to get clarification on what you were saying about a future bill, is that in regards to unregistered practitioners?

Ms Sketcher-Baker: That is correct, it is in relation to the unregistered practitioners.

Mr MOLHOEK: My question is around concerns raised about access to services in regional, rural and remote Queensland. Dr McDougall, you mentioned that Queensland Health already have escalation pathways in place. If a case does escalate and there is significant bleeding which would require, say, surgical attention, or some other complication as a result of that termination, what do the pathways look like for someone in, say, Boulia, Mount Isa or Chinchilla, some of the more remote places? Chinchilla is not as remote as Boulia. What does that look like? What is the worst that could be expected in terms of an escalation in terms of timeliness?

Dr McDougall: With respect to the overall quality and safety framework, as you describe, there is policy, teaching and training, education and then escalation pathways. With respect to the escalation pathways in particular, if you start at the worst case scenario, the clinicians working in our most isolated areas are experienced in having to deal with things that are unplanned. There are principles around stabilising people and potentially retrieval services is the most likely, if it something that is urgent. As part of the overall safety framework, however, in the majority of circumstances, with good consent and education around what to look out for, there is guidance to be able to get hopefully these women to report and to front up for care at an earlier stage. We really would expect and hope that it is very rare that someone is in extremis. Certainly our data suggests that rare complications, serious complications, would be bleeding, as you suggest, or sepsis from infection. For both of those things, there is evidence of progressive symptoms that people can be made aware of, and then we use our usual pathways to retrieve.

Mr MOLHOEK: You mentioned data. Is there any current data on the incidence of more acute symptoms like bleeding and sepsis, and how are they categorised? I am assuming there is a significant difference between some mild bleeding as a result of MS-2 Step versus someone who has actually got a significant issue that requires surgery. What is the incidence of that currently?

Dr McDougall: The evidence in the studies on MS-2 Step says the incidence of severe bleeding is less than one in 1,000. The incidence of some bleeding is very common; in fact, it is 10 per cent. When we are discussing complication and risk with the patients, there is almost like there are three groups. For this, it is nausea and vomiting, abdominal pain and some bleeding, and that is reasonably common—about 10 per cent. Requirement for a surgical procedure in a non-urgent setting potentially related to a D and C or because the termination was incomplete might sit at about five per cent. Infection and significant bleeding requiring transfusion in the data is less than one in 1,000.

Mr MOLHOEK: We have labour force shortages right across the health system. I think you mentioned that only registered nurses who had had adequate training or specialised training would be able to prescribe and oversee that process. Is there a risk that nurses perhaps working in more remote and rural settings will feel pressured to go and do the training, or that the system will put more pressure on them, increase the expectation on them? We heard from either the College of Nursing

or the Nurses and Midwives' Union who said a lot of nurses just want to be nurses. They do not really want to be having to take on extra responsibility and be accountable for other procedures and other processes beyond just looking after people.

Dr McDougall: I would defer to Shelley for that question.

Ms Nowlan: Our registered nurses are highly qualified, coming out with a Bachelor of Nursing or Bachelor of Nursing Science. The nurses who work in our rural and isolated practice environments tend to want to work to their optimal scope. They are very dedicated to meet all of the needs of their community and, in many cases, have already undertaken broad depths of knowledge and education in anything that is experienced in a rural community. Many of our nurses whom I have worked with advocate very strongly for women's health and for sexual health in that regard. If a nurse did not feel that they were wanting to work in this environment, or get this extra education, we do have processes around conscientious objection and support for them. More broadly, within the education and training that will be provided for them, additional education and training will be developed to support them in their role and to make it align to the education and training that they already have, pivoting them to termination of pregnancy care. The resources that we plan to put in place are very practical, pragmatic but at the same time provide enough education and training for them to be highly qualified in that area.

Mr MOLHOEK: Would they have to, say, come to Brisbane to attend training courses, or can it be done regionally? Where would a registered nurse access that training and extra qualification? Is it a three-month course or six modules—how does it actually work?

Ms Nowlan: We are currently working through what that will include. We know that these resources will be aligned with the *Queensland clinical guidelines—Termination of pregnancy* and a standardised clinical pathway for the termination of pregnancy using MS-2 Step. We want to be able to have these nurses access this education so it is not necessarily, 'Come down to Brisbane.' We have educators throughout our system that will support the uplift of the requirement to get the skills and knowledge. To safely prescribe or administer medication, all nurses and midwives will undertake the following: they will have education around assessing the patient, including medication history; understanding the legal requirements associated with the medication and clinical situation that they are in; have pharmacological knowledge of the medication; and have skills and knowledge related to safe medication administration. The assessment processes of the termination of pregnancy of care may include, but not limited to, performing the pregnancy test that they need, discussing the date and the person's last menstrual period, as well as arranging any other tests that are required. We will work very closely with the educators throughout Queensland Health to make sure education is accessible.

