ABORTION LEGISLATION REFORM BILL 2023

Committee

Resumed from 12 September. The Deputy Chair of Committees (Hon Sandra Carr) in the chair; Hon Sue Ellery (Leader of the House) in charge of the bill.

Clause 8: Part 12C Divisions 1 to 5 inserted —

Debate was adjourned on the following amendment moved by Hon Ben Dawkins —

Page 8, line 6 — To delete "23" and insert —

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Hon SUE ELLERY: Before we get to where we left off, which is the first amendment to clause 8, I will provide the chamber with information that was requested yesterday or the day before. This is not related to the matter we are debating now, but was information sought during the course of the day. Hon Nick Goiran asked a question about whether the coroner was consulted. I can confirm that the coroner was consulted, as were other heads of jurisdictions, but I am not in a position to table any of that communication. A couple of members asked about the statistical report for years 2019 to 2021. The report has not yet been completed, however data continues to be reported to the Chief Health Officer and remains available on request. One of the pieces of work was impacted by the work the Office of the Chief Health Officer needed to do in respect to the pandemic. To aid members in the debate, I am able to table the general statistical information for the past five years. The document is headed "Statistical information on abortions in WA from 2018–2022." I ask that we get copies made because it is ridiculously small.

[See paper 2494.]

Hon SUE ELLERY: I was asked about key stakeholders who received a written invitation to participate. There were 43 organisations or bodies with relevant expertise invited to make a submission. I have a list that I can table. Of course, more than 17 500 responses were received in total. I table the list as well.

[See paper 2495.]

Hon SUE ELLERY: I was also asked about the consent to treatment policy. The WA Health consent to treatment policy is available online. I can make it available in hard copy if requested. Another query, from when we sat last month, was about an outline of the changes made to data collection. I have a table headed, "Comparison of Form 1 to the new Bill" and the "Comparison of DoH Report to the new Bill." I table those two documents.

[See paper 2496.]

Hon NICK GOIRAN: At the outset, as we embark again on the scrutiny of this bill today, I thank the minister and her advisers for taking those matters on notice. At least in accordance with my notes, I think all the matters have been covered. Obviously, we will have the opportunity to peruse and consider those documents shortly. I am mindful that we are currently considering the deletion of the numeral "23". I propose, perhaps with the Leader of the House's encouragement, to park any follow-up that arises from the answers she has provided until we have dealt with this matter here.

Hon Sue Ellery: Yes, otherwise it would be very disruptive.

Hon NICK GOIRAN: It is not that they have been forgotten, particularly regarding consultation with the coroner.

To return to the present question before the house, which is whether we should delete the numeral "23" and subsequently, if that is successful, insert the numeral "20". When we left off yesterday evening, I was trying to get to the bottom of what the difference would be, particularly with a case of anencephaly. The context here is that the minister indicated to Hon Ben Dawkins that one of the reasons the government has chosen 23 weeks as the gestational limit before the more restrictive regime of late-term abortion applies is that during the weeks leading into the twenty-third week, scans are undertaken. It is the government's view that it is important to provide a pregnant woman time to be able to make a decision following having received information as a result of those scans. Under further examination, it was revealed that the government does not intend that to mean that they would be scans of the sex of the unborn child. That is not what the government intends here. Rather, the government intends, as I understood it yesterday evening, that these are scans for what might be described as "fetal abnormalities". We started to discuss whether these might be lethal abnormalities or otherwise. We left the debate on the hypothetical case of anencephaly at 21 weeks. To the best of my recollection, before we had to adjourn proceedings, the minister was taking advice on that particular scenario and whether the difference between what I might describe as the Dawkins amendment and the proposal by government in the bill was simply the involvement of either one or two doctors.

Hon SUE ELLERY: I have re-read *Hansard* and where we left the debate. I will essentially quote from the uncorrected *Hansard*. Hon Nick Goiran sought an explanation for why the government, in his words, had chosen to extend the period from 20 weeks to 23 weeks. He said —

> … we need to understand exactly why there is a proposal to move from 20 to 23 weeks.

I want to go back and remind members how we got to the point of 23 weeks. In the second reading speech, members will recall I said —

> The bill, at part 1, division 2, will reflect a change to the current gestational age limit for additional medical oversight for the termination of a pregnancy from 20 weeks to 23 weeks.

It continues that being able to provide —

> … general abortion access up to 23 weeks will better align Western Australia with other jurisdictions and ensure fewer patients feel they have no option but to travel interstate for medical care.

