HEALTH AND ENVIRONMENT COMMITTEE

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

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

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

TRANSCRIPT OF PROCEEDINGS

Thursday, 1 February 2024

Brisbane

THURSDAY, 1 FEBRUARY 2024

The committee met at 10.06 am.

CHAIR: Good morning. I declare open this public hearing for the Health and Environment Committee's inquiry into the Health and Other Legislation Amendment Bill (No. 2) 2023. I am Aaron Harper, chair of the committee and member for Thuringowa. I would like to start by respectfully acknowledging the traditional custodians 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 people, whose lands, winds and waters we all now share. With me today are Mr Rob Molhoek, member for Southport and deputy chair; Mr James Martin, member for Stretton; Mr Tom Smith, member for Bundaberg and substituting for the member for Pumicestone; and Mr Andrew Powell, member for Glass House.

On 30 November 2023, the Hon. Shannon Fentiman, Minister for Health, Mental Health and Ambulance Services and Minister for Women, introduced the Health and Other Legislation Amendment Bill (No. 2) into the Queensland parliament and referred it to this committee for detailed consideration and report. The purpose of today's hearing is to assist the committee with the examination of the bill.

This hearing 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.

CHESTERMAN, Dr John, Public Advocate

CHAIR: Good morning. Thank you for your written submission and your participation today. I invite you to start with an opening statement and then we can move to any questions.

Dr Chesterman: Thank you very much for the opportunity to be here. I also acknowledge that we are on the traditional lands of the Turrbal and Yagara peoples, and I pay my respects to elders past, present and emerging.

As members of the committee know, as the Public Advocate for Queensland I undertake systemic advocacy to promote and protect the rights and interests of Queensland adults with impaired decision-making ability. There are several conditions that may affect a person's decision-making ability including intellectual disability, acquired brain injury, mental illness, neurological disorders such as dementia, and alcohol or drug misuse. As members would know from my submission, my contribution to today's discussion is on one relatively narrow issue concerning the use of Mental Health Court reports and transcripts in criminal proceedings.

As I mentioned in my submission of 20 December and as members know, the bill would amend sections 157 and 157A of the Mental Health Act to allow expert reports given in evidence in the Mental Health Court and transcripts of Mental Health Court proceedings to become admissible in relation to 'any offence alleged to have been committed by the person'. This would include proceedings unrelated to the set of circumstances that gave rise to the production of the Mental Health Court report or transcript.

Currently, section 157 allows an expert report to be used in a criminal proceeding in relation to the same set of facts being considered by the Mental Health Court. Such a report can currently be used to assist the court in deciding about the person's legal culpability and in determining whether to sentence the person or place them under a forensic order. The proposal is to allow reports and transcripts to be admissible in relation to any offence. This could be in the person's interests, and I do support it in principle, but I have suggested some further safeguards such as requiring that the person consent to the use of relevant materials. Otherwise, as my submission notes, past reports and transcripts could be prejudicial to the person's interests, and I can talk about that further in discussion later on.

My submission also discusses section 157A, which enables a magistrate to use an expert report tendered to the Mental Health Court in considering the dismissal of a complaint because of the person's unsoundness of mind or unfitness for trial, or an adjournment due to the person's unfitness

for trial. The change would allow a magistrate to use a Mental Health Court report or transcript in proceedings for any offence, not just in relation to the set of circumstances that gave rise to the production of the particular report or transcript. As I say in the submission, I am not troubled by this, given the more limited use to which such reports and transcripts will be able to be put—namely, to potential dismissal or adjournment of Magistrates Court proceedings—and indeed the fact that it would be a magistrate considering them. Thanks again for the opportunity to comment on the Health and Other Legislation Amendment Bill No. 2. I welcome members' questions and observations.

CHAIR: Thank you very much, Dr Chesterman. I am just trying to bring up the submission of the Queensland Law Society because they had a view on parts of this as well. I will examine that in a little bit and come back to you.

Mr POWELL: You have said—and it is reiterated in your written submission—that the safeguard you are proposing is that the individual be able to consent to those Mental Health Court reports being used. Is it always going to be the case that the individual will have the capacity to provide consent or otherwise?

Dr Chesterman: Yes, that is a good question. I was reflecting on that before I came here. You are right: there will be some situations where a person will not be able to make that determination because of the nature of their current situation, illness or disability. I think the way to craft it might be to say that they do not object to it but to be given the opportunity if they were to object. The concern I have simply—and this is just looking at the possible use to which these materials could be put, not so much the intention of the proposed legislation—is that you could have a situation where, for instance, a previous report suggests a person was not able to make their own decisions back then but now currently they can or vice versa. There would be situations where it could work against the interests of the person and indeed lead to some inaccuracies, but I think offering the person the possibility of saying, 'No, I do not want that to be used,' is an important safeguard.

Mr POWELL: A bit like you, I can see there is potential benefit to the individual that some of that material might be provided to the court, but you have just again highlighted one of the possible drawbacks is that, because it is historical, events may have moved forward and the individual is no longer suffering perhaps the illness that they were when those reports were provided. Thank you for that.

Dr Chesterman: That is right. To follow on from that, I think largely this is beneficial because the person will not be subject to getting multiple reports, and that is important for them and for the system generally. However, I am thinking through some of the uses to which this could be put. Another example is that something is said in a transcript of evidence that the person may subsequently be embarrassed about but might be used in sentencing, which could again be unfortunate.

CHAIR: I will read this paragraph out of the submission of the Queensland Law Society, who delved into this as well. It states—

> QLS is also supportive of the proposal to ensure that Mental Health Court transcripts are admissible in criminal proceedings for the purpose of consideration of a person's unsoundness of mind, fitness for trial or for the purpose of sentencing a person. QLS can see the benefit of these transcripts being admissible in certain circumstances and importantly, we note the Courts will retain their discretion to admit evidence in this regard.

Do you have some comments with regard to that?

Dr Chesterman: No. I think that is right. I would agree with that. I am just trying to think of one way of providing an additional safeguard, which would be just to give the person the opportunity to say, 'I do not want this utilised.' I would think ultimately the court would have the discretion to use it or not use it. I think giving the person that opportunity is an important potential safeguard, to make sure that if the person, for instance, is objecting then the court takes that into account in making a determination.

Mr MOLHOEK: Thank you, Dr Chesterman, for your advocacy on this—as always, an excellent submission. Are you suggesting that the best way to deal with this would simply be that at the starting point a person has a right to say, 'I do not want that information made available,' but the court can still determine whether it is relevant and should be made available?

Dr Chesterman: I think that probably is the best way forward, yes, as we talk about it now and as I think about operationalising it, how it would work, because there may be situations where a person vehemently objects to it but it is not a particularly sound reason to object to it. It may still be relevant. But I think that is right. I think giving the person an opportunity to voice that and allowing the court to make the determination is the right way forward.

Mr MOLHOEK: I do not know if you saw the CCC's submission, but are they referring to the same information?

Dr Chesterman: I have not read their submission.

Mr MOLHOEK: They talked about some drafting concerns around access to information, but I am not sure if they were referring to the same information or something different.

Dr Chesterman: Sorry, I have not read that. I can go away and do that.

Mr MOLHOEK: I had trouble understanding what they were referring to. I thought you may be able to shed some light on it.

Dr Chesterman: I may, too.

Mr SMITH: I am just trying to go through the steps. Before we get to the Mental Health Court or criminal court proceedings there is a review through the Mental Health Tribunal, is that correct, if that is forming a defence?

Dr Chesterman: A matter can be referred to the Mental Health Court where the issue in play is that a person was potentially of unsound mind when the alleged offence was committed or, indeed, that they are not fit for trial. That is a referral that can be made to the court by the prosecutor or, indeed, the person's representative can argue that that should be heard by the Mental Health Court.

Mr SMITH: In a sense, does that protect capacity of a defendant in a criminal proceeding if they have been judged fit by the Mental Health Review Tribunal to be of sound mind; therefore, they have capacity in a criminal proceeding to make the decision themselves as to whether or not they wish to agree to having a former document come forward through the Mental Health Court?

Dr Chesterman: I will get you to rephrase that.

Mr SMITH: Your concern—very valid concern—is that if someone is in a criminal proceeding and they are in a criminal court, they should have the right to consent as to whether or not a previous document through the Mental Health Court will come into this criminal proceeding. If they have been judged by the Mental Health Review Tribunal that they are of sound mind and that the proceeding can go through the criminal court and not through Mental Health Court, does that not safeguard their judgement of capacity?

Dr Chesterman: If they are deemed to have capacity then it is a criminal court matter and so this is not so much in play. Where it is in play is: where the Mental Health Court is considering a ruling on unsoundness of mind or unfitness for trial, they can use, under the proposal, in relation to any offence, a previous report. If it goes through and the person is deemed to have the capacity in relation to the particular offence—and that may be partly because they are relying on a previous report or for other reasons they make that determination—then it is treated as a criminal matter.

Mr SMITH: What I am saying is: if there are questions around the capacity of an individual who is a defendant in a criminal court setting, does the Mental Health Review Tribunal have the ability to put forward to the courts that they believe that this person may not be of sound mind and capacity? I suppose what I am getting at is: if we have the Mental Health Review Tribunal and we have the Mental Health Court and then we have the criminal courts, if there is an assessment that has been made that this person is fit and of sound mind to go through the criminal court proceedings instead of the Mental Health Court, does that not safeguard the judgement of capacity?

Dr Chesterman: I think the issue of capacity is what is determined at the Mental Health Court level in relation to an alleged offence. We were also talking earlier about the person's ability to make a determination on whether you should use this report or not, and there will be some situations where the person is not able to make that determination, but I think my response to that question was to say that they ought to be given the opportunity to express their view and for that to be taken into account by the court. The whole Mental Health Court system is there to safeguard a person who is, for one reason or another, deemed to be not competent at the time of the alleged offence or not fit to be tried.

CHAIR: Thank you, Dr Chesterman. Thank you for your contribution here today.

BAKER, Mr Alan, Vice-President, Cherish Life Queensland

PURCELL, Dr Donna, President, Cherish Life Queensland

CHAIR: Welcome. Would you like to make an opening statement?

Dr Purcell: Thank you for the invitation to speak to our written submission, which addresses part 6 of the bill pertaining to changes to the Termination of Pregnancy Act which would permit nurses, midwives and other health practitioners to provide medical abortion. I will briefly summarise the reasons for our opposition to this. Cherish Life Queensland's founding principle is respect for all human life, from conception to natural death. Because the termination of pregnancy is actually the termination of a living, unborn human being, we oppose this legislation, as we did the Termination of Pregnancy Act when it was debated and passed in 2018. The development of the unborn is an amazingly intricate unfolding of genetic encoding from conception, when a new human life begins. Sciences are uniquely positioned to inform the debate on abortion, yet it is curious that no-one objects to information being provided when a woman is happy about being pregnant but it is suppressed, ignored or reduced to being a blob of tissue when abortion is proposed and championed.

The second reason is the process of medical abortion itself, which has a range of possible serious consequences. The principal serious side effects of a medical abortion are pain and bleeding, which can continue on average for 10 to 16 days and can be serious in five per cent of cases, requiring emergency treatment. Bleeding can also be an indication that the abortion is not complete or did not occur at all. Failure of medical abortion occurs in up to seven per cent of cases before 63 days of pregnancy, which is the limit of this bill. An incomplete abortion is also a potential source of infection and has caused the deaths of women, as reported in large overseas studies. Two further deaths have occurred as recently as April 2021 in Argentina following the legalisation of abortion there the year before and in Canada in 2022. Both of these women died from septicaemia, or septic shock as some people call it. There is also the chance of failing to diagnosis an ectopic pregnancy, where the unborn is situated outside the uterus, usually in one or other of the ovarian tubes. Medical abortion in this circumstance will fail due to the abnormal positioning, but the consequent bleeding can mask and confuse the cause of the bleeding which can be caused by an ectopic pregnancy and delay the necessary surgery for this condition.

For all these reasons, the Therapeutic Goods Administration has consistently urged ultrasound to be performed where possible prior to medical abortion to have an exact gestational age, because risks increase as the unborn is more advanced, and to exclude ectopic pregnancy. The TGA is also insistent on the need for a follow-up appointment within 14 to 21 days, even if there have been no obvious adverse consequences, to ensure the abortion is complete. Although the TGA lifted its regulatory requirements on doctors and chemists last year, it has not seen fit to change any of the cautions and warnings around the use of these agents. This includes a requirement that patients must have the ability to access 24-hour emergency care if and when required for incomplete abortion or bleeding.

The stated purpose of this bill is to increase the provision of abortion in areas of the state referred to commonly as a postcode lottery—that is, more rural and remote areas. However, this will be accompanied by the maternal morbidity associated with medical abortion which I have outlined, and they are also areas that already lack the necessary resources the deal with the consequences. As this bill does not allow nurses and midwives to perform surgical abortion or the procedure called a curettage, which is necessary to handle excessive bleeding and incomplete abortion, they will then still have to call upon medical practitioners or accident and emergency facilities in larger regional towns which may be several hours travel away. There may also be delays and limits on essential radiography services—that is, ultrasound.