Mr ANDREW: In respect of consultation with registered nursing staff throughout Queensland, what percentage of registered nurses are going to pick this up and run with it? Have you done any consultation across that? Is everyone in the registered nursing sector happy to pick this up? Is there an overwhelming percentage?

Ms Nowlan: At this point in time, I do not have that specific data or percentage of the registered nurses, but what we do know is that the staff we have worked with absolutely want to work to their optimal scope of practice and be able to support community and women's needs, or the staff that they work with. In many instances, we know that in a multidisciplinary team, particularly in regional and rural areas, nurses complement doctors and midwives, as well as other health professionals, to ensure that that is available. As I mentioned before, if a registered nurse is a conscientious objector, there are processes in place to support that personal view.

Mr ANDREW: There is no personal liability at all to the nurses if they go and hand out the medication; it basically falls under the big banner of Queensland Health?

Ms Nowlan: This legislation will be supportive of the registered nurse or midwife or nurses per se to be able to participate in either the support assisting termination of pregnancy or providing the treatment dose. We have professional indemnity insurance as an employee, and every nurse and midwife is required to have that. Of course, this is not taken in isolation of following the protocols that would be set out in the *Queensland clinical guidelines*.

CHAIR: Following on from the member for Mirani's question, there is no obligation here on the registered nurse to do it; it is up to them to take up the additional training?

Ms Nowlan: Yes, that is correct.

Mr ANDREW: I was just asking if there was any consultation done, Chair, that is all.

Mr SMITH: This may assist somewhat the member for Mirani. I want to go to the point around registered nurses and midwives will have extended practice. Perhaps it has not been noted in the bill, but clause 22, proposed new section 6A(2)(b), is 'The practitioner is authorised under the Medicines and Poisons Act 2019', section 54. Let me know if I am right on this: section 54, 'Authorisation of prescribed classes of persons', under regulation. Regulation 2019—'extended practice authorities' which is section 232 in the act. Section 232 in the act, 'Making extended practice authorities'. Clause (1) 'The chief executive may make a document (an extended practice authority)'. Am I right, following that chain down, that then shows that registered nurses and midwives must be approved by the chief executive for extended practice before they can prescribe MS-2 Step? Nailed it?

Dr McDougall: Yes, that is correct. You nailed it.

Ms Nowlan: And also through organisational credentialing at their hospital and health services.

Mr SMITH: That is the legislation chain. I think that is good for all of our witnesses who came before us on the committee as well, making sure that that is there, which is really good. To follow from that, we were provided data by other groups saying that they had data that said that five per cent of delivery of the medication MS-2 Step resulted in complications. Does Queensland Health dispute that particular data set that was put forward? Have you seen that data set put forward by those groups?

Dr McDougall: I have seen it. When you talk about complications, it can get confusing for people because side effects and complications can sometimes be grey. What is clear is that the five per cent mark is well described in the evidence as the number of women who have used MS-2 Step that then go on to requiring a form of surgical procedure because their termination might be incomplete. I think that that is probably the number that has been described. I want to reassure the committee that usually that is not in an emergent-type situation. That is identification and planned, but it would mean that women, in particularly rural or remote areas, might then have to be transferred to a larger centre for that procedure. It is clear in the evidence that severe or serious complication in the form of infection and sepsis or bleeding requiring transfusion is less than one in 1,000.

Mr SMITH: Moving back to the Health Ombudsman, they made a suggestion that for registered practitioners, when the QAC makes a report to the HHS CEO, it then automatically be presented back to the Ombudsman as well; that the QAC do that instead of the HHS CEO. Is there merit in that, or are there any concerns that Queensland Health would have about the QAC making a direct report back to the Health Ombudsman?

Ms Sketcher-Baker: Currently, if there is a registered practitioner who is a quality assurance committee member, they have mandatory reporting obligations. Their mandatory reporting obligations actually require them to report a public-risk notifiable-conduct type issue. They are issues where a registered practitioner has identified that the public are at risk of substantial harm because a registered practitioner has either practised with an impairment or they have practised in a way that constitutes a significant departure from acceptable professional standards. They are already required to do that.