It was then canvassed during the course of the second reading debate, for example, by a number of members and I responded to it in my second reading reply. It is not common for me to quote myself but I said it was about accessing abortion services. I said —

> This bill will help improve access to abortion care … The bill will remove the requirement under the Health (Miscellaneous Provisions) Act for earlier abortions to be considered by two medical practitioners. It provides that the authorisation of one medical practitioner will be required to perform an abortion on a person who is not more than 23 weeks pregnant. That change alone will significantly address some of the barriers to access …

That is, access to abortion services. It has also been made clear during the course of the debate that the requirement for late-term abortions is driven by a range of reasons. The decision to go to 23 weeks includes the government having considered the advice from clinicians about access to and the type of scans that are done in that 18-plus week period, but there is a combination of reasons. They were canvassed during the course of the second reading debate and again during the course of the clause 1 debate. It is a combination of reasons. I will come back and answer any questions the honourable member might have specifically about scans, but it would not be accurate for the house to think that that is the sole driver and the only reason abortions are sought post 23 weeks. It is not the case. It has not been claimed by me to be the case during the course of the debate. We oppose the amendment for all the reasons I outlined in my second reading reply, in the clause 1 debate and in my formal response to the amendment when it was moved. I reiterate that the parameters for the bill have been carefully considered in close consultation with health practitioners who provide abortion care and relevant health services. All relevant peak bodies and health organisations supported an increase in the gestation age at which additional requirements will apply. As I mentioned yesterday, there were a range of views on the most suitable threshold. However, none of the key stakeholders supported maintaining the status quo of 20 weeks. It is also the case that the community showed a majority support to increase the gestation age at which additional requirements will apply. I indicated that the Minister for Health hosted two clinical round tables and I attended both. Having listened to all the clinical and consumer views, the government determined that 23 weeks is the most appropriate for the Western Australian context. If we retained the status quo of 20 weeks, or even, say, amended it to 21 weeks, Western Australia would continue to have decreased access to abortions compared with other Australian jurisdictions and we would continue to find ourselves in a position whereby women from Western Australia would likely have to continue to travel interstate to seek that care.

We oppose the amendment for all the reasons that I have outlined in the various parts of the debate so far, for the reasons that I outlined yesterday and for the reasons that I have reiterated today. I will go back to the question the honourable member asked about scans and see if there is a response to that. But I want the house to understand that it would be wrong to characterise this as solely being driven by the particular scans that are conducted in the period that we have referred to, post–18 weeks. That is not the only driver.

Hon BEN DAWKINS: I will say a couple of things just because Hon Nick Goiran has covered everything that I wanted to cover in speaking to this proposed amendment. It appears to me that the minister is just not being specific enough to counter what Hon Nick Goiran has said. Hon Nick Goiran was very specific. In a nutshell, the reasons that are being proposed by the minister for extending it to 23 weeks are reasons—including the scans—for which someone could obtain access to an abortion in phase 2, particularly if we look at the amendments concerning mandatory considerations that Hon Kate Doust referred to. The very reasoning for this extension to 23 weeks has already been countered by the fact that someone could access an abortion in phase 2 for all those reasons that the minister says that it is necessary to extend it to 23 weeks. It is not. It can stay at 20 weeks and someone can access it anyway in phase 2.

I remind the minister that—I said it before—Professor Joanna Howe's amendment that did not get through, she did not progress with initially; she proceeded with it in South Australia, attempting to keep it at 20 weeks. That

did not progress in her amendments so it seems she was successful in singlehandedly getting these other amendments through. It is not as though it is coming from nowhere. It was one of Professor Joanna Howe's initial proposals for staying with 20 weeks, and I have been through the reasons recently.

I would just like to thank Hon Nick Goiran for isolating and narrowing these issues. I say that it removes the need for an extension. I just do not think the case has been made out by the minister for an extension to 23 weeks.

Hon NICK GOIRAN: I want to return to the question that I asked, which was in respect of a case of identified anencephaly at 21 weeks' gestation and whether the difference between what I have referred to as the Dawkins amendment and the proposal of the government in the bill is whether one doctor or two doctors would be involved.

Hon SUE ELLERY: To answer both the proposition put by Hon Ben Dawkins and Hon Nick Goiran, the difference between 20 weeks and 23 weeks is that under the current arrangements for a late-term abortion post–20 weeks, someone is required to get —

Hon Nick Goiran: That is not my question.

Hon SUE ELLERY: Let me answer the question, honourable member. Let us just focus on—I will respond to Hon Ben Dawkins. The difference in access, honourable member, is that if we keep it at 20 weeks, someone seeking a late-term abortion post–20 weeks would need to seek approval from the ministerial panel. Seeking that approval —

Hon Ben Dawkins interjected.

Hon SUE ELLERY: Yes; okay. I will not respond then because the member was trying to say there is no difference and I am saying the difference is the ministerial panel.

Hon Nick Goiran's question is about what the difference is in the case of a patient who has a scan and makes a decision on the basis of that scan that they want to seek a termination. That is the member's question.

Hon Nick Goiran: At 21 weeks and the scan identifies anencephaly. Is the difference that there is one doctor involved or two doctors involved?

Hon SUE ELLERY: Under the legislation as proposed at 21 weeks the difference would be one doctor.