Parliamentarians are being asked to vote on a bill which will increase the number of abortion providers, the majority of whom will still likely live and work in urban and metropolitan areas. Since legalisation of abortion in 2018, the incidence of medical abortion has increased, as discussed in our written submission, and this bill will further that expansion. It will also result in an increase in the morbidity caused by medical abortion. Those working in the more regional and remote areas will still be faced with limited means to handle emergencies which will inevitably arise. This bill is bad law because it will put the lives and health of more women, particularly those in those regions, at risk and we urge you to recommend that that section of this bill not proceed.

Mr POWELL: Thank you for your written submission. My views on abortion are on the public record and probably align very closely to those of Cherish Life. I have been around the parliament long enough now to have considered a number of bills around abortion. The first bill that we dealt

with early in my political career was actually expanding the definition of how an abortion could be administered from just surgical to include medical. Many of us took an approach that that was not expanding who could receive an abortion; it was just changing the means by which an abortion could be administered. There was then the Termination of Pregnancy Bill, which clearly expanded the numbers of who could apply for an abortion, and now we are back at a bill where it is more around how it is administered, not who can receive one. I think I have heard very clearly that you still object for a range of reasons and most of them are to do with morbidity of the mother and concerns around that, but is there anything you want to add based on that sort of historical little synopsis I provided where we have gone from looking at the technical application of an abortion, to expanding abortion, to now back looking at the technical application of it?

Dr Purcell: Not myself, I suppose. I would like to draw attention to the fact that in the Termination of Pregnancy Act and then in this one also there is no real reference to the idea of people collecting data about all this. I know that in the Termination of Pregnancy Bill there were amendments to do that and they were refused or voted down. Similarly here, there is certainly no reference to doing that. You are expanding the arena of people who can do this. I think it is very important to find out exactly how that might affect the number of side effects and the range of problems that might exist where you have gone from medical people who obviously have more training—I am not trying to be demeaning of nurses, but that is obviously the fact of the matter. Nurses have to be able to recognise when indeed there is a problem to start with. Sometimes where a woman has been bleeding for a length of time, the bleeding can be disguised in a way and they actually can be sicker than they think they are. I am just talking about gathering statistics and data. You are expanding it to nurses and you are also talking about other health practitioners who are not named, whatever type of people they may be, but there is no idea or concept to collecting information about this. Indeed, even in terms of medical abortion itself in Queensland, I am not aware that there is any way of people actually collecting data about it.

CHAIR: I draw your attention to the submissions from peak bodies QNMU, the College of Midwives and the College of Nursing. Earlier you talked about the postcode lottery. Those submissions certainly talk about equity and access to termination of pregnancy, particularly in rural and regional Queensland where there could be significant delays in travelling to a major area. Do you have a view on those three submissions?

Dr Purcell: I did read them initially when I was preparing, but I have not refreshed my mind about it. There are delays there, but there are delays in getting help if necessary too. I suppose that is my main concern.

Mr Baker: Our main concern is about the health and welfare of women. In 2014, the TGA stated that when heavy bleeding occurs due to the pills it usually reflects incomplete abortion, is observed in approximately three to 12 per cent of cases and necessitates a blood transfusion in up to 0.2 per cent of cases. You are probably well aware of Dr Pecoraro's statement about the risks of expanding medical abortions to remote and rural areas that are far away from emergency facilities needed to save a woman's life. He says that he had a patient who was flown in from northern New South Wales and he had to save her life. Dr Pecoraro stated—

> It's a dictum in medicine that you shouldn't be prescribing something if you can't deal with the complications of it. I'm just concerned that on the surface this looks like a wonderful thing to increase access to regional and remote disadvantaged women … but the first rule has to be to do no harm, and I'm not convinced we're not going to do harm.

A 40-year-old woman was flown from New South Wales after being prescribed the abortion pill. Dr Pecoraro was summoned. She was experiencing significant side effects and bleeding. He said she nearly died.

We are going to unnecessarily put women at risk in remote and regional areas by allowing nurses and midwives to administer the pill when they have no way of treating that woman or saving her life and they are going to be hours and hours away from the medical help that is required for that woman. That is our main concern: the health and safety of women.

Mr MOLHOEK: Is that part of your submission?

Dr Purcell: Yes, it was in the written submission.

Mr MOLHOEK: I am sorry. I did not read that.

Mr MARTIN: I note from your submission that you claim that this legislation will put women's lives at risk. My question relates to the roles of trained nurses and trained midwives and doctors. Queensland Health has advised the committee that nurses and midwives have the necessary qualifications and skills to essentially administer this medication. Do you disagree with that? Are you saying that they cannot be qualified or they do not have the skills? Is it only doctors—

Dr Purcell: It is not so much the skill of giving it; it is dealing with the consequences. As I noted in my opening statement, they are not given the permission to do a surgical abortion, which follows up an incomplete abortion. That is what most people would go on to do, although some women have decided not to if the abortion failed. They do not have the ability to do the other procedure, a curettage—or some people call it a D and C—which is used to treat heavy bleeding or incomplete abortion. I am not saying that they cannot give a pill. Most people could do that. Obviously, they have to be, I think, also skilled in the provision of the information, the pros and cons, and giving information about what could happen and alternatives. That is the big problem: they are not equipped to do what has to be done. Maybe very urgently they might have to arrange transport or talk to a doctor, if there is a doctor in town who does it, which obviously in remote areas is going to be pretty unlikely.

Mr MARTIN: What is the difference between that example and, say, if a GP was in town and a GP prescribed—

Dr Purcell: The difference between what, sorry?

Mr MARTIN: In the example that you gave, the nurse would not do the follow-up surgery and a GP likely would not do it either. It would be referred on.

Dr Purcell: Most GPs would not do it, no. Obviously you have to have anaesthetics as well, the whole set-up, in that town to be able to do the follow-up work if necessary. Obviously, a transfusion requires a blood bank or access to blood supplies. That may take some hours to get to them, too. It is all those things together.

Mr SMITH: Previously when I have met with Cherish Life around voluntary assisted dying it has always been very cordial. I really do respect the positions you are taking in being here today. I will frame my question within the context of the 2018 act, where termination of pregnancy is decriminalised. It is happening. It is very much a part of society and community. Women are accessing some form of termination of pregnancy. Women in regional, rural and remote communities who wish to have a pregnancy aborted but are unable to access medical health care are finding their own ways to have a termination of pregnancy that often can lead to very severe complications and the risk of death. Within the context of the law of the land as it stands, is it safer to provide MS-2 Step to women in regional, rural and remote communities or not provide that medical point of contact and continue to allow women to do backyard abortions? Which is a safer method?

Dr Purcell: Personally, I have not heard of any cases of backyard abortions occurring in those areas. It is a very unlikely and outdated thing to happen these days.

Mr SMITH: So you do not believe that anywhere throughout Queensland women who are unable to access medical forms of termination of pregnancy, whether through a medical drug or surgery, are finding ways to abort right now? You do not believe that?

Dr Purcell: I do not know if they are but I have not heard of any. Usually it would be quite prominent in the media if they are. To be honest, they probably usually go on and have the baby.

Mr Baker: There is no evidence whatsoever of what you are suggesting, Mr Smith, is there?

Mr SMITH: Which would be safer, though? Would it be safer to allow women to try to perform their own abortion—

Mr Baker: It is a speculative scenario.

CHAIR: We do not want to argue.

Dr Purcell: There are obviously risks—

Mr SMITH: We will not argue. I note that I have put the question and the question has not been answered.

Dr Purcell: We have as well as we can.

CHAIR: I will ask you a question around conscientious objection. The provisions within the Termination of Pregnancy Act will apply to the extended class of health practitioners being authorised to provide medical abortions; however, your submission notes on page 8 that the requirement of those provisions for objecting practitioners to refer to another participating practitioner will create difficulty for nurses and midwives in rural and remote areas of the state. Do you have any further submissions for the committee regarding that statement?

Dr Purcell: No. It was more of a question than a statement. What I was referring to is that, under the current legislation, anybody who is a conscientious objector and is not wanting to be involved in an abortion must then find another person who will. I understand that referred to doctors. This is probably a different situation because I understand that the nurses or midwives would have to

prove their ability to do this, so that is somewhat different. There could be a situation where a nurse is asked to do it in a remote area. If she is not willing to then is she covered by her hospital or her union for that purpose? It can put pressure on her to try to find somebody else to do it. It was more of a question rather than a statement when I wrote it.

Mr Baker: Dr Gino Pecoraro, to whom I referred earlier, is President of the National Association of Specialist Obstetricians and Gynaecologists. His estimation is that five per cent of all medical abortions lead to complications. The manufacturer of the MS-2 Step, in the product information, says that the failure rate is seven per cent prior to 63 days, making follow-up mandatory. There is this health risk if we are going to be pushing it out. The only reason I would suggest that midwives and nurses are going to be given, under this law, the legal ability to perform medical abortions is for the supposed benefit of women in regional and remote areas because it is so easily accessible elsewhere in the state, as is evidenced by the big increase in the numbers of medical abortions over the last five or six years since the act came into force.

CHAIR: There are no further questions. I understand this is a divergent topic and I understand your position. I take your point, member for Bundaberg. We have always listened respectfully to everyone's views on this. Thank you very much for your participation today.

FISCHER, Ms Christy, Senior Team Leader, Children by Choice (via teleconference)

VALLURY, Dr Kari, Senior Research Officer, Children by Choice (via videoconference)

CHAIR: Thank you for your written submission and your participation today. Would you like to make an opening statement before we move to questions?

Ms Fischer: Thank you for the opportunity to speak to Children by Choice's submission to the inquiry into the Health and Other Legislation Amendment Bill (No. 2) 2023. I would like to acknowledge that we are on unceded Turrbal and Yagara people's land, Meanjin. We recognise that reproductive justice for First Nations women and children traditionally has not been available to them and that the right to have children and choose to keep children, as well as the right to abortion, is important to First Nations women.

Children by Choice was founded in Queensland 52 years ago and is funded by the Department of Justice and Attorney-General in Queensland to deliver counselling, information and education services on all pregnancy options. We advocate for improvements to law and policy that would expand Queenslanders' access to compassionate, trauma informed abortion and contraception services. Our service speaks to people daily who face significant access challenges due to unclear public pathways and systemic challenges such as workforce shortages, while an overwhelming majority of our clients interact with termination-of-pregnancy care in their first trimester of pregnancy. Delays before nine weeks gestation often force abortion seekers to find surgical options that are becoming less available in Queensland. This can be attributed directly or indirectly to service failures within systems of care. Our submission speaks to the real-life impacts of barriers to abortion including abortion stigma, inadequate access to affordable referring or providing doctors, unclear information about public pathways in HHSs, and workforce shortages that all contribute to negative physical and psychosocial outcomes for Queenslanders.

Poor access to timely, quality abortion care disproportionately affects priority populations. For example, our clients from regional, rural and remote Queensland seeking pregnancy decision-making support and abortion access, when compared with metropolitan clients, require more contact with our client counsellors, need greater financial support and are more likely to report experiencing domestic violence and sexual assault. Our data shows that those clients also travel more than five times the distance to access abortion services. These inequities undermine Australia's commitment to universal reproductive health care by 2030, established by the National Women's Health Strategy.

It has been five years since the decriminalisation of termination of pregnancy in Queensland and there is an expectation from consumers that anyone can receive compassionate, affordable health care from their health system. This will require a commitment from the Queensland government for appropriate, adequate resourcing to ensure statewide collaboration and consultation with consumers and health practitioners. The proposed amendments align with the needs and experiences of our clients and with evidence-based practice. The changes will enable substantial access improvements for Queenslanders.

Children by Choice supports the Queensland government's commitment to updating legislation that allows nurse practitioners and endorsed midwives to prescribe and administer a registered termination-of-pregnancy drug. Increasing service accessibility is integral to delivering equitable and universal health care for all, recognising that abortion is health care. Our submission outlines how the proposed changes will lead to substantial and tangible benefits to the lives of our clients. These changes will likely reduce abortion delays and harm by lessening pressures on overburdened GPs and medical specialists. These changes are in line with international best practice.

Across Queensland, nurse practitioners and endorsed midwives already work as champions of HHS pathways and have substantial roles in the delivery of abortion care including post-abortion care. To not approve these proposed amendments will severely limit Queensland's capacity to meet the community's commitments outlined in the Queensland Sexual Health Framework, the Australian government Women's Health Strategy 2020-2030, the upcoming Queensland Women and Girls' Health Strategy, as well as the Termination of Pregnancy Action Plan being developed by Clinical Excellence Queensland.

We are also supportive of updating the proposed legislation to align with non-gendered and inclusive language. Currently the Termination of Pregnancy Act 2018 does not align with inclusive language adopted in similar legislation in the ACT, New South Wales, South Australia and New South Wales. This change would also align with other recent Queensland legislation which removes unnecessary gendering to ensure public information meets the needs of groups requiring plain

language. The proposed amendments support consistency as well as inclusion. Laws are designed to encapsulate all relevant people and acts, and the proposed language will ensure all pregnant people fall under the act. We welcome any questions from the committee.

CHAIR: Thank you very much. Just before we move to questions, Dr Vallury, I am wondering whereabouts you might be at the moment. Do you practise in Queensland or whereabouts are you situated?