Mr SMITH: The membership on that QAC would have to independently do that anyway?

Ms Sketcher-Baker: That is right.

Mr SMITH: So you would just be doubling up if the QAC, as a body, put in a submission?

Ms Sketcher-Baker: The intent of this change in the legislation is really to be able to notify the health service a lot more quickly so that they are able to consider that information and act a lot more quickly than if it is given to the Health Ombudsman because the Health Ombudsman then has time to actually consider that and then investigate and then will contact the health service. If the health service is notified more promptly, they are able to act appropriately and consider the information and then make the changes required to ensure that the public are protected.

Mr MARTIN: I have a question about implementation. If this bill is passed, do you have an idea of how long it will take for nurses and midwives to be able to provide medical termination of pregnancy? Is it the case that Queensland Health is ready to go or are there gaps that you will have to fill with extra training such as you talked about before?

Dr McDougall: There will be a time period. Certainly, there is still a requirement for the development of materials and additional components of the framework once the bill is passed. As for a time line, Shelley, do you want to talk to that?

Ms Nowlan: Once we know that the legislation is going to move forward, we will actually undertake development of the educational resources that I mentioned before, going to the member's question. We will ensure that the access is given to those nurses and midwives in a timely manner to be able to support that. In the meantime, we will have nurse practitioners, medical officers and endorsed midwives who will have already had access to or be working in that environment. It will just be that they will now be able to do the prescribing of the actual treatment drug for the termination medicine. At the moment, they are assisting medical officers in that role, but mainly it will be the registered nurses and midwives who will need to work under the extended practice authority to have that education and training. There will be a mixed tranche in regards to rolling it out.

Mr Liddy: I might add that the provisions of the bill commence on proclamation and there will need to be supporting regulations developed as well for the medicines and poisons aspect to approve the change to the extended practice authority. That will need to be done as well, before the provisions commence.

CHAIR: Under the banner of the nurse-to-patient ratio, of course, we are moving to a ratio for midwives to babies, which is a fantastic. Can you confirm what the ratio numbers will be? Again, there will be a proclamation. Is there a recruitment program for more midwives as part of this move forward?

Ms Nowlan: Currently, the bill amends the Hospital and Health Boards Act to make clear that, for the purpose of midwife-to-patient ratios in maternity—for a future decision to be made by the minister—a baby should be counted as a separate patient when they are staying in a room on a maternity ward with their parent. The amendment will include stillborn babies in recognition of the care of midwives within that. In regard to actually making the legislation around those ratios, there has been an evaluation undertaken and it is currently informing the department on what that ratio number would be. We did do a trial of one-to-six and we also know that in some areas one-to-eight could potentially be the ratio number as well, depending on the acuity of the mother and the baby and the size of the maternity ward that would be supporting that.

In regards to midwife numbers, there is national work underway with the Nursing and Midwifery Board of Australia called the Midwifery Futures project, which is about understanding the pipeline of midwives nationally. Queensland, the ACT and the Northern Territory are also working on a project at the moment to understand the workforce required for maternity services. We know that there is a balance between the number of midwives coming in and those exiting. At the moment, our current numbers are meeting workforce needs.

Mr MOLHOEK: This is a bit left of field, but I am not sure I got an answer to this question previously. When we were looking at VAD and end-of-life issues, there were some issues with the federal law on carriage laws. Are there any potential issues if there were requirements for a telehealth appointment around termination of pregnancy? If someone were in a rural setting and they needed to contact a doctor in the city or a major region, are there any issues under the current laws that would impact on the ability to provide advice over the phone?

Mr Liddy: I am happy to answer that one. We did provide an answer. It was a question that was taken on notice at the last hearing.

Mr MOLHOEK: Yes, I had trouble printing them out.

Mr Liddy: The Commonwealth provisions are specifically about counselling suicide. That is what they relate to. They do not apply to termination of pregnancy, only suicide.

Mr SMITH: Dr Allan, for us battlers, could you talk us through the Mental Health Court provision and provide some more battler language?

Dr Allan: Simple. When a person goes to the Mental Health Court, a lot of the work is done by having expert opinions given for them. They will see a psychiatrist who will provide a report to the court. That might be one or two reports, depending on the nature of the offence, its complexity and so on. The court uses those things, along with other evidence, to make a decision and they are assisted by two psychiatrists. They are really good reports. There are really good things about the patients, it talks about their life, about their outcomes and can be very helpful. If the matter does not proceed in the Mental Health Court and has to go off to a criminal court, there has been a holdup in releasing those reports and it is only about the offence that took them to the Mental Health Court, but they might have a lot of other offences for which this is relevant.