Hon NICK GOIRAN: Right. That is what I wanted to get to, because I absolutely acknowledge that the bill deals with the removal of the panel and that is a completely different situation. That is not what I am talking about here. I am trying to understand what difference it would materially have if members were to agree to the Dawkins amendment. We are being told that at 21 weeks' gestation, in the case of anencephaly, with the Ben Dawkins amendment, two doctors would be involved. Without the Dawkins amendment, one doctor would be involved. The next question is: is a case of anencephaly considered to be a serious case?

Hon SUE ELLERY: There are a couple of things. Anencephaly is the incomplete development of the brain and/or the skull, and it is on a spectrum. There is a variety. It might be, if I can describe it, at the low end, in the middle or at the high end. The other point I want to make is that there are instances when other associated fetal anomalies may not be detected until the detailed anatomy, including cardiac ultrasound, is done around 20 to 21 weeks' gestation, which may affect outcomes and prognosis.

Another point I want to make to the house—it is important to understand this—is that we could take an example and say that the clinical presentation of this example at 21 weeks showed X. In another example, the presentation, or the combination of factors, could be completely different and the mother's health could be completely different. I do not think it is necessarily helpful to hang our hat on one particular case of an anomaly and consider that one presentation of it equals X and therefore we should change the limit for the number of weeks' gestation from X to Y. The point of the way it has been drafted is to take into account the fact that there are a variety of reasons—all of them awful—for why a person finds themselves needing a late-term abortion. The thinking into how we landed on the number is reliant, in part, on a particular time frame within which a certain set of scans can be undertaken. That is a helpful tool for us to use to decide where we should land on the gestational period. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists provided the government with a consensus statement titled *Prenatal assessment of fetal structural conditions*, which states —

> Fetal structural conditions affect 2–3.5% of all pregnancies. Routine screening for FSA by ultrasound has become a part of standard prenatal care throughout the world.
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> …
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> Approximately 25% of fetal conditions manifest only in the second and third trimesters and therefore cannot be identified at 11–14 weeks. These include microcephaly, subtle midline brain conditions, echogenic lung lesions and renal structural anomalies and tumours.
>
> …

> The second trimester fetal anomaly ultrasound has been the mainstay for diagnosis of structural conditions over the past 30 years. The examination is generally performed between 18–22 weeks.
>
> …
>
> It is recommended that all consenting patients be offered ultrasound assessment for fetal structural conditions in the mid trimester (generally between 18-22 weeks).

I am just trying to make the point that we can pick any range and any potential fetal anomaly and explore it and land on a particular position, but this has been crafted in the bill to take advantage of the information that is provided by the scans. We also need to acknowledge that that is one factor that is taken into account and that all the factors to be taken into account by the relevant clinicians will be different from patient to patient.

Hon Dr BRIAN WALKER: I get the sense from the questions that have been asked that there is an incomplete understanding of how we go about the process of assessing what is wrong. The first question is the one doctor, two doctor thing. That is wrong. It is actually a team effort. We have the sonographers, the assistants, the radiographer who assesses the sonographer's report and maybe the gynaecologist or obstetrician, who is certainly very capable of looking at the ultrasound and making a determination. That is something to be checked again. The fact that we are talking about one doctor or two doctors does not reflect the actual practice.

Secondly, we have to recognise that when we come to a decision about what to do, we are not taking into account one single factor; we are looking at a wide variety of factors, including personal decisions. The mother might be entirely happy to take to term a child who would have a miserable quality of life. It is entirely her right. It is also entirely a mother's right to be informed about what would happen to the child should it progress to full-term delivery. Does she want that? Is that going to be something she cannot bear? Would it be such a difficult task that her life would be ruined? To try to simplify things to yes or no or a tick-box resolution is simply not appropriate. I think the debate so far indicates that there is a great lack of understanding about what actually goes on in the clinical services surrounding this very difficult type of situation. To be clear, this is a complex decision and no single factor will make a determination. Were members to see an anencephalic child born, they would realise how distressing it is for all concerned—the doctors, nurses and parents. Members might say that perhaps the child could have quality of life with a partial anencephaly, which is true. I personally—this is background information—went into medicine hoping to become a paediatrician. I realised very quickly, seeing the suffering that the children go through, that my heart would break and I could not do that job. I chose not to go into paediatrics because the pain of seeing what the children have to go through was too much to bear. That was just from walking around the ward and seeing what could be done and walking on. I did that in my training and it was more than I could bear, and I think that it would be for most people.