Dr Vallury: I work for Children by Choice. I am currently on Kaurna land in South Australia but I have been working in Queensland for three years now.

Mr MOLHOEK: Can you ask the same question of Ms Fischer. Are you based in Queensland?

CHAIR: Christy, whereabouts are you?

Ms Fischer: I am based in Meanjin, Brisbane, in Queensland.

Mr MOLHOEK: In your submission on page 7 you raise concerns that your clients who live in rural and remote parts of the state require additional supports to be able to access services. I ask for some commentary around whether you think the proposed amendments will help those people. We just heard from Cherish Life and they raised concerns around complications. I would be interested in your comments on that as well.

Dr Vallury: Sure. I can talk to this. As we say in our submission, our rural, regional and remote clients travel further, spend more money, experience more delays and are more likely to get pushed out of the nine-week limit that is currently on early medication termination of pregnancy. We also know, because we work with health practitioners as well through all of the training and advocacy that we do, that there are teams of nurses and midwives ready to go, already doing all aspects of abortion care in these regional areas except the prescription.

In Mount Isa they have been doing all aspects of this care, including post-abortion care, for some time now but have to wait up to four weeks for someone to come and prescribe the medication. If someone presents at five weeks gestation looking for a termination, which is very common—that is very early in the pregnancy; it is actually about one week after your expected period—they will automatically be pushed out of that time line. We are then forcing rural people who need a support person with them to access a surgical termination to travel, get child care and deal with all of the costs and the additional complications that do not need to be there, psychosocially. Absolutely these amendments will make an incredible difference and quite immediately. We also have teams ready to go in Townsville. We have teams of nurses and midwives ready to go in multiple places.

In terms of complication rates, I did not listen to the Cherish Life discussion but I have read their submission. They cite an approximately five per cent complication rate, which is not exactly accurate. The research shows that 4.8 per cent require a surgical or manual evacuation, or aspiration evacuation, which in itself is not a risky procedure. It is just inconvenient, I suppose, for someone to need that, but it is not risky in itself. The major complication rate of early medication termination of pregnancy is under 0.03 per cent. This is lower than almost all drugs on the market. The question of risk and danger has been already decided and clarified by the TGA. The TGA are the pharmaceutical experts. They would not have expanded the provisions to a broader range of health professionals if it was unsafe. I think there is no reason that we or all of the members in this room today would claim expertise over the TGA.

Mr MOLHOEK: Dr Vallury, have you or Ms Fischer done any rural or remote health service? Have you worked in a rural or remote health services yourselves?

Dr Vallury: Yes, Christy has.

Ms Fischer: We as an organisation have done work, and we do quite a lot of education work in rural, remote and regional Queensland in particular. We did a whole project which was a number of years. A lot of the work that we do is in collaboration with sexual health and hospitals in those areas. From Children by Choice's position, it is within an advocacy, training and support capacity as we are not a medical service.

Mr MOLHOEK: So neither of you have actually been a rural doctor or a rural nurse or health practitioner?

CHAIR: I do not think that is the case here.

Dr Vallury: I am not sure if that is relevant because we were not invited here as health practitioners. We were invited here as experts because we speak to many thousands of abortion seekers a year and thousands of health practitioners who are practising regionally. I am not sure whether we should spend time on that, to be perfectly honest.

CHAIR: I note in you submission the thousands of people you have assisted with education.

Mr POWELL: Thank you for your submission and for appearing today. Dr Vallury, you just confirmed that potentially 4.8 per cent of women who use the medical form of an abortion may require a subsequent procedure. Are they surgical procedures that you referred to? If MS-2 Step was administered by a nurse or a similar health practitioner somewhere in Western Queensland, would they be able to receive those subsequent surgical procedures close by? Say it was Boulia, Longreach—

Mr MOLHOEK: Mount Isa.

Mr POWELL:—or Mount Isa. Can you clarify that?

Dr Vallury: A manual or a vacuum aspiration is the exact same procedure done for miscarriage. We know that most hospitals provide services like this, even if they are not calling it abortion services for whatever reason. I cannot speak to specific health clinics. If someone in Mount Isa currently gets a prescription from a GP, takes the early medication termination and then needs to seek surgical follow-up, it is the exact same procedure. We know that that is already happening. There is no change there. Those systems need to be in place throughout Queensland anyway. People who need follow-up from surgical termination of abortion are back in communities often when they are needing that follow-up. There needs to be a whole-of-health-system approach here to a full, comprehensive suite of abortion care. This is not changing anything except for accessibility, and the numbers are low. We have talked about the low numbers. That sort of care is not often urgent, but I think you need to speak to a doctor around the specifics of time frames.

Mr POWELL: Thank you for expanding on that.

Mr MOLHOEK: To clarify, if someone in Boulia, for example, does the [MS-2 Step process and ends up with significant bleeding, as was alluded to in some of the submissions, are they going to be able to get to, say, Mount Isa in a timely enough manner to avoid risk to life? We have heard people talk about excessive bleeding. How at risk are they if they are perhaps a two-, three- or four-hour drive away from being able to have that evacuation procedure?

CHAIR: Medical retrieval would probably assist there.

Dr Vallury: We are not medical doctors. This is the same as any other major health issue in the health system. As we said, the proportion of EMA patients requiring transfusion is 0.03 per cent—not even 0.3 per cent but 0.03 per cent—so it is very uncommon. I would hope the health system is set up to help anyone who is experiencing haemorrhaging from any procedure or health condition they might have.

Mr MARTIN: The legislation is not proposing to change any of the conscientious objection provisions; however, I note that in your submission on page 12 you state—

> Health services receiving public funding should not have the institutional right to conscientious objection and must provide compassionate abortion care as a public good.

Could you expand on some of the problems you see with conscientious objection and people receiving health care?

Ms Fischer: When we are looking at conscientious objection it is really looking at the impact on individuals, and the impact is great on individuals who are being refused care. The stance that Children by Choice has is that publicly funded hospitals should be providing health care and making sure systems are set up to ensure that is being provided for when they do have doctors or health professionals who are conscientious objectors. Where we stand is that publicly funded hospitals and health institutions should be set up so that all health care is provided to people and that if there are conscientious objectors who are within those healthcare systems there are systems set up to ensure that is not causing harm or delay to people seeking that basic health care.

CHAIR: In your submission on page 4 you talk about appropriate information and resources that will be required to support health practitioners and consumers in light of the proposed amendments in the bill. What resources do you suggest will be required?

Dr Vallury: As we have said, we work with health professionals all of the time who are debating and entering into this kind of work. They need supportive systems. Those supportive systems are difficult to put in place without resources, so they might be physical resources—their training or their values clarification activities. They need evidence-based information to be able to psychosocially and practically provide that care—for example, having phone numbers, knowing who to call if they need follow-up support, and of course they need all the technical information—all the other aspects of reproductive health. Christy, do you want to add to that?

Ms Fischer: Yes. It is also about making sure that information is accurate and available. I think there is a lot of misinformation online. It is really challenging for people to find information on what the pathway is, what the process is—particularly information that is in plain English or that is in easy English for different population and priority groups. We think it is really important that resourcing and education is rolled out across Queensland around what this looks like and how you would get access.

Mr SMITH: The Abortion and Contraception Services Map is a very important tool that is being displayed by Children by Choice. Is this self-reporting in terms of: do the practitioners enter the information or how often is it updated?

Dr Vallury: Providers register to be on the map. They can be on the public-facing map, which you can all see. We also have an internal version, which has more listings for people who want us to be able to refer to them our counsellors but who do not want publicly available services. About 75 per cent of providers are on the public map and about 25 per cent are on the internal map. It is not mandated. It is based on how well we are able to promote it. It was funded by a grant and it is topped up by very small donations by different bodies. The map is not government funded. We update it monthly, which some providers find challenging, but the costs of physically engaging with the software company to update it are so expensive that we cannot update it more than monthly. That involves taking people off, changing names, changing details and putting new practitioners on.

Mr SMITH: I ask because I have been talking to Wide Bay health professionals based in Bundaberg who have raised concerns that women in Hervey Bay and the Fraser Coast are unable to access any form of termination of pregnancy because of conscientious objection, and they are highlighting concerns where they have reported to me of women taking their own methods which can even be something as excessive drinking of alcohol in the belief that that will terminate a pregnancy. Are there similar circumstances where Children by Choice have had women come forward to tell stories about the non-medical methods they have used to attempt an abortion?

Dr Vallury: I looked at the data very recently. It is about two per cent of people who seek our post-abortion counselling support, and I have seen other research that suggests in Australia it is at about two per cent as well. From our perspective, two per cent is way too much in an area where service is legal, and it really speaks to barriers. Christy, do you want to speak to client experience?

Ms Fischer: Yes, I would agree with Kari that what we are hearing from clients is that when people cannot access the abortion care that they are needing or wanting they do try self-abortion methods, which is dangerous, and then end up presenting to hospitals in emergency situations.

Mr HARPER: Thank you very much to both of you for your contribution today.

YIM, Dr Nick, Vice-President, Australian Medical Association Queensland (via videoconference)

CHAIR: Dr Yim, thank you for your written submission. I invite you to make an opening statement before we move to questions.

Dr Yim: I thank the committee for the invitation to attend this public hearing about the bill. The amendments of most relevance to AMA Queensland are those concerning medical terminations of pregnancy. As such, I will be confining my comments to those parts of the bill. AMA Queensland understands the real issues patients have in accessing medical abortions, including medicine including MS-2 Step. Doctors know that this is a critical issue, particularly for those people living in regional, rural and remote communities. I am a GP in Hervey Bay and I know that even in my community there are limited doctors who can prescribe and there are limited pharmacists who can dispense MS-2 Step. This is because the training, until now, has been overly burdensome. I myself have never managed to complete the previous mandatory training requirements because it demanded too much of my time. It was quite bureaucratic and it took me away from treating my own patients.

Changes are clearly needed to improve access for all patients, regardless of where they live. That is why AMA Queensland welcomed the recommendations made by the Australian Senate Community Affairs Reference Committee. Those recommendations included that the burdensome training requirements for doctors and pharmacists be removed. We anticipate that this will greatly increase access to medical terminations throughout Australia, not just Queensland, and we look forward to seeing its impact.

In addition to removing the training requirements, the Senate committee also recommended extending those practitioners authorised to prescribe MS-2 Step to registered midwives, nurse practitioners and Aboriginal health workers. It did not likewise recommend it extend to registered nurses. That is because the practitioners specified by the Senate committee already have requisite training and experience to safely prescribe these medicines. They also work within suitable settings, including private teams, to ensure safe treatment.

Medical abortion carries serious risks for patients including uncontrolled bleeding which can result in the need for blood transfusion or even death. Other risks include infection and incomplete termination of pregnancy. It is a schedule 4 medicine, which means it carries certain risks and must only be given after proper clinical assessment. This is why MS-2 Step prescribers must be able to accurately date pregnancies, exclude ectopic pregnancy via pelvic scan, and determine if patients are at risk due to other (inaudible).

Prescribers must also ensure appropriate escalation pathways are available, including access to local emergency health care. This means patients must be able to reach a local hospital emergency department within two hours of experiencing adverse symptoms such as heavy bleeding.

It is AMA Queensland's view that registered nurses do not have the necessary training or skills to independently prescribe MS-2 Step. It is also not safe for registered nurses to administer these medicines outside of a collaborative setting with appropriate clinical oversight. This is likely the reason the Senate committee did not include RNs in its recommendation for extension of authorised MS-2 Step prescribers. For those reasons, AMA Queensland urges the current committee to recommend the Queensland government only make those amendments in the bill that would enact the Australian Senate committee's recommendations. Those recommendations were based on broad and comprehensive consultation with a range of independent research bodies and appropriately qualified stakeholders. This means the committee must only recommend extending the range of practitioners authorised to prescribe MS-2 Step to registered midwives, nurse practitioners and Aboriginal health workers but not to registered nurses.

AMA Queensland likewise submits that the committee considers recommending all Queensland Health hospitals be required to provide termination-of-pregnancy services, or at least associated pathways, in line with recommendation 15 of the Australian Senate committee report. That would ensure all amendments are evidence-based and consistent with Australian government reforms and other jurisdictions. It is also something that AMA Queensland has consistently advocated for the Queensland government to do as standard practice. Thank you for your time. I am happy to take any questions.

CHAIR: Thank you, Dr Yim. When medical practitioners prescribe MS-2 Step, does every single patient get a pelvic scan? What is the current situation?

Dr Yim: The current situation, speaking with colleagues, is that the majority of patients do undertake a pelvic ultrasound scan. It is those practitioners—prescribers, doctors who are highly experienced; those are the ones who work day in and day out—who may prescribe without a pelvic ultrasound scan.

CHAIR: You said 'majority'. Do you have some data there, or can you provide the committee with data?

Dr Yim: I do not have specific data but, based on my own practice—we do have prescribing in in my practice—Kay organises a pelvic ultrasound scan for all of her patients.

CHAIR: That cannot happen across the state currently.

Dr Yim: Correct. A lot of it is anecdotal data. Anecdotally, it is probably 50 per cent.