The idea is that, to assist that person, those reports would be available to the criminal court, and I will go through the process in a minute, and can only be used for three things: to determine if a person was of unsound mind, if they were not fit for trial or to assist in the sentencing—so to use that material to help in the sentencing. It is the report and the transcript that make the context of the

discussion of the report important. It is really to try to help people to get that assistance in other matters that they might have. It has not been used a lot but, as I say, there is material there that could help the person.

There was a bit of debate about whether the person needed to consent but the issue is that in the Mental Health Court they are represented, they have a lawyer, so the court has to make a decision about sending that. Then the criminal court has to decide whether it would accept that evidence and, again, representations can be made to that court to do that but it is limited. Remember, these are mental health interviews; they are not records of interview like the police would have. It is not about whether the facts are there; it is about the diagnosis and the care of the person. That is the main one about the court.

A report might be provided to the court by an independent practitioner. For example, a person could be in jail. Their lawyer recognises that they have a mental illness. They get a psychiatrist in. They do a report. That report says, 'This person is unwell' and it goes off to the court. In that court, that report is then sitting on the court registry waiting for the hearing to be used and in the past the court had to have a mention to be able to get to use it. The court registry, with the court's permission, can then put that off to a treating service so the person can be available for their treatment straightaway.

There might be other circumstances where that report is necessary, say, for other reports. There might be something that arises in that report and the Mental Health Court might like to have another report from another psychiatrist. They can make that report available to help the second person answer a particular question for them about someone. It is all designed to make the information that is gathered in those expert reports more available for the care of people and more available for their outcomes. That is pretty much it in a nutshell.

Mr SMITH: Let us say this comes in and the report comes through to the criminal court. Is it the judge reading the report and then determining how they want to run the case through this? We are talking about getting consent. Is that so that the prosecution cannot use it against the person? In what way is the court going to use it?

Dr Allan: I think we were looking at the criminal law aspects of it. I think the way that it is used is that if the Mental Health Court releases it to the criminal court, and I will be corrected by my colleague here if this is not right, then the court decides whether it wishes to admit evidence or not. That is the judge deciding whether the evidence is admitted and that is on representation from the various lawyers so it could be the defence or it could be the prosecution who will make representations as to why they think this is useful. As I said, it is limited in what it can be used for so it is not a substitute for other evidence. It is about the expert opinions that are available to the court to help them in making a decision.

CHAIR: I have a final question in regards to gender neutral language. The department would be aware that the QAIHC had some concerns with that. Can you clarify if there was any consultation with any Aboriginal and Torres Strait Islander groups in the development of that?

Mr Liddy: We definitely consulted on the bill with Aboriginal and Torres Strait Islander groups and that is where we got the information from QAIHC about their concerns. They provided those representations. We did consider those carefully. A number of different ways of framing the provision were considered and discussed. We did look at alternatives. Unfortunately, the laws have to be drafted for the statute book as a whole. We cannot have special provisions just in health legislation because it then casts doubt on provisions elsewhere across the statute book about their interpretation. In this case, the advice was that the simplest legally effective way to do this was to use 'person' as the gender neutral term and that is consistent with other legislative changes that have been made recently.

Mr MOLHOEK: On that point, in their submission QAIHC came up with an alternative or a solution. At about the fourth page of their submission they asked if it is possible that the legislation could be amended to refer to a woman or person who is pregnant but does not identify as a woman. Was any consideration given to that recommendation?

Mr Liddy: Quite a few of our stakeholders made suggestions during the consultation process about alternative formulations and they were all considered. They were all considered very carefully. What we are going to do, though, is ensure that when care is provided to people in practice—this is about the wording that is in the act. All of the materials and all of the information that is provided to people can use different terminology. It can use broader terminology like 'women' and 'pregnant people' et cetera. Queensland Health's intention is to adopt broader language for all of our materials, our websites and our guidance for people so that it is inclusive.

CHAIR: Do you have any final questions, member for Mirani?

Mr ANDREW: I am good, Chair, thank you.

CHAIR: I thank the Chief Medical Officer, Dr McDougall, and team for coming before us today. Your contributions are very helpful for the body of work that the committee is dealing with at the moment. No questions were taken on notice. I declare this public hearing closed.

The committee adjourned at 12.44 pm.