We have to bear in mind that we are not dealing just with a diagnosis, but with a whole spectrum of issues, and trying to reduce it to a common factor that we can then legislate for is entirely inappropriate. Yesterday, I mentioned that the more regulations we put in place, the more the doctors hate it because we need to make decisions based on clinical conditions in consultation with the people who are directly involved, not with the outsiders and bystanders or people with a moral view, whatever their moral view may be. It is entirely up to the caring clinicians and the grieving parents to make a decision about this. It is not at all simple. A process must be gone through, allowing a bit more time for people to process this. Supposing at 21 weeks a decision has to be made, the mum and dad will be talking about it constantly, worrying about it and praying over it. At 22 or 23 weeks they make the decision that they cannot go on. In that very moment, we are not going to make the decision: we have discovered this and now you must do this. That is not the way it happens and that is not the way it should happen. That is placing an intolerable burden on the parents. The idea of limiting it to 20 weeks and specifying what can and cannot happen is entirely inappropriate, clinically. I am speaking from the point of view of a doctor with some experience in this area. It is a terrible situation. The non-clinicians have to get into that mindset of what is actually going on and not deal with this at a distance and speculate on what would happen if this or that occurred and make points about it. That is just not the way things work in medicine.

Hon NICK GOIRAN: The minister explained to the house what anencephaly is. The description the minister provided was that it was either the absence of a brain or, shall I say, a deficient development. That is what I would describe as a serious condition. Under the proposed legislation, if anencephaly has been identified during the scans and a woman seeks an abortion at 24 weeks' gestation, which would be her right under this legislation, there would be no panel and two doctors would be involved in that serious condition. If the bill is not amended, and this was done at 21 weeks for the exact same condition, which is the serious condition anencephaly, it would require a single doctor. As I understand it, that is the only difference here. We need to understand, in practice, what the difference is between accepting Hon Ben Dawkins' amendment or not accepting it. Does the anencephaly case warrant two doctors being involved or not? As I understand it, anencephaly does not apply at 13 weeks' gestation because it cannot be identified at that time. By the government's own logic and reasoning, it has said it would like people

to have the opportunity to consider the scans. It follows that the scans must be of serious matters. In fact, to use the words of the Leader of the House, all the reasons are awful. If all the reasons are awful, and if it is all about the scans and we want to give people the opportunity and time to consider them, it follows that it would be preferable to have two doctors involved.

I take the point Hon Dr Brian Walker made and the objection, if you like, to the regime and the regulation. If he has a grievance with that, I would say that he should take it up with the government because it is not my legislation. Whether we like it or not, moving forward, doctors will be subject to some kind of regulation. The question is whether one doctor or two doctors will be involved, and the government is drawing the line at 23 weeks. I am putting the government to the test about why 23 weeks is the determining factor. If the reason provided by the government is that it needs people to have time to access the scans, I would not quibble with that; that is fine, but what is the purpose of the scans? We have already identified that it is not about sex selection—at least that is not the intention of the government. It is about what have been described as "awful decisions". I interpret awful decisions to mean that there has been a very significant diagnosis. In earlier debate, the minister drew to our attention that there are conditions such as trisomy 18. We have already discussed the anencephaly situation. I know that there are also cases of hydrocephalus; in fact, there were two cases in Western Australia—one was at 27 weeks and the other 28 weeks. A number of other conditions will be of consideration to members, and particularly to the practitioners at the time.

I am just asking for some further elaboration or clarification on why, having received a scan showing a serious condition, the government says, quite genuinely and with good intent on its part, it wants people to have more time to consider the decision they are making. I understand all of that. Whether I agree with it or not is irrelevant. The point is that if a scan shows a serious condition, would we not want two doctors involved rather than one? If not, why is it a case of anencephaly at 24 weeks warrants the involvement of two doctors? By the government's own logic, we should just dispense with having two doctors involved at any particular point in time, and it should always be one doctor.

Hon SUE ELLERY: We are going back to a matter that has been canvassed a number of times. There are differences in clinical practice over the spectrum of time. The honourable member has asked the question of whether it is one doctor or two doctors a couple of times. In the circumstances that he describes, at 21 weeks it would be one doctor, and at 24 weeks it would be two doctors. That is because clinical judgements have been made that say that the requirement is that two doctors be involved when it is past point X. It is based on the best clinical judgements that are available to be made.

However, I think we have to go back to make sure that we are not—I say this with the most generous heart—being verballed. I just scribbled down that the member made a comment along the lines of, "The minister says it is all in respect of the scans." I am trying to make the point that the scans are an important tool and piece of information and advice that may be relied upon, but they are not the only tool nor piece of advice that will be relied upon. I think that is one of the points that Hon Dr Brian Walker made. It is the case that each patient will present with a different combination of reasons for why the decision is being made.

When trying to determine the best way to set the policy of the bill about the regulatory framework around these clinical decisions, the government relied upon advice provided by clinicians. They stated that one of the things we should take into account, depending on the presentation of the woman, was the period between 18 and 22 weeks when a range of scans are done. That was seen to be a useful factor to build into how we developed the policy about the point at which we put in extra regulatory framework around the provisions of that kind of health care. I do not think I can explain it in any other way, honourable member. We listened with great intent to the clinicians at the two round tables to get the best advice. I think the honourable member has already made the point that the discussion paper that went out floated 24 weeks. Based on the consultations we undertook, we landed on 23 weeks. I do not think I can explain it in any other way. We acted on the best advice available to us. We put the patient at the centre, with the principle of seeking to improve access to abortion care. We sought to make sure that for circumstances requiring a late-term abortion, we would have the appropriate regulatory framework in place. Generally, we are trying to make abortion care as accessible as possible. I am not sure that I can describe it in any other way.