CHAIR: I note also you talk about training. Your submission raises patient safety concerns about RNs. I am going to take you somewhere. I have a 30-year history with Queensland Ambulance Service. Critical care paramedics are trained to give thrombolysis. That carries a significant risk of ongoing bleeding. I have done that myself in my clinical career, and there are a number of safety steps that you go through. It has clinical oversight as well. We just heard from Children by Choice. They said 0.03 per cent may have a need for follow-up with a D and C or whatever step might be required. I am trying to put it in context. When you talk about risk of bleeding, there are medical practitioners out there doing thrombolysis and things like that. I wanted to get your view on that. You are saying that RNs and nurse practitioners should not or could not?

Dr Yim: We are recommending that nurse practitioners get it, as per the Australian Senate committee recommendations—so nurse practitioners, Aboriginal health workers and midwives to prescribe MS-2 Step.

CHAIR: But not registered nurses?

Dr Yim: Correct. We acknowledge that there is a challenge with access and we acknowledge the reasons why we do support nurse practitioners prescribing, along with midwives and also Aboriginal health workers, but I think the blanket approach of approving all RNs is probably going to be fraught with danger. We are recommending that it does require a collaborative arrangement. We also need to ensure there is an escalation pathway available. From an access point of view, the mandatory training that was legislated for pharmacists and prescribers has been removed only recently, so we have not seen the benefit from that at this point in time.

CHAIR: I note that Queensland Health considers that further education and targeted training may be needed to ensure the successful rollout. You do not agree with the Queensland Health response?

Dr Yim: We do not agree with the blanket rule of all RNs being approved for MS-2 Step prescribing.

Mr MOLHOEK: Dr Yim, thank you for your submission and for appearing today. I am interested in your comments around registered nurses. I spoke with one the other weekend and her comment was, 'I just want to be a nurse. I don't want to have to be involved in more and more complex issues.' How concerned are you about registered nurses being able to prescribe and participate in this? There is an awful lot of them and I assume the levels of competency vary significantly. There are some who are just happy to be nurses and turn up and look after patients, and there are others who are very competent and probably quite ambitious and hold fairly senior roles. I am interested in your comments around this broadbrush approach: 'Let's give more and more people the opportunity to administer these drugs.'

Dr Yim: That is one of the key aspects here. These drugs are schedule 4 medications. That is the Therapeutic Goods Administration saying that they do need a prescriber. You have rightfully said that there is a broad range of registered nurses. Some of them might be new graduates; others have 30 or 40 years experience. The pathway is already in place with regard to nurse practitioners and midwives. They are already prescribing some medications, whereas registered nurses are not currently prescribing any medications.

Mr POWELL: Thank you for your submission and for appearing today. Your submission and your contribution have done a lot to clarify for me where the primary concern around the legislation sits—that is, patient safety in that rare 4.8 per cent of cases where a medical termination does not quite go to plan. You have explained that this bill goes beyond what the Senate recommended. Let's face it: there are challenges within our health services across regional and remote Queensland and

the ability to respond to that small percentage of adverse outcomes. I think some of your final statement said that it would have to be the case that all Queensland hospitals were equipped to deal with that kind of response. Am I correct or am I misquoting you there?

Dr Yim: That would be correct. We would like to see that in all Queensland hospitals, especially if they have emergency departments, so that essentially there is a pathway. We do not want to see women needing to travel four or six hours to get emergency care. That is not acceptable. There needs to be a pathway to ensure they receive emergency care in those small number of cases where things do not go well.

Mr POWELL: Would it be true to suggest that perhaps we need to get that sorted first before we come back and expand the application of the bill to include registered nurses?

Dr Yim: We definitely need to assess the outcomes of the expansion to nurse practitioners and midwives first. Then obviously, yes, you are absolutely right: we need to ensure the backups are in place before we expand further.

CHAIR: Part of my former career was in flight retrieval. We have Retrieval Services Queensland and the RFDS, but we are a big, expansive state. People have complications. As a hypothetical, if someone is haemorrhaging as a result of a complication or haemorrhaging from anything, those systems are in place. Would you not agree that Retrieval Services Queensland is able to respond to cases where it is determined that people need to go to a tertiary hospital for urgent care?

Dr Yim: I would agree that the retrieval services are in place. To use ear, nose and throat surgery as an example, all of my patients who have ear, nose and throat surgery currently stay. There is no ear, nose and throat surgery in Hervey Bay so they stay in that town, whether it be Brisbane, the Sunshine Coast or Bundaberg, for the 10 days that is recommended. Personally, I think it would be unwise for a woman to take medical termination of pregnancy medication in a remote town. If something does go wrong, we would have to rely on the retrieval, which is probably not the ideal thing. Ideally, that woman, unfortunately, is moving into a motel from the moment they take the medication in that location so they are closer to those emergency services. It does not have to be a tertiary service; it can be a secondary service at a regional hospital.

Mr SMITH: Are there schedule 4 medicines that registered nurses can currently prescribe?

Dr Yim: No. That would be nurse practitioners and midwives. They do have access to some of the schedule 4 medicines but not as a blanket, no.

Mr SMITH: What would a registered nurse need to undergo for the AMA to feel sound with a registered nurse prescribing MS-2 Step?

Dr Yim: I think we need to look at what the windows and the training involves. To take things into consideration, clinicians, doctors, do a minimum four-year medical graduate course. For prescribing in hospital, the interns and the JHOs—junior health officers—before they get a fellowship, are always under direct supervision by their consultant. Those are the elements that we need to be aware of. Correct me if I am wrong, but I believe a registered nurse does a three-year bachelor—so it is a little bit different—and they can work independently outside. Some of the nurses in my practice are straight out of university. That level of experience is totally different from, say, someone who has completed a fellowship or a nurse practitioner or midwife.

Mr SMITH: I completely understand your medical expertise and your concerns around registered nurses. Given the difficulty in accessibility across regional and remote Queensland, would the AMA be committed to working with Queensland Health on a structure that would provide that peace of mind? If certain registered nurses undergo particular training that has been created through the AMA working with Queensland Health, would you be able to give your consent to registered nurses who have done a particular structured training course being able to provide this particular schedule 4 medicine?

Dr Yim: I think AMA Queensland always is happy to consult and work with the Queensland government on particular structures. One of the key components, as per my statement, is that we need to ensure any prescribing is done in a collaborative manner to ensure the tertiary referral escalation pathways are in place. That is something where we can definitely work together.

Mr MOLHOEK: I am not sure if you can comment on this part of the submission, but I note that the AMA Queensland submission raises concerns around the time frames for feedback. There is a suggestion that there was a 'secretive approach' to the drafting of these legislative arrangements.

Are you concerned that this legislation is being rushed and that there needs to be more time and consideration of these issues? What gave rise to those concerns that you have raised in your submission?

Dr Yim: One of the greatest challenges for AMA Queensland is that we are a membership organisation, and to ensure we have robust feedback that we can provide to any legislation or any comments from the Queensland government we need time to weigh up the paper, do our own research and consult our members. Some of the feedback turnaround times are between one and two weeks, which can be quite short. As you can imagine, many of our members are clinicians. We do see and treat the community and, obviously, sometimes a more extended comment time would be appreciated.

Mr MOLHOEK: You also touch on the right of Queenslanders to know what legislative amendments are coming forward. Are you concerned that there has not been enough consultation on these proposed changes?

Dr Yim: Definitely there are elements where we do need to ensure that appropriate stakeholders are consulted and also that we look at the evidence. Do not get me wrong: as a clinician and a member of the community, I always like access and convenience, but we do need to balance the safety over access and convenience.

CHAIR: Thank you very much, Dr Yim, for your contribution today.

Dr Yim: Thank you all for your time.

Proceedings suspended from 11.21 am to 11.35 am.

GRACE, Ms Karen, MACN, National Director of Professional Practice, Australian College of Nursing (via videoconference)

CHAIR: Welcome. Thank you for your written submission. Would you like to start with an opening statement before we move to questions?

Ms Grace: Karen Grace national director of professional practice with the Australian College of Nursing, and I am a proud registered nurse and registered midwife. I would like to start by thanking the committee for the opportunity to attend today to speak to the Australian College of Nursing's submission to the Health and Other Legislation Amendment Bill (No. 2) 2023. As the peak professional body and leader of the nursing profession, the Australian College of Nursing is committed to our mission of 'shaping health, advancing nursing'. We support nurses to uphold the highest possible standards of integrity, clinical expertise, ethical conduct and professionalism through our advocacy, membership, leadership and policy work.

We recognise that the changes incorporated in this bill aim to support quality improvement and patient safety in public health facilities and improve the operation of health legislation in Queensland. As such, the Australian College of Nursing supports the changes in principle. We support all actions that ensure health and wellbeing of communities, and particularly the most vulnerable within those community. Importantly, the Australian College of Nursing welcomes any changes that support the removal of existing legislative and policy barriers to enable nurses and midwives to work to their full scope of practice. This, in turn, due to the fact that nurses are the largest and most geographically dispersed health workforce in Australia, improves equity of access to health care in rural and remote Australia.

In relation to the changes related to the obligations for quality assurance committees to disclose information under specific conditions, and proposed changes to the use of reports and transcripts under the Mental Health Act, the Australian College of Nursing recommends careful consideration of the actual and potential impacts of these changes on both health professionals and consumers of healthcare services. It will be essential to the success of any changes that the intent, implications and requirements are well understood by all parties at the point of implementation.

I was listening to the previous presenter and I would be very happy to answer questions in relation to registered nursing prescribing, if that would be helpful. I welcome the opportunity to answer any other questions that you may have.

CHAIR: Thank you. I was going to start by following up from Dr Yim from AMAQ. They have a position: they do not feel comfortable that registered nurses should be providing MS-2 Step under the current guidelines. The way I see it is that, like any scope of extended practice authority, the department will set up training for the medication. I think I used the example of paramedics and thrombolysis and things like that. Do you want to respond to some of the concerns raised by AMAQ in terms of registered nurses undertaking training to provide this medical termination drug?

Ms Grace: Yes, I would be happy to. As we all know, registered nurses, like all health professions, are well regulated. We are obligated to practise in line with a scope of practice for which we are trained, educated and competent, and that is true of all registered nurses. Therefore, it would not be expected that all registered nurses, when this legislation comes into force, would then be able to openly prescribe any medication, including MS-2 Step, because in order to prescribe anything the nurse would have to be able to demonstrate the skills, training and competence to do so.

In line with that, there is a consultation that is underway at the moment through the Australian Nursing and Midwifery Accreditation Council, which is developing standards for nurse prescribing which build on the previous and existing standards for nurse practitioners. Nurse practitioners have a fairly long and proud history of being able to work to a much broader scope of practice that has included prescribing.

The consultation that is underway at the moment is proposing that we would introduce standards that would ensure registered nurses are both trained and competent in order to prescribe. There would be standards for any sort of training program that are nationally endorsed, and then only nurses who have completed a training program that is approved by ANMAC would be able to prescribe. There are a lot of regulatory protections underway before any registered nurse would be able to participate in any level of prescribing.

I was actually really pleased to see registered nurses incorporated in the proposal because I feel that Queensland is futureproofing its legislation. It does not mean that any registered nurse would then be able to prescribe or be endorsed to prescribe until they had completed whatever the program is that is aligned to the final standard once it is complete. For me, the risk is minimal because nurses should never do anything that they do not feel appropriately qualified or competent to do.

CHAIR: Thank you. That is well articulated.

Mr MOLHOEK: I also want to move to some questions around comments by the AMAQ and their reference to concerns raised in the Senate inquiry, which I think is titled *Ending the postcode lottery: addressing barriers to sexual, maternity and reproductive healthcare in Australia.* It is a big leap for us in Queensland to go, 'There's just been this national inquiry that is recommending against this but we actually know better and we think'—

Mr SMITH: Point of order, Chair.

Mr MOLHOEK:— 'that we should go against that advice.' Who is right? Have we got it right or has the national inquiry got it right? That is really the question.

CHAIR: I will let that go.

Ms Grace: To be fair, I think what the inquiry reported was aligned to the professions that are currently endorsed or approved to prescribe. At that point in time it was very clear that, in terms of professions able to prescribe in this particular context, there are medical doctors obviously and then there are nurse practitioners who are endorsed by the board to practise as nurse practitioners, which includes prescribing, and there are endorsed midwives who have similar endorsement for prescribing. The recommendations were in line with what is currently regulated in terms of professional prescribing.

There is a body of work at the national level that is going through, as I said, the Australian Nursing and Midwifery Accreditation Council which sets the standards for education and training for nurses and midwives nationally. That would be approved through the Nursing and Midwifery Board of Australia so there would be a national agreement to the standards that nurses need to meet in order to prescribe. I think it would be appropriate under those circumstances for all jurisdictions to consider whether there are any legislative barriers to enabling that to happen.

One of the problems we have experienced over recent years in terms of nurse practitioners—and this has been really well articulated in the 10-year nurse practitioner plan that is currently being implemented—is that most of those recommendations are addressing removal of barriers that currently exist that prevent nurses working to their full scope. If we are going to address what we are experiencing both across Australia and internationally in terms of our workforce challenges, particularly in rural and remote areas of Australia, we need to be forward-thinking. Legislation that futureproofs us does not necessarily create risk because we are regulated professions, and I think that is the point I am trying to make. If we then go down the path that by the end of this year we have a nationally agreed approach to RN prescribing and it is not incorporated in your bill, there would be a need to review the legislation in order to ensure it aligned to national prescribing regulation, if that makes sense.