Hon NICK GOIRAN: Can I get some advice from the chair? The question before the house is to delete "23". The foreshadowed question that would follow in the event of that question being successful would be to insert "20". I think I flagged this in my contribution to the second reading debate. I have given some consideration of whether I will move an amendment myself regarding whether the limit be 23 weeks or 22 weeks. Again, the minister has not provided any other information to the ordinary person. They would say, "What would be the difference between 23 and 22?" The simple response I have to that is that we are drawing a line here as members of Parliament, whether we like it or not. The line at the moment is 20 weeks in Western Australia and has been for 25 years. The government

is proposing to draw the line at 23 weeks. We need to have a rational and substantive reason to draw the line if we are going to change it. The government has provided some explanation in that respect.

The reason that I suggested we might consider 22 weeks is because the Australian Medical Association advocated for that during the consultation process. In and of itself, it is not sufficient for me to make a case to members to say that we should do this just because the AMA says so. However, I simply make the observation that the government does rely on third-party endorsement from time to time. The more substantive point that I would make with regard to 22 weeks is that from answers to parliamentary questions we know that Western Australian babies have survived at 22 weeks. They have not survived at 21 weeks or 20 weeks—at least according to the answers to parliamentary questions. They have survived at 25, 24, 23 and 22 weeks, but not at 21 and 20 weeks. On that basis, if the government is going to draw an arbitrary line, it follows in my mind that it would be at 22 weeks. Why? Because from there on, a very significant change occurs in terms of what might be described as viability.

I am asking some advice from the deputy chair at this particular point. If the question to delete "23" is successful and then the question to insert "20" is unsuccessful, is it open for a member to move to insert "22"?

The DEPUTY CHAIR (Hon Sandra Carr): Honourable member, yes it is.

Hon NICK GOIRAN: In the same way then, if the question to delete "23" is unsuccessful, would there then be no opportunity to move to replace "23" with "22" because the primary question was defeated?

The DEPUTY CHAIR: That is correct, honourable member. It cannot be replaced with anything else.

Hon NICK GOIRAN: I thank you for the clarification. I presume that puts all members in some form of a dilemma. They will have to make a decision about what they are going to do about the question before the chamber. At the present time, I am inclined to support the amendment to delete "23" for the reasons I have already outlined, not the least of which is that there is an objective and rationale basis for there being viability at 22 weeks' gestation and that answers provided in question time state that Western Australian babies can survive from 22 weeks' gestation. If viability is a factor, if viability matters and if viability changes people's view—what some people might regard as a fetus suddenly becomes an unborn child because at that point they are considered to be "viable"—then to me it follows that that would be the threshold. But that is not the option available to us because the proposal by Hon Ben Dawkins is that it be 20 weeks. That is why I have spent some extra time, more than I perhaps planned when we first looked at debating this bill, trying to fully understand the government's rationale with regard to why it had decided to shift from 20 to 23 weeks. I accept that the Leader of the House has not on one occasion, but on more than one occasion, endeavoured to explain that it is not only about the scans. I accept that that is what has been said.

The point I make is that despite that, it is not apparent what it is other than the scans. It is one thing to say that it is more than the scans, but it is not apparent what else is different. Why are we changing from 20 to 23 weeks other than because we have this extra information provided by clinicians to say that between 18 weeks and 22 weeks' gestation, it is quite common that scans are taken to identify any fetal anomaly. I accept that. My point is that if we identify a fetal anomaly and that is the key driver behind this change, because what other driver can there really be—it cannot be about access because presumably the whole point of this bill by the government is to stop the scenario in which people are allegedly going interstate. There is already significant access in Western Australia. There will be even more access moving forward because the panel has been removed. The panel is no longer a barrier. All that is left in the case of a serious fetal anomaly being identified is a decision as to whether one or two doctors are involved. As I said earlier, it may be the case that that causes offence to doctors in the house, but I would just put to members that if that same fetal anomaly is identified and a decision is made a few short weeks later, two doctors have to be involved.

I have not been provided a response by the minister for why a 24-week case of anencephaly warrants the involvement of two doctors. Do not get me wrong, deputy chair and members, I support the involvement of two doctors. I am not making a case for there to be one doctor involved in the case of anencephaly at 24 weeks' gestation. I am not making that case. Others may want to, but that is not the proposal before the house. We have a system under the government's bill that will mandate that two doctors are involved from 23 weeks onwards. The question that members should ask themselves is why. What is so special that it would warrant the involvement of two doctors? One of the reasons that I might offer is viability. That makes sense. As members of Parliament, we are saying that we know that if these unborn humans are born from 22 weeks onwards, they are viable and can survive, so we want to take a different approach. We want to give special consideration and have extra circumstances considered and we would like the benefit of having two doctors involved. I assume that is why the government and members support a different regime from 23 weeks onwards. If there is another reason why we want two doctors to be involved after 23 weeks, I am open to be persuaded by members, but during the course of this debate I have not heard of any other explanations as to why two doctors are involved from 23 weeks onwards. I am left with the information provided by the honourable minister that significant weight has been put towards the existence of scans between

18 and 22 weeks. The scans are not for sex selection but for determining the existence of fetal anomalies. It follows that if this "awful" decision has to be made any time after 18 weeks actually and a scan has been provided, that the family would benefit from two doctors being involved just as they are from 23 weeks onwards.

Hon MARTIN PRITCHARD: This is not a question but just a quick statement. Reflecting on the advice of the Chair of Committees and taking the opportunity to read the uncorrected *Hansard* from last night, I would like to say that I made a mistake about one aspect of Hon Ben Dawkins' contribution on his amendment. I was wrong to suggest that he implied that there would no longer be abortions after 20 weeks and I apologise for that part. However, I will still not be supporting his amendment.

Division

Amendment put and a division taken, the Deputy Chair (Hon Stephen Pratt) casting his vote with the noes, with the following result —

Ayes (4)

Hon Kate Doust	Hon Nick Goiran	Hon Neil Thomson	Hon Ben Dawkins *(Teller)*

Noes (27)

Hon Martin Aldridge	Hon Sue Ellery	Hon Shelley Payne	Hon Dr Sally Talbot
Hon Klara Andric	Hon Lorna Harper	Hon Dr Brad Pettitt	Hon Wilson Tucker
Hon Dan Caddy	Hon Jackie Jarvis	Hon Stephen Pratt	Hon Dr Brian Walker
Hon Sandra Carr	Hon Ayor Makur Chuot	Hon Martin Pritchard	Hon Darren West
Hon Peter Collier	Hon Steve Martin	Hon Samantha Rowe	Hon Pierre Yang
Hon Stephen Dawson	Hon Kyle McGinn	Hon Rosie Sahanna	Hon Peter Foster *(Teller)*
Hon Colin de Grussa	Hon Sophia Moermond	Hon Matthew Swinbourn	

Amendment thus negatived.

Hon NICK GOIRAN: We have dealt with the first of the amendments on the supplementary notice paper and the following two now fall away. The next amendment on the supplementary notice paper, at 18/8, stands in my name. Before I move that amendment, I note that it pertains to page 9, line 13 of the bill and proposed section 202ME, "Performance of abortion by medical practitioner at more than 23 weeks". Before we get to proposed section 202ME, I will continue to ask a few questions on the two preceding proposed sections—that is, proposed sections 202MC and 202MD, just to assist the deputy chair with the management of the bill.

I take the Leader of the House back to where we were prior to the amendment being moved, when we were considering the information she kindly provided to the chamber earlier this afternoon. One document was on the impact of data collection changes on the triennial report. The Leader of the House kindly tabled a document that set out the changes to form 1 under the bill—the reporting information—and also the triennial report. I indicate that I am yet to receive a copy of that tabled paper; I think it was the last of the ones provided by the Leader of the House. I have been provided with a copy of the statistical information on abortions in WA from 2018 to 2022—that is, the last five years—and the list of organisations and bodies invited by the Department of Health to make a submission to the abortion consultation in 2022. I thank the Leader of the House for providing that information, and I thank the deputy chair for arranging such an efficient way for that other tabled document to now be provided to me! I want to conclude the consideration of the issue of the triennial report. As I said, I thank the Leader of the House for providing five years' worth of data. Is it intended that the triennial report for 2019 to 2021 will still be prepared?

Hon SUE ELLERY: I am not able to give the honourable member a precise answer. The decision is still with the Chief Health Officer on whether he will do that. No decision has been made just yet.

Hon NICK GOIRAN: I am happy to take this by interjection. If a report is to be provided and these arrangements have not yet commenced, it is reasonable for us to expect that the report will be similar to the previous triennial reports. If it is prepared after these new arrangements are in place, it will be in a modified form, as that was the explanation provided in the tabled paper.

Hon Sue Ellery: I expect that to be the case, but I have no further information than what I have already given the honourable member.

Hon NICK GOIRAN: The final outstanding matter that was taken on notice concerns the State Coroner. There may have been some misunderstanding. I asked whether the coroner was consulted. The Leader of the House indicated yesterday that that was the case and she reaffirmed that point today. The Leader of the House indicated today that the coroner was not the only person consulted, but the communication on that consultation cannot be tabled. My question still remains about the coroner's recommendations, not the consultation on this bill.