Mr POWELL: Thank you to you and your profession. It is a fantastic profession and much admired across Queensland. You have given me a level of comfort that there is a framework around RNs prescribing medical terminations and other medications potentially. The concern that has been raised with us, though, is patient safety for that small percentage where things do not go well with a medical termination. They are suggesting that the response required is surgical and therefore not always available where an RN is present. Can you comment on that?

Ms Grace: Yes. I have one last point in relation to RN prescribing. The standards as they stand at the moment talk about prescribing in partnership, which would require registered nurses to have a partnership with a nurse practitioner or a medical practitioner, so there is an additional level of assurance there.

In terms of management of complications, the issues are fundamentally the same in that nurses should not start any sort of course of treatment if they are not confident and competent to deal with the possible side effects, implications or adverse reactions to that course of treatment. That is the same as any other health professional. It comes back to nurses only working to the scope for which they are qualified, appropriately trained and competent. I would expect that nurses who plan on participating in prescription of medical abortion would be clear on all of the possible implications of that—all of the adverse events that could happen—and there should be a plan in place in terms of policy within the health service to ensure there is an escalation pathway that is appropriate to manage those events should they occur, as with any profession.

That being the case, a point was made in the previous session that not all nurses actually want to be all things to all people, and I think that is absolutely valid. Again, it comes back to nurses undertaking the training to acquire the skills they need in order to undertake the scope that is comfortable for them and that fulfils their career objectives.

CHAIR: Stepping away from the termination-of-pregnancy issue, your submission notes concerns on page 2 around the quality assurance committees and that that proposal may make clinicians less likely to participate in review processes. Can you expand on that in two minutes or less?

Ms Grace: Sure. Under existing quality assurance committee privilege, as we know, health professionals who are participating in an investigation root cause analysis process are open to disclose on the understanding that whatever they say is under privilege. We try to address that through this amendment in order to ensure we are balancing that privilege with patient safety risk. The alternate side of the coin, by reducing the protection to the health professional, is that it may have an impact on how openly people are prepared to participate in investigations if they are aware that there is a potential that their actions may be reported outside of privilege. I am not necessarily saying that would happen, but the college are of the view that that is a potential consequence of changing the legislation.

CHAIR: We are out of time. We have gone over, so I apologise to members on my right. You will have some questions in the next session. Thank you for your contribution today.

GRIBBLE, Dr Karleen, Adjunct Associate Professor, School of Nursing and Midwifery, Australian College of Midwives—Queensland Branch (via videoconference)

WARRINER, Ms Michelle, Chair, Australian College of Midwives—Queensland Branch

WEATHERSTONE, Ms Alison, Chief Midwife, Australian College of Midwives—Queensland Branch (via teleconference)

CHAIR: Welcome. I invite you to make an opening statement, after which we will go to questions.

Ms Weatherstone: I would like to acknowledge the lands we are presenting from today and pay my respects to First Nations elders past, present and emerging and any First Nations people here today. On behalf of the Australian College of Midwives, the ACM, I would like to thank the committee for the opportunity to appear today. ACM is the peak professional body representing midwives in Australia. Midwives are primary maternity care providers and provide women and their families support, care, education and advice from pre conception and during all stages of pregnancy, labour, birth and the postnatal period, and influence the best start to life for a child for their first 2,000 days.

Midwives are also experts in sexual and reproductive health. Universal access to reproductive health care is a priority to improve outcomes for women and children, in particular in rural and remote areas of Australia. Equity of access to termination-of-pregnancy services plays a key role in improving access and thus outcomes for women in Australia. Midwives excel in delivering respectful maternity care, inclusive of all diversity, and has representatives from the largest profession made up of predominantly females providing care for women, who make up 50.7 per cent of the population.

ACM commends the amendment 22 insertion of medical termination by particular registered health practitioners. Inclusive change to allow appropriately trained midwives to provide termination-of-pregnancy care ensures women have broader access to termination-of-pregnancy care services. Termination-of-pregnancy care is a fundamental human right. ACM commends the changes to prescription of minimum nurse-to-patient and midwife-to-patient ratios. The inclusion of babies in ratios will have a broad impact on workforce outcomes, clinical outcomes and the improved provision of high-quality and safe maternity care.

While appreciation is extended to the above-mentioned changes, ACM opposes the removal of the word ‘woman’ from the legislation and its replacement with the term ‘person’. It is important to understand that sex, a reproductive category; gender, a societal role; and gender identity, an inner sense of self, are not synonymous. The word ‘woman’ can have a sexed or gender identity based meaning. The legislation being amended makes it clear that ‘woman’ is used in its sexed meaning to refer to female people. Given the inherently sexed nature of pregnancy, this is entirely appropriate. However, the explanatory notes and statement of compatibility for the bill indicate that the word ‘woman’ should be understood in a gender identity based meaning to refer to people who have a gender identity of woman. The removal of ‘woman’ from the legislation is therefore not the common understanding and as such appears flawed.

The use of the word ‘woman’ in its sexed meaning rather than from a gender identity use must be understood by all decision-makers here today, including the unintended consequences of removing sexed language from legislation. Keeping ‘woman’ in legislation is crucial for acknowledging and safeguarding the specific rights and experiences of women as a group encompassing all female people. ‘Woman’ in its sexed meaning in legislation ensures that legal frameworks recognise the unique challenges and needs faced by women, ensuring targeted protection against discrimination and the promotion of gender equality. Preserving the term ‘woman’ in the legislation specifically under consideration accurately reflects the reproductive rights held by those who can and do become pregnant, while removing this word obscures who it is that this legislation applies to.

Retaining the term ‘woman’ supports targeted healthcare strategies and upholding a woman’s agency over her own body. ACM would like to highlight the Queensland Aboriginal and Islander Health Council’s submission for today’s inquiry. The submission notes that, while QAIHC accepts that the proposed amendments are well intentioned, it does not support replacing ‘woman’ with ‘person’ in legislation. Their submission states that the proposed amendment, intended to be inclusionary in a western cultural context, may have the unintended consequence of excluding Aboriginal and Torres Strait Islander women and trans and gender-diverse people who have a different concept of what it means to be a woman.

ACM believes that the same could be said for many women who do not apply the concept of gender identity to themselves, including those from diverse cultural and linguistic backgrounds. ACM is concerned that, if legislation related to female reproduction in Queensland is desexed through the removal of the term 'woman', it will encourage similar changes in health contexts, including health promotion. Public health interventions utilising desexed language are predicted to create barriers for marginalised individuals with lower health literacy. An example of this is evident in the public health intervention for cervical screening inviting 'anyone with a cervix' for screening rather than 'women'. Women with low literacy, low health literacy or low English language skills are at risk of not understanding that such interventions are directed at them. This example demonstrates potential real-world negative impacts of desexed language, further disadvantaging marginalised groups. Alternatives for 'woman', like 'anyone with a cervix', that refer to women by bodily organs, processes or diseases are also dehumanising and unacceptable.

ACM would like to draw to the attention of the committee the importance of accurate data collection on sex and the need for recognition of this in legislation and policy. Data collection relies on specific categorisations in language. Accurate recognition of and recording of sex is vital to safe healthcare provision, including for transgender and gender-diverse people, and also in relation to pregnancy. Data collection on sex is critical to closing the female data gap that results in poor health outcomes for women. Removal of the word 'woman' from legislation addressing female reproduction, making invisible the sex of those whose rights are central to the legislation, constitutes a marginalisation of women through language. In contrast, using the word 'woman' demonstrates a firm commitment by government to women, their rights and health care. ACM highlights that there are multiple strategies that are focused on women, including the Queensland Health women's health strategy and the national women's Centacare strategy, and we note that the Queensland government has a Minister for Women, and we therefore consider it appropriate that this legislation would contain the word 'woman'. We welcome questions.

CHAIR: Thank you. We do not have a lot of time left for questions but we will extend the program to get questions in.

Mr MOLHOEK: I had a question around the Aboriginal and Islander Health Council submission but you have actually dealt with it. I am happy to pass to other questions.

Mr POWELL: That was all self-explanatory.

CHAIR: I think it was well articulated.

Mr MOLHOEK: Were you listening in earlier when the AMA gave their contribution or the College of Nursing?

Ms Weatherstone: No. Unfortunately, I will have to play that back.

Mr MOLHOEK: One of the issues that has been raised is a concern around whether registered nurses should be permitted to administer medical termination of pregnancy. In particular, I think the concern has been around the availability of appropriately trained people. I would be interested in comments from your organisation around the extent of who should be able to administer medical procedures.

Ms Weatherstone: ACM would support a suitably trained health professional to administer termination-of-pregnancy medication. At this point in time, that would be medical officers, select nurse practitioners with experience or scope of practice within sexual and reproductive health, and endorsed midwives.

CHAIR: What about registered nurses with extended practice authority and training?

Ms Weatherstone: If that is their specialty and they have undertaken postgraduate training and it is appropriate training in sexual reproductive health as a specialty, I think that could be considered.

Mr SMITH: I might expand on that. You mentioned endorsed midwives, but are midwives not supported?

Ms Weatherstone: Currently, to be an endorsed midwife you have undertaken postgraduate education for prescribing and you hold a medicines endorsement, so that allows you to prescribe certain medications. At this point in time, that qualification does not sit in the undergraduate degree where you enter into practice being able to prescribe. However, within scope of practice you are able to administer medication.

Mr SMITH: Would the college be willing to work with Queensland Health around a structure that would enable a pathway forward for that extended activity for midwives—that is, being able to administer MS-2 Step under a particular training course and program whilst not being an endorsed midwife as a whole?

Ms Weatherstone: Yes. The College of Midwives would be very pleased to work with Queensland Health for that framework.

CHAIR: I am mindful that Michelle is in the room and Karleen is on videoconference. Do you have any comments or thoughts on any of this, because we are almost out of time?

Ms Warriner: No. Thank you for your time today. I have no further comments.

Ms Gribble: No. Thank you for your attention.

CHAIR: We appreciate your contribution. It was well articulated.

Mr POWELL: It was probably the best articulated contribution yet. Thank you for that.

CHAIR: Thank you very much for your time.

BEAMAN, Ms Sarah, Secretary, Queensland Nurses and Midwives' Union

MAIER, Dr Belinda, Strategic Midwifery Research and Policy Officer, Queensland Nurses and Midwives' Union

PAWSEY, Ms Ashleigh, Research and Policy Officer, Queensland Nurses and Midwives' Union (via videoconference)

CHAIR: Welcome and thank you for being here. There is quite a range of amendments in the bill. I will hand over to you for an opening statement before we move to questions.

Ms Beaman: I start by acknowledging the traditional owners, the Yagara and the Turrbal people, and pay my respects to their elders past and present. I want to extend my thanks to the committee for the opportunity to speak with you today. The Queensland Nurses and Midwives' Union is the principal health union in Queensland representing the interests of over 71,000 nurses and midwives who provide health services across Queensland. As the QNMU, we are the Queensland branch of the ANMF, the Australian Nursing & Midwifery Federation, which is Australia's largest union and professional nursing and midwifery organisation.

No doubt you have a copy of our submission on the Health and Other Legislation Amendment Bill (No. 2) expressing our broad support for many of the proposed legislative changes in the bill. Today, I will limit my opening statement to the key elements raised in our submissions. Belinda Maier will be available to answer any technical questions that may come from the committee around aspects of our submissions. I also wish to make some brief opening remarks about the important milestones of the bill and the provision of health services in Queensland.

Regarding midwife-to-patient ratios, the QNMU and our members have spent many years campaigning to establish and maintain safe workloads for nurses and midwives. Currently, there are no laws in Queensland governing how many patients can safely be allocated to a single midwife. We know that babies on postnatal wards are often not counted in the allocation of midwives' workloads, which effectively adds to their load and impedes their ability to deliver safe, quality care to mothers and babies. The absence of such laws has resulted in midwives frequently experiencing dangerously high workloads and burnout and expressing their distress for patient safety and conditions.

A recent audit that the QNMU undertook of inpatient maternity wards found that individual midwives were being allocated a workload of up to 20 women and babies, or 20 individuals. This audit clearly demonstrated it is unsustainable and at times dangerous, the workloads that midwives have in Queensland midwifery services and maternity services. Research has shown that legislating minimum safe staffing for Queensland nurses has improved patient outcomes and saved lives and money.

It is time for midwives and the care they provide to also be recognised and valued. I commend Minister Shannon Fentiman and the Queensland government more broadly for listening to and acting on the concerns of Queenslanders and midwives by legislating minimum midwife-to-patient ratios. This is a nation-leading step that acknowledges the crucial role that midwives play in delivering safe, high-quality care for all Queenslanders.

The benefits that will come from midwife-to-patient ratios are numerous. Supporting midwives to have more time and ability to provide the best quality care will improve outcomes for mothers, babies and the broader Queensland community and create a safer working environment for our midwives. We will continue to work with Queensland Health to ensure ratios meet the needs of the Queensland public and the midwives who work tirelessly to keep the system safe. To facilitate the implementation of this legislation, we expect that additional midwives will definitely be required to meet the ratios. We call for a state workforce plan and increased funding to address existing and forecast staff shortfalls.