Hon Sue Ellery: I know what you are referring to.

Hon NICK GOIRAN: Can that be provided?

Hon SUE ELLERY: I am advised that the advice from the Attorney General is that, no, we are not in a position to provide the honourable member with that information.

Hon NICK GOIRAN: I will take it up at another time. I do not understand why the Attorney General has said that to the Leader of the House or the advisers, given that he told Hon Peter Foster's committee—a point we discussed a little earlier this afternoon during consideration of committee reports—that the reason it could not be provided at that time was that it had yet to be deliberated by cabinet. The implication was that once it had been deliberated by cabinet, it could then be publicly released. Having pursued this issue for some three years, including by way of a parliamentary petition, and now at the pressing point of needing to decide about the coroner's jurisdiction in these matters, I do not understand why that matter is not going to be released to us. We will take that up at the relevant clause.

Going back to proposed section 202MC, during the consideration in detail stage in the other place on 15 August, the member for Vasse asked the health minister questions about whether any pain relief is given at the 13-week gestational level and above. The response by the health minister was —

> There is no indication that birth in itself is a painful process …

I refer to a 2020 study in the *Journal of Medical Ethics* titled "Reconsidering fetal pain". The researchers recommended —

> Fetal analgesia and anaesthesia should thus be standard for abortions in the second trimester, especially after 18 weeks when there is good evidence for a functional connection from the periphery and into the brain.

In light of that study, is it the case that pain relief is given in Western Australia after 13 weeks? The context, of course, is that proposed section 202MC will allow a medical practitioner to perform an abortion at no more than 23 weeks.

Hon SUE ELLERY: The first point, of course, is that I do not have a copy of the study that the honourable member referred to. I believe him when he said that he was quoting from its findings, but we do not have a copy of it, so I take it on face value. I can tell the honourable member that the position in Western Australia is based on the advice of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, which is that by studying the neural pathways and brain development of the fetus, the scientific community has determined that the fetus cannot perceive pain as a noxious stimulus before 23 to 24 weeks' gestation. Prior to this time, the nervous system is not developed enough to perceive noxious stimulus as pain. Guidelines for abortion procedures take this into account. It should be noted that sedation and pain relief given to the mother will cross the placenta and also act to sedate and anaesthetise the fetus. It is for this reason that maternal morphine and midazolam is used at King Edward Memorial Hospital for Women. That ensures that the fetus is always treated with due care and respect. The American Society for Maternal–Fetal Medicine stated in its 2021 paper that the use of analgesia and anaesthesia for maternal–fetal procedures makes it clear that the experience of pain is dependent on specific development of the nervous system, which is not present prior to the late second or early third trimester at 23 to 24 weeks. As I said, this position is supported by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Hon NICK GOIRAN: All of which is to say that under proposed section 202MC, which authorises a medical practitioner to perform an abortion on a person who is not more than 23 weeks, pain relief is not given to the unborn baby. I heard what was said about pain relief being provided to the mother. Does it follow that for abortions performed by a medical practitioner at more than 23 weeks under proposed section 202ME pain relief is provided?

Hon SUE ELLERY: I am advised that the practice in Western Australia at King Eddy's is based on the fact it is feticide. If the mother decides otherwise, for reasons that we canvassed before, a decision is made based on the circumstances of what is happening in the theatre at that time. It may be the case that if the mother has not chosen feticide and the birth occurs, a clinical judgement will be made on what is the best way to provide immediate care to that child. That may include pain relief or some of analgesia. It will depend entirely on the clinical circumstances.

Hon NICK GOIRAN: That seems to exclude pain relief being provided when feticide occurs.

Hon SUE ELLERY: Yes. In feticide, the fetus is dead. There is no need to provide pain relief. If I anticipate the member's next line of questioning, the answer is no. There is no pain relief when feticide applies.

Hon NICK GOIRAN: I accept that that is the outcome with feticide, but the performance of feticide on the unborn baby may, I take it, involve pain, depending on the gestational age of the unborn baby.

Hon SUE ELLERY: To be clear, when the feticide practice is used, it is normal practice to provide the mother with some form of analgesia or sedation, and that goes through the placenta to the unborn child.

Hon NICK GOIRAN: For the benefit of members, I indicate that I have no further questions about proposed section 202MC, and I move to proposed section 202MD. I note that this does not prevent members from going back to that proposed section to ask further questions if they wish. Proposed section 202MD looks at incorporating a group of registered health practitioners to be involved in phase 1 abortions or those done prior to 23 weeks. The definition of a prescribing practitioner is a person who —

> (a) is authorised under the *Medicines and Poisons Act 2014* to prescribe an abortion drug …

It also goes on to state —

> (b) is prescribed by the regulations for the purposes of this definition.

Who are the registered health practitioners it is intended will be able to prescribe other than those captured under proposed section 202MD(1)(a)?