Regarding the Termination of Pregnancy Act 2018 amendments, we strongly welcome the change to improve access to safe early medical termination services. Nurses who practise under an extended practising authority and midwives have the necessary experience, qualifications and training to undertake this critical role and provide greater access to reproductive health care, particularly in rural and remote communities. Allowing nurses and midwives to perform early-termination services means greater access to care. With the tyranny of distance rurally, people will not have to travel a long distance to access these services. We do, though, highlight a number of opportunities to refine and enhance the appropriateness and applicability of the legislation and its implementation.

As outlined in our submission, we would like the committee to consider providing greater clarity and certainty around the following issues: firstly, developing additional education and training resources to support health professionals in their role in providing termination-of-pregnancy care and a plan for education for the community; developing a statewide health management plan to establish a level of clinical governance and standardised processes across the sector within Queensland; ensuring any of the additional health practitioners authorised to provide termination-of-pregnancy services are suitable and qualified, with sufficient regard to confidentiality, expertise and continuity of care required; and retaining the term 'woman' in the termination-of-pregnancy legislation to safeguard the specific rights and experiences of women.

Regarding the Hospital and Health Boards Act 2011 amendments, we reiterate our concerns with enabling a quality assurance committee to disclose information about health professionals to their chief executive in specific circumstances. Whilst we acknowledge that there is a desire for rapid and direct responses to patient safety concerns, these really need to be balanced with the need to protect and consider the impact of this on health practitioners. In our view, the amendment does not give sufficient regard to the wellbeing or intent of health practitioners. We also question the need for further regulatory burden and creating additional pathways as we already have substantial regulatory oversight within this space from multiple groups.

Regarding the Mental Health Act 2016 amendments, again, we have broad support of the proposed amendments to clarify how Mental Health Court experts can report and when transcripts may be released and used. We reiterate the need for this process to make sure that reports are deidentified and only used and released in appropriate circumstances and that appropriate consent is obtained from the subjects of the reports or the transcripts.

In summary, the bill introduces a number of significant reforms that will improve access to safe, quality health care for Queenslanders. We thank the state government for its commitment to value and work for our members in providing safer working conditions and supporting them to provide a level of care that Queenslanders need and deserve. That concludes our opening remarks. We are happy to take questions.

CHAIR: Thank you very much, Ms Beaman. I start by acknowledging those 70,000 hardworking and dedicated health professionals and nurses you have right throughout Queensland.

Ms Beaman: Thank you.

CHAIR: Since 2015, this health committee, or iterations of it, has had carriage of nurse-patient ratios in acute wards and in our state-run aged-care facilities and now we see it, in this bill, relating to mums and babies. As a former health practitioner who has delivered the odd baby in the back of an ambulance, I loved getting to a maternity ward because it was safer. I know from some of that direct experience that when you have the right people there it is a safe environment for both mum and baby, particularly if there are complications. I want to expand a little on resources, education and training. In its response, Queensland Health has made some broad statements in terms of providing termination-of-pregnancy medications for registered nurses. Do you want to expand on what that might look like?

Dr Maier: It will look exactly like it would be for any medical practitioner who accesses these educational resources and supports. Traditionally, nurses and midwives have not been able to access that same education because it was specifically for doctors, as they were the only ones able to provide those services. We are looking for nothing different, really, to the safe provision of those termination-of-pregnancy services for appropriately trained midwives and nurses.

Mr POWELL: Thanks for your submission and for appearing today. Thank you for being nurses, too.

Ms Maier: Midwives.

Mr POWELL: Midwives. No doubt you have heard some of the opposing views expressed by the AMAQ and just then by the Australian College of Midwives that this should not be expanded to include RNs. I suspect you just added an element there when you said that they should be appropriately trained and have access to that training. Is there anything else that you would like to say in response to the AMAQ and others saying that it should not be applied to registered nurses?

Dr Maier: We absolutely support registered nurses having access to the training. Registered nurses, nurse practitioners and midwives, so long as they are appropriately trained and educated, we absolutely support. In rural and remote communities, they are often the first port of call for women to access any sort of health services. We support all of them having the appropriate training.

Mr POWELL: That is the distinction, isn't it? It is not all registered nurses that you are suggesting—

Dr Maier: No. It is so long as they access the education. It could be any registered nurse, but they need to have the appropriate training.

Ms Beaman: Further to that, many of our nurses working rurally and remotely actually already practise under an extended practice authority, which actually gives them the authority, the education and the training to administer S4s. This would be a continuation of that. MS-2 Step is an S4. They are already well qualified and well positioned to be able to provide this care.

Mr POWELL: The flipside of that was a concern around the availability of necessary potential surgical interventions if it does not go well, so in that small percentage where the medical termination does not go well and there are complications. Is there a comment you would like to make on that? I get that those nurses in those instances may be able to apply the medical termination, but are they able to respond to any complications?

Dr Maier: Yes.

Mr POWELL: It is as simple as that?

Dr Maier: The simple answer is, yes, they can. It needs to be within a health system that is collegial and collaborative so that those nurses or midwives are able to then consult, refer or transfer appropriately to a greater level of services if that is needed. International evidence shows that it is very safe. We would argue that women should be able to access earlier terminations instead of going through the pathways they are now where it takes a visit to a GP who might not refer them on so then they have to find another GP, if they can afford it. This is why we are getting the later termination of pregnancy, which holds a lot more complications than the early medical termination.

Mr MOLHOEK: We heard earlier from the College of Nursing. I think the quote was 'not all nurses want to be all things to all people'. If it is opened up to registered nurses to be administrators or prescribers of this, are you concerned that it is going to add another layer of responsibility or expectation on nurses, particularly in rural and remote areas where they are already feeling incredibly stretched? You talked earlier about safe workloads. I would assume the same would apply to expectations around, 'You can do this, this, this and this.' 'How much more am I expected to do?' Are you concerned about nurse welfare in that respect?

Dr Maier: No, in that not all nurses are going to have to do it. It is open for nurses to do it, but they still have to do the education and training to set up that model of care where they are providing the service. Not all nurses will have to provide medical terminations of pregnancy and not all midwives will have to, either. Then you have conscientious objection, which everyone has a right to. We know that there will be a number of midwives and nurses who will be conscientious objectors. That is fine, so long as they are able to refer. For those nurses who do not want to opt in to doing that, it is just a matter of making sure there are still pathways for women.

Mr MOLHOEK: Would it be fair to assume that the Queensland Nurses and Midwives' Union would continue to support the position of conscientious objection?

Dr Maier: Absolutely, yes.

Mr MOLHOEK: It is a choice for each individual health practitioner?

Dr Maier: Yes. We definitely support that. That is everyone's right. It is a part of our professional roles. We certainly have education for our members around what conscientious objection is and how that works. We are doing a lot of work in that space.

Mr MARTIN: I have a question in relation to the amendments to the Hospital and Health Boards Act. The bill proposes additional pathways for health practitioner misconduct reporting to be made by quality assurance committees in addition to the Health Ombudsman and Ahpra. You have noted on page 5 that you do not agree with that. Could you elaborate on that for the committee?

Ms Pawsey: In line with what was mentioned by Ms Grace from the Australian College of Nursing earlier, we are seeking that the proposal provides a more balanced approach. In terms of considering the need for rapid and direct responses to patient safety concerns, we fully support that, but there is a need to protect and consider the impact on health practitioners as well. In our view, what this means is sufficient safeguards, and consideration needs to be given to ensure any additional regulatory powers do not exacerbate the stress on health practitioners unnecessarily. What we are urging is that, with more ability in the bill to disclose and report on health conditions and conduct, the provisions must also be made to ensure that notification regarding practitioners is sufficient, that consideration is given and that it is not vexatious.

Mr SMITH: Thank you for being a real union delivering real outcomes for your members. I go to schedule 4 medications, about which there is a notable absence in submissions. The AMAQ previously in today's hearing said that there were no registered nurses in Queensland prescribing schedule 4 medications. I think you mentioned before that that is not the case.

Ms Beaman: They can administer under an extended practice authority schedule 4 medications.

Mr SMITH: I wanted to confirm that. Perhaps you might be able to provide the context in which a registered nurse or a midwife will be presented with a woman coming in and wanting to have that initial conversation about a medical termination and the way in which it will proceed. Some people might think it will be someone going to an emergency department, whereas it could be more a sexual health clinic or some sort of appointment base. Could you provide some context around what the setting looks like?

Dr Maier: It would vary quite dramatically because the Queensland Health geographical context is dramatically varied. It could be a nurse or a midwife who knows the community and the community knows them. In your smaller or remote communities, people will know that there is a nurse or someone to go to for whatever the context, whether it is immunisations or health check-ups or those sorts of things. It is the same for midwives in the communities. The context would come from that, I think, where the woman would then approach the nurse or the midwife in another health context and talk to them or ask for options around that early termination of pregnancy.

We did some research that was published—one of our members, a professor of obstetrics in Cairns. What we found is that over 80 per cent of our members support women's access to early-termination-of-pregnancy services. About 40 and 50 per cent would be prepared to undertake it themselves. We are not going to have a rush of nurses and midwives wanting to provide early-termination-of-pregnancy services for a range of reasons. It will just come through community health settings in rural and remote areas more so where the women will approach the nurses or the midwives they know to talk about their options around early termination of pregnancy.

Mr SMITH: Noting your dedication to making sure you are protecting your members, I imagine that at this point you would encourage any RNs or midwives to engage in the prescription of medical termination without undergoing that extended training and practice. Would that be correct?

Dr Maier: Absolutely. I do not think any nurse or midwife would want to do that without having the education and training anyway.

CHAIR: Thank you all for your contributions today and for your articulate answers. We welcome you being here. Thank you very much.

COULSON BARR, Dr Lynne OAM, Health Ombudsman, Office of the Health Ombudsman

McLEAN, Mr Scott, Executive Director Legal Services, Office of the Health Ombudsman

CHAIR: We welcome from the Office of the Health Ombudsman Dr Lynne Coulson Barr and Scott McLean, who are very well known to the Health and Environment Committee. Would you like to start with an opening statement? Thank you for your submission. I note that you have some concerns with some elements of the bill. We also now have the member for Mirani on the phone.

Dr Coulson Barr: I would like to start by acknowledging the traditional owners on whose land we meet today and pay my respects to all elders past, present and emerging. Thank you for the opportunity to speak to our submission on the amendments. At the outset, I would like to say that the OHO is supportive of the purpose and intent of the amendments, and we particularly support the amendment that will enable the sharing of findings and the deidentified information from root cause analysis reports, the RCAs, so that they can inform actions and service improvements to address the issues of safety and quality in services. We think that is a really positive development.

We also support the amendments which will require members of quality assurance committees—I will call them QACs—to disclose identifying information about a health practitioner's health, conduct or performance where the members hold a reasonable belief—I am going to emphasise that—that the health professional, because that is defined in the act, poses a serious risk of harm to persons. The amendments also require the committee to disclose this information to the chief executive of the service, as we understand, to enable that officer to take action where necessary to address the identified risks.

The concerns that we have raised about the amendments really can be seen more about drafting issues rather than intent. We note that the Department of Health has raised potentially complex drafting issues. We have a view—and we will speak to it at the end—that we think they can be addressed, and we have had some preliminary discussions about that.

The focus in our submission is what we see as the missed opportunities to realise what we see is the overriding intent for actions to be taken at the earliest opportunity to address issues of serious risk of patient harm that have been identified in the course of the QAC's work. We think that is an important way of strengthening the current systems for addressing serious risk and protecting public health and safety.

I flagged earlier that some of the issues seem to be more about definitions and how they are applied. The definition of a health professional in the Hospital and Health Boards Act includes both registered and unregistered practitioners. The definition means a person who is either registered under the Health Practitioner Regulation National Law or a person other than a person registered under the national law—and this is the definition—who provides a health service including, for example, an audiologist, dietician or a social worker. There are other examples such as sonographers and AINs, assistants in nursing. Our office deals with notifications and complaints or concerns around the conduct and performance of those practitioners.

You would be aware that the OHO has functions and powers to take protective action in the form of immediate registration action or taking an interim prohibition order in respect of the unregistered practitioners. That is where I form a reasonable belief that the practitioner poses serious risks to public health and safety or the action is otherwise in the public interest. These actions are obviously broader than the actions available to a chief executive officer and they are not specific to one place of employment. You would be aware that practitioners can move between places of employment—so they can work in more than one setting.

The current wording of the amendments requires the QAC to disclose the information to the chief executive officer where they form a reasonable belief that the health professional poses a serious risk. That means that the chief executive of a service may receive information that an unregistered health practitioner is considered to pose a serious risk. However, the disclosure provisions in proposed section 85A(4) only allow the chief executive officer to notify us if the serious risk identified by the QAC forms the basis for a notification about the practitioner under the Health Practitioner Regulation National Law. There is a real gap there. The scenario is that the chief executive can receive information about serious risk but they are unable to disclose that to us unless they can find another source of information to make that notification. The proposed amendments also do not require the QAC to notify the OHO at the same time as the chief executive of the serious risks that they have identified.

There is an existing reporting pathway in the legislation. It is under section 84(1)(d) of the Hospital and Health Boards Act. It allows a member of the QAC to directly notify the Health Ombudsman. It is about when they form a view that the practitioner has behaved in a way that constitutes public risk notifiable conduct, which is defined also in the act. That is narrower than the provisions of this proposed amendment where it is requiring the QAC to notify the chief executive officer when they have a reasonable belief about serious risks of harm posed by the health, conduct or performance of the practitioner. There is a gap there. There is not a positive obligation to notify us of that serious risk.

Perhaps we did not emphasise that as much in our submission—the difference of creating a positive obligation to notify a chief executive officer but not ourselves as the regulatory body and the one able to take broader protective action. We note that there are some inconsistencies in the relevant legislative schemes with respect to positive obligations to notify our office of serious risk posed by the conduct or performance of healthcare workers. It exists in respect to healthcare workers under the National Code of Conduct for Health Care Workers, in clause 4, in terms of the obligation to notify us of serious risk observed in the course of treatment. It would be consistent to address the absence of the lack of a positive obligation for members of the QAC to notify the OHO. They are required to form a reasonable belief that a practitioner poses a serious risk of harm to a person.

Our submission really draws attention to what appear to be unintended gaps and impacts that limit the protective actions that can be taken with respect to the issues of serious risk that are identified by a QAC. It is really a missed opportunity to strengthen the protective provisions and also the timeliness of actions that can be taken. No doubt, we have not had these provisions and some of the matters identified by a QAC mighty eventually find their way to a notification to OHO, but there will be a gap in timeliness and the ability to act.

In conclusion, our submission is really focused on two amendments to proposed section 85A in the HOLAB. We have worded it to allow the QAC to be able disclose to our office at the same time as disclosing to the chief executive officer, but I think our commentary and narrative in the submission was really that we think there should there be a requirement or a positive obligation to enable our office to act in the most timely way to assess that risk and also to provide for the chief executive of the health service to notify us about issues of an unregistered practitioner, because it is currently not allowed in the provisions. We appreciate that the amendments are a priority. We feel that they could be accommodated. We understand that there are some drafting challenges, but we would be happy to assist and work with the parliamentary drafters who are expert in drafting these types of amendments. We think there is a way forward and we wanted to bring that to the committee's attention.

CHAIR: Dr Coulson Barr, I really appreciate your concerns there. I tend to agree. For the benefit of the newer members on the committee, from the work we do with the Office of the Health Ombudsman—not disclosing anything—I know that some of the concerns over previous years have been about some individuals who perhaps have moved to another jurisdiction and pose a risk. I absolutely agree with your proposed amendments—that they should notify the office and work in conjunction. If that is around drafting then it is around drafting to prevent any of those potential impacts such as people moving to other jurisdictions or indeed other countries.

Mr MOLHOEK: This might seem like a dumb question, but for the public record and for my benefit can you briefly explain the difference between registered health practitioners and unregistered health practitioners? Can you give some examples of how that applies?

Dr Coulson Barr: There is a list of health practitioners who are registered under the national law and then there is a range of professions that are not registered under the national law. There are some examples actually given in the act. They include social workers, audiologists and sonographers. They were some of the examples. The mandatory notification provisions under the health practitioner national law do not apply to those professions. They are professions that can be working within hospital and health services.

Mr MOLHOEK: Thank you. I thought it was good to get that on the public record and to clarify it for my own sake.

Dr Coulson Barr: I can say for the public record that we deal with complaints and notifications where issues of serious risks and concerns around conduct have been raised around those professions and we do take action. The proposed amendments that we are putting forward would enable us to do that in a more fulsome and timely way.

Mr MARTIN: It is not so much that your suggested changes will create additional complaints to the OHO; it about getting onto them quicker, really?

Dr Coulson Barr: Absolutely, yes.

Mr MARTIN: For the benefit of the committee, do you have any examples of investigations where you would have benefited if you had been notified sooner? 'Scenarios' might be a better word.

Mr SMITH: Hypothetical scenarios.

Dr Coulson Barr: Scott and I were just talking about how our system does not allow us to identify if there had been an issue identified by a QAC that subsequently became notified to our office. We are unable to track that trajectory. We would say that, given the nature of the work of the QACs, they are reviewing clinical incidents and they are likely to come across issues of potential harm caused by the practitioner's health, conduct or performance. They are doing it in a timely way by reviewing those incidents so it is likely that they will identify issues that should be brought to the attention of our office so that we can have a fulsome assessment and determine whether action is necessary. The ability to notify us does not necessarily equate with regulatory action. What it does give us is the capacity to assess and consider whether action is required.

Mr POWELL: My question was answered by your verbal submission.

Mr SMITH: I am new to the committee and this is more of a question about your powers to investigate. Say a QAC says that they are concerned about a health professional's ability to perform their job and part of their suspicion is that the health practitioner is using illicit drugs, which is impacting their ability to keep patients safe. How far is your scope of investigative powers?

Dr Coulson Barr: There are provisions under the national law and, in our work with Ahpra. Ahpra is the regulatory body to deal with issues of health impairment affecting a practitioner's ability to practise safely. We do not have the jurisdiction to deal with those issues. We have what is called a joint consideration process where we jointly consider a matter and identify whether the alleged conduct or performance could be linked to a health impairment, and those matters are referred to Ahpra. Who can do health assessments and assess more deeply whether the health impairment is driving the concerns around conduct and performance.

Mr SMITH: Is the threshold on that more as in a civil matter, so it is based on reasonable grounds rather than that they would have to prove the health professional is using illicit substances? What is the threshold of guilt?

Mr McLean: For the purposes of this legislation, it seems to be a reasonable belief. At that point, that is not one where you are going to have evidence as such. It is a belief that is formed on reasonable grounds.

CHAIR: When I first read your submission, I wondered if there is a risk of duplication of investigations if you are not being notified, for a start, about the potential risk to patient safety, practitioner conduct and so on. Is there any risk of two investigations when you have a very well articulated system of assessment of risk and action? Do you have any thoughts about that when you first read about another body investigating without the powers of the OHO, basically?

Dr Coulson Barr: I think the functions of the QACs are quite different in terms of reviewing clinical incidents. As I understand it, the purpose of this amendment is to identify issues in relation to individual practitioners in relation to either health conduct or performance that may be posing a risk that requires action by another body and a different nature of investigation where we look at the relevant code and standards.

CHAIR: Member for Mirani, do you have any questions?

Mr ANDREW: No at this time, thank you, Chair.

CHAIR: There being no further questions, we thank the Health Ombudsman and Mr McLean for being here again today. We look forward to seeing you again throughout the year.

Dr Coulson Barr: Thank you for the opportunity.

BASSINGTHWAIGHTE, Ms Claire, Deputy Chair, Health and Disability Law Committee, Queensland Law Society (via videoconference)

FOGERTY, Ms Rebecca, President, Queensland Law Society (via videoconference)

CHAIR: Thank you for your written submission and for appearing today. Ms Fogerty, would you like to make an opening statement? Then we will go to questions.

Ms Fogerty: Thank you for inviting the Queensland Law Society to appear at the public hearing today and thank you for allowing us both to appear by way of video link. We respectfully acknowledge the traditional owners and custodians of the land on which this meeting takes place. From the outset, we support the legislative measures and any measures that foster a healthcare system that is accessible and respects principles of justice and fairness. As noted, we have made a substantial submission on this bill.

With respect to the proposed Mental Health Act amendments, we support the proposed clarification regarding the use and the release of Mental Health Court expert reports and transcripts in other criminal proceedings. We acknowledge the benefits of these types of reports and transcripts being admissible at the trial of a person in certain circumstances, and we note again the importance that the courts retain discretion to admit this evidence.

In relation to the amendments to the Hospital and Health Boards Act, we support the proposed provisions that seek to allow broader sharing of information contained in root cause analysis reports. We emphasise the need for additional resource training in relation to the importance of these reports to ensure efficient and appropriate use of the procedure.

Having had the opportunity to review other submissions, we support the issue raised by the Queensland Nurses and Midwives' Union regarding section 85A, which will enable a quality assurance committee to disclose information about a health professional to the chief executive. Our members with experience in this area report that this proposal overlooks the purpose of the QA committee processes and risks deterring people from coming forward to raise issues to be discussed openly at these forums.

We support the aspects of the bill that seek to expand the scope of the registered health practitioners who can perform early medical terminations of pregnancy. From a legislative drafting perspective, we have raised reservations with the regulation-making power in proposed section 6A(1)(c).

I am joined today by Ms Claire Bassingthwaighte, the deputy chair of our Health and Disability Committee. She is also appearing via video link. We welcome any questions.

CHAIR: I am not sure if you could hear the contribution of the Health Ombudsman.

Ms Fogerty: No.

CHAIR: At page 2 of your submission, down the bottom, you state—

Under the current legislation, de-identified RCA reports are required to be submitted to the OHO. Our members with expertise in this area report that incidents are being processed through 'RiskMan'—

I do not know what that is but I will ask—

(Which do not need to be disclosed) and avoiding the RCA process and need to notify.

As such, we highlight the need for training on the importance of the RCA process or the publication of a series of key points.

The OHO had some concerns about the speed of notification if there is a risk of harm. Could you clarify your position in those two paragraphs and try to expand on it for us?

Ms Bassingthwaighte: Yes, certainly. I am happy to do that. RiskMan, just to answer your question, is another risk-reporting tool that is within the hospitals' use. It is an alternative tool. It does not lead to the report or the findings being sent to the Office of the Health Ombudsman.

To understand the importance of this particular area, the principle that really underpins both the root cause analysis process and the quality assurance committee is creating an environment where there are protections and confidentiality does arise to encourage people to come forward and speak up in circumstances where they might otherwise be concerned about doing so. It is crucial that that is maintained; otherwise, it can cause problems in terms of encouraging people to participate meaningfully in that process. That is the principle that underpins that and forms part of why we have made the submission that we have.

CHAIR: Thank you for that. I will come back if we have time.

Mr MOLHOEK: The Public Advocate expressed concerns about the bill's proposal to permit the entirety of transcripts from Mental Health Court proceedings to be admissible in other proceedings. What is the Law Society's position in that regard? I think what I picked up is that you broadly support that position. I would be interested to know if there are any alternative ways that that evidence could be admitted without the use of transcripts. I am just asking for your response on the recommendations of the Public Advocate around the use of transcripts and the protection of people's rights.

Ms Fogerty: Do you mean in the context of the Mental Health Act?

Mr MOLHOEK: Yes.

Ms Fogerty: Our cautious support is based on long experience of our members. There are reports that can be very relevant to a matter. For instance, where a person is charged with a criminal offence and the matter has gone before the Mental Health Court, findings may not have been made and the matter then still proceeds in the normal criminal jurisdiction. Those reports can have a huge impact on the matter. Being able to make that more accessible, obviously subject to the court's discretion, is something we support, particularly because the range of defendants who are in that situation tends to come from very disadvantaged backgrounds and matters are on a legal aid basis. That small change is something that reduces burden on practitioners and leads to better information exchange between the courts and other relevant agencies. Generally then that makes for a result of more integrity.

Mr MOLHOEK: Just to be clear, I think what the Public Advocate was saying is that the patient's rights need to be protected but at the court's discretion, so it would be the court that would decide whether those transcripts or past records could be called up or used in evidence in a current matter.

Ms Fogerty: It is subject to judicial discretion. The rights of the patient is one of the matters that a court would take into account. In the example that I have given, in most cases I think you would expect the patient/defendant to be supportive of that.

CHAIR: I have a question with regard to clause 22. You hold some reservations about the regulation-making power in proposed section 6A, which you understand is intended to allow additional types of registered health professionals or practitioners to be added in the future. This is with regard to medical termination. You suggest that 'the inclusion of additional health practitioners should be the subject of appropriate stakeholder consultation as well as sufficient scrutiny by the Legislative Assembly'. Do you want to expand on that? We have been talking today and there has been a fair bit of commentary around support for registered nurses to prescribe MS-2 Step. Do you have concerns about other health practitioners within the draft bill?

Ms Bassingthwaighte: Our submission is that it should be something which is given the appropriate level of scrutiny, which would arise if it goes back to legislative power rather than as a regulation. It is important. There are a wide range of registered health professionals. We need to make sure the legislation is thoroughly considered in the light of what those proposed amendments are under the regulation, with sufficient stakeholder consultation as well.

Ms Fogerty: As a general rule, the Law Society, whilst we acknowledge the flexibility that regulation-making powers provide, notes that there are different views among submitters about what range of health professionals should be granted the extended power. We say that it underscores the importance of stakeholder consultation because it is not unanimous among concerned parties.

CHAIR: We heard different views from different people.

Mr MOLHOEK: Some of the stakeholders raised concerns about the intent to change the definition from 'woman' to 'person' in respect of pregnancy. Some of the submitters made some fairly strong statements around potentially undermining the rights and standing of women in particular settings. Are there any concerns that changing that definition would have any impact in any legal matters regarding patients?

Ms Fogerty: We are not aware of that issue impacting on the application of legislation. Our submission is supportive of those amendments.

Mr MARTIN: I have a follow-up question about transcripts. The Queensland Law Society supports extending a proposal to admit expert reports and transcripts not just for criminal proceedings but also for civil proceedings. I think you said in your submission that, whilst you acknowledge the concerns of Queensland Health about that going beyond the scope of the bill, you can provide further information about the benefit of providing those in civil cases. Could you share that with the committee?

Ms Fogerty: I would have to take that on notice. I note that in that aspect of the submission the members of the Criminal Law Committee were making particular reference to situations where guardianship was an issue and capacity was an issue and where there were simultaneous guardianship matters on foot. If we could take that on notice, we would be pleased to give further examples, if that is what you would like.

CHAIR: Yes, if you want to take that on notice and expand on that, that is fine. We need any answers to questions on notice to be back by Thursday, 8 February. I thank you both for your contributions today.

NORMAN, Mr Rob, State Director, Queensland, Australian Christian Lobby

CHAIR: Welcome. Would you like to make an opening statement before we move to questions?

Mr Norman: Thank you, Chair and committee members, for allowing me to present at this inquiry. The Australian Christian Lobby currently has around 250,000 supporters Australia-wide, almost 45,000 of whom are Queenslanders. We are one of the largest, most active grassroots political movements in Australia and our stated mission is to bring truth into the public square.

ACL fundamentally opposes the liberalisation of abortion laws. All three of the great monotheistic religions embrace the inviolability or sanctity of human life from conception to natural death. This is our position as well. Increasingly liberalised abortion laws present an ethical dilemma particularly for people of faith and conscience who believe that human life is precious. Indeed, the Queensland parliament rightly acknowledged the sanctity of human life when it passed the Justice and Other Legislation Amendment Bill 2023, which included what is known as Sophie's Law. The ACL commends the Queensland parliament for passing that bill, and I encourage members of this committee to reflect on that moment before adopting a more cavalier approach to abortion.

Our submission focuses on two serious consequences of expanding access to medical abortions. The first is to the safety of women. The Australia-wide shortage of doctors in regional and remote areas is well documented, as is ambulance ramping in Queensland emergency departments. Our submission referred to articles in the *Australian* newspaper in which the president of the National Association of Specialist Obstetricians and Gynaecologists criticised this bill for allowing nurses and midwives to prescribe the MS-2 Step abortion pills. Dr Gino Pecoraro OAM was quoted as stating that earlier this year he had been called in to help save the life of a 40-year-old woman who was flown in from regional New South Wales after being prescribed the abortion pill and experiencing significant side effects and bleeding. Dr Pecoraro said that she nearly died. Of all medical abortions, he estimated that about five per cent resulted in complications. Dr Pecoraro also said, 'There's a general principle in medicine that you shouldn't be prescribing a treatment unless you can deal with complications from it. Safety shouldn't be offered up on the altar of convenience.'

The convenience of administering pills should not mask the very real risk of complications that arise in one in 20 women who access MS-2 Step abortion pills. A shortage of qualified medical practitioners, along with problematic ambulance ramping, long wait times for medical procedures and increasing numbers of women who will access these substances, have the very real potential of setting up the perfect storm, particularly in regional, rural and remote areas of the state. The ACL submits that by allowing nurses and midwives to prescribe abortion pills the Queensland government would fail in its duty of care to Queensland women particularly in regional, rural and remote areas.

Our second point is about conscientious objection. The Termination of Pregnancy Act 2018 already fails to protect the rights of medical practitioners who conscientiously object to being party to terminating a human life. Section 8(3) of the act stipulates that health practitioners must refer the woman, or transfer her care, to a health practitioner or health service provider whom the referring practitioner believes can perform the termination. We submit that requiring conscientious objectors to refer or transfer the burden of responsibility for performing an abortion to another health practitioner creates an ethical dilemma that implicates the referring health practitioner in the termination of a human life. Let me give you two trains of thought that conscientious objectors might have in this situation. No. 1: if intentionally terminating a human life is considered a sin then implicating others in that sin is also a sin. No. 2: if intentionally terminating a human life is considered homicide then referring to a third party makes the health practitioner an accessory after the fact.

I personally listen to a growing group of doctors who are deeply concerned about inadequate rights to real and proper conscientious objection within abortion and euthanasia laws in this state. These are mostly people of faith who believe that human life is sacrosanct and who struggle to balance their faith with deficient conscientious objection rights. If not addressed, the rising tide of liberalisation could alienate a growing number of highly skilled people from the medical professions and place further pressure on the health system. Conscientious objectors to terminating a human life, unborn or living, should be able to simply decline the patient's request without further obligation. The ACL submits that section 8(3) of the Termination of Pregnancy Act 2018 should be deleted, allowing health practitioners the right of true conscientious objection. Thank you, Chair and members.

CHAIR: Thank you, Mr Norman. With respect to your members, the issues of conscientious objection with the Termination of Pregnancy Bill and the Voluntary Assisted Dying Bill have been debated, ventilated and passed in the House. I am curious as to why you are bringing this up now after a number of years have passed, including the passing of those bills.

Mr Norman: Because there is now an increasing number of people—nurses and midwives—who will have the authority to administer the MS-2 Step pill. It is like a rising tide, I guess, and there are more voices out there. As I said, I speak to a group of doctors who suffer, I would not say PTSD—that would be probably overdramatising it—but they are certainly torn between their position of faith and their obligation to refer. What we are doing by including others—nurses, midwives et cetera—in this is exacerbating an existing issue. I believe it is an appropriate time to draw a line in the sand and say that this is probably enough.

I have been a pastor for 30 years. I speak to a lot of young people who have ambitions to join the medical professions, and I have to say that there is a growing number of young people in churches who are hesitant to do so because it brings an immediate conflict in terms of their faith. The two points I raised are not just hypothetical; they have been spoken to me by different people. We may disagree with that—obviously people have the right to disagreement—but the fact remains that people of faith will hold those positions.

Mr POWELL: To be fair, Mr Chair, the ACL and others did raise it in the consideration of both those bills, and both of those matters were raised by members of parliament on all sides of the political divide in that debate.

CHAIR: Fair point. We will move to questions.

Mr MOLHOEK: I do not have a question on this. Mr Norman, I do not know if you heard the presentation by the Queensland Nurses and Midwives' Union, but I think you would be somewhat comforted by their response that they absolutely support conscientious objection for their members, notwithstanding the distinction you made around the issue of referral, but I understand what you are saying.

Mr Norman: That is good. We appreciate that. Our view is that the current conscientious objection guidelines—or law, I guess—are not adequate. The problem basically is: if it runs full course, do we really want to see people of faith abstaining from the medical professions? I do not think so. We obviously have a shortage of medical people, and cutting one group out of that potentially would be problematic and only exacerbate existing issues.

Mr ANDREW: Surely people could abstain from being involved in that process should there be a situation where nurses and midwives do not want to do this. Surely the medical profession would not make them do this. Can you comment on that situation?

Mr Norman: I hope that that would be true, but that is not clear through the current acts. Section 8(3) of the Termination of Pregnancy Act requires medical practitioners or health practitioners to refer to someone who would reasonably do that. I am not sure of the exact wording, but that is the gist of it.

Mr ANDREW: When we first hit this termination bill and all of this was brought in, everyone said in parliament that an increase in terminations of pregnancy did not show up, or did not actually have any teeth throughout the world. Would that be wrong? I have not seen the current figures. I think it is inflated almost twice: there have been two times the amount of terminations without this actually being in play.

Mr Norman: I am not sure of those figures either, but the stated objectives of this bill are that it will increase access to termination. The stated objectives actually have that in mind. I think it is logical to assume that if we legislate to allow more people to have abortions then that will be the case. It certainly has been the case with euthanasia. Queensland now has the highest termination rates in Australia, so I have no reason to expect that that would not be different with abortion.

CHAIR: To clarify, the bill talks about providing access particularly to those living in rural, remote and regional Queensland who cannot access these services. I just wanted to clarify that that was the intent of that.

Mr Norman: As I said, the two major parts of our submission are that issue itself and the dangers that I think have been well discussed during the course of this inquiry that raised problems with women's health—basically, the danger of five per cent of complications. I believe the AMA even expressed concerns about RNs having access to that. There is that part of it. The other side is purely on the basis of conscientious objection, particularly when it comes to people of faith. I have outlined that the view of many Christians—probably the majority—and certainly the other two major monotheistic religions is that they would universally believe that human life begins at conception. Again, that is debatable and people will disagree with that, but that is their religious view. We are certainly affecting a vast number of the population. There is no doubt about that.

CHAIR: I certainly respect that there are divergent views on this topic.

Mr Norman: Sure.

CHAIR: I do not want to get into a debate, but what do we say to those people living in rural, remote and regional Queensland from an equity point of view to access health care? Should they not be afforded the same as those in a metropolitan area?

Mr Norman: Again, that is a problem. We cannot oversimplify a problem like that. I guess Dr Pecoraro's response to that was that convenience is not always the best route, and if it puts five per cent of women's lives at risk then we should approach that very cautiously. I do not have any solutions to that, I am afraid. I wish I did. I sympathise. I have lived in the bush for long periods of time, so I know what it is like to have no access to medical care. You spend a lot of time in the car or travelling, unfortunately, and that is part of the deal when you live in the country. However, I do not think we can justify that problem by introducing risks that, to me, are unacceptable and may be to many others as well.

Mr SMITH: I really do appreciate you coming in and the sensitive way in which you are expressing your faith and the faith of your members within the context of what is law made by humankind at the end of the day. Did you hear any of the witnesses previously today, especially in that first session, and Children by Choice at all?

Mr Norman: I did hear a little bit of that before I drove in, yes.

Mr SMITH: I was highlighting that because they spoke about that five per cent complication which is quoted in the *Australian* article. Complication does not always mean risk of life but a complication within that particular procedure. I think they quoted risk to life at about 0.02 per cent, on average. They then, in response to my question, said that of their data, following termination of pregnancy, two per cent of women report that they engaged in a non-medical or non-surgical form of termination of pregnancy. They undertook some form of measure that was a risk to themselves in trying to end the pregnancy themselves—alcohol abuse or some other form.

Mr Norman: Yes.

Mr SMITH: Keeping in mind conscientious objection and the right for people to maintain their faith, do you perhaps concede that, in a sense, somebody who is saying, 'No, I do not wish to be your practitioner, but under law I am going to refer you to another practitioner,' with the understanding that that practitioner must then do an assessment of that individual's mental health and may in fact refuse that medical health care, is still better than a woman not being able to access this in regional, rural and remote communities and then going away, being denied medical assistance and harming themselves in an attempt to terminate a pregnancy? Is it still a better situation—even though, yes, I understand there is a faith element—and is it still a greater sense of faith that you are keeping a life safe by making sure they do access some sort of health care that could then lead to a reassessment of that woman's point of view of whether or not she wishes to continue the pregnancy?

Mr Norman: That is a big question. I hear what you are saying. There is a lot in that. I was curious with the response from—I forget who the submitter was, but the one that you mentioned.

Mr SMITH: Children by Choice.

Mr Norman: Thank you. I do not want to be adversarial in this, but I was interested that they did not provide a source of data. I think it was anecdotal, which is fair enough—and I agree that people on the ground can observe those things happening, and I am not denying that that could happen. I do think it is probably overstated. I think the people who represented Cherish Life mentioned that as well. They said that they felt the most common outcome would be that the person would have the baby which may or may not be considered a disaster. I certainly would not consider that a disaster; I would think that was a good outcome.

I hear what you are saying. I think it is a very theoretical question, and I do not think it trumps the right to a conscientious objection. Now, there would be a situation where a conscientious objector may be in a situation where they need to choose a life; in other words, the woman is at risk of losing her life. I do not know of any doctors who would not save the woman's life in favour of losing the baby's in that situation, so we are not arguing that particularly. We are looking at the situation where conscientious objection is not really conscientious objection if others are implicated in that decision. There is a kind of questioned conscience, I guess.

Mr SMITH: I appreciate that. I suppose where you are saying it is a theoretical reality, conscientious objection is a theoretical point of view as well in terms of theory or faith.

Mr Norman: It is.

Mr SMITH: It is definitely a much bigger question. I wonder if you can appreciate that we, as legislators, need to make sure we are legislating to the law of the land which has been brought in, in 2018, and appreciating that if there is going to be conscientious objection as it stands under 2018 we need to apply that throughout, for fairness of all health practitioners so that one health practitioner group does not have a higher level of conscientious objection to another.

Mr POWELL: Unless the parliament chooses to legislate accordingly through an amendment.

Mr SMITH: I look forward to your amendment.

Mr Norman: Our solution is maybe overly simplistic, but it is simple nonetheless. Our recommendation is that section 8(3) of the Termination of Pregnancy Act 2018 be deleted which simply removes conditions on conscientious objection. It is reasonably simple. I would not have your job for quids. At the end of the day, I take my hat off to legislators, to people who sit in parliament. Our job is to raise voices from people out there whom we represent, and I appreciate the opportunity to do that.

CHAIR: Thank you very much, Mr Norman. You have done that very well for your members. We thank you for your contribution here today. I now close the hearing.

The committee adjourned at 1.15 pm.