Hon SUE ELLERY: It is anticipated that we would include only nurse practitioners or endorsed midwives in those regulations, but their scope of practice is such that they could only be included in that list for terminations that are performed up to nine weeks. There is no intention to add anyone else. For those that the proposed section intends to add, it is within their scope of practice, which is up to nine weeks. If that is helpful, that is the Therapeutic Goods Association guidelines.

Hon KATE DOUST: With the addition of two categories of practitioners, and that earlier provision about the restricted period of time, are they mainly being added to perhaps provide better access in remote or regional areas or will they also be able to perform that function in the metropolitan area as well?

Hon SUE ELLERY: It is not just about rural or remote. It is also important to note that these practitioners are already authorised under schedule 4. However, it is generally about improving access. It will include rural and remote, but it is not limited to that.

Hon MARTIN ALDRIDGE: This is an area I talked about at length in my speech at the second reading stage, and I highlighted that it was an area of interest. Subsequent to that, the health minister's office reached out to me and arranged a meeting with Dr Zoe Bradfield, a nurse, midwife and academic at King Edward. She is also the vice-president of the Australian College of Midwives. She addressed a lot of the practical questions that I wanted to understand about the application, scope of practice, the ability to order diagnostics and a range of other things. I was also interested in the interaction between a midwife and the abortion process. That relationship would probably happen later in a pregnancy, although I appreciate that there are circumstances in which people are on their second, third or other pregnancies and may have an established relationship with a midwife at that point. My question is about proposed section 202MD, which states —

> (1) In this section —
>
> ***prescribing practitioner*** means a person who is a member of a class of registered health practitioners that —
>
> > (a) is authorised under the *Medicines and Poisons Act 2014* to prescribe an abortion drug; and
> >
> > (b) is prescribed by the regulations for the purposes of this definition.

Is my understanding correct that a prescribing practitioner needs to meet both limbs, in that they need to be authorised under the Medicines and Poisons Act and be prescribed by the regulations?

Hon Sue Ellery: By interjection, yes, honourable member.

Hon MARTIN ALDRIDGE: Okay. Why is an authorisation under the Medicines and Poisons Act 2014 not sufficient?

Hon SUE ELLERY: Essentially, there are two reasons. Firstly, medicines can be used for a variety of purposes so a person may be authorised under the Medicines and Poisons Act to prescribe an abortion drug but that particular drug may not be just for the purposes of abortion. It is adding an additional layer of accountability so that we are specifically saying, for abortion care, that is the test they have to meet. The formal explanation is that the Medicines and Poisons Act provides the class of registered practitioners who can prescribe a scheduled drug. Any authority to prescribe what is confirmed under the Medicines and Poisons Act is done so by broad schedule classification only—not a specific drug, but the entire schedule. For example, currently, the act provides that a medical practitioner, nurse practitioner or endorsed midwife can prescribe a schedule 4 medicine. This includes any medicine in schedule 4 and so would not exclude one that may or may not be used for abortion. A drug can be included in more than one schedule and can be prescribed for any number of medical uses. For example, this is the case for MS-2 Step, which, prior to 2012, was approved in Australia only for the treatment of gastric and duodenal ulcers. It is about adding an extra level to the provision of this particular form of care.

Hon MARTIN ALDRIDGE: Thanks, minister. That makes sense. I mentioned the Therapeutic Goods Administration approval in my contribution to the second reading debate. The TGA amended its previous decisions and approval of MS-2 Step, which I understand is the common abortion drug that is used. It extended it to nurse practitioners and endorsed midwives and therefore the relevance of this section before us. Is my understanding correct that jurisdictions beyond Australia authorise the use of MS-2 Step after nine weeks of pregnancy? I ask that because we are talking about nine weeks now but obviously if a TGA decision occurs in the future that it is safe to use at 10, 11 or 12 weeks, will that automatically flow through to our regime as a decision of the TGA?

Hon SUE ELLERY: There were two questions. On whether other jurisdictions allow the use of MS-2 Step beyond nine weeks, the best advice is that we think, yes, in the USA, but do not take that as gospel because it is not tested. The second question was whether, if the TGA makes a decision to extend the period, it would automatically flow. It would not automatically. If such a decision was made, our regulation-making power in Western Australia gives us the capacity not to change the gestation period within which that drug could be applied by people who practice here. I am advised that common practice is that we follow the TGA rules, but we are not obliged to.

Hon MARTIN ALDRIDGE: That is interesting because my natural assumption was that if I am a prescribing practitioner, I am authorised under the Medicines and Poisons Act 2014 to prescribe an abortion drug and I am prescribed by the regulations for the purpose of this definition. As long as I comply with the other clinical guidelines and policies, including those of the TGA and probably many other bodies, it is within my scope of practice to do so. The minister is saying that we are able to limit that by regulations. Where in the bill is the ability to provide that regulatory limitation?

Hon SUE ELLERY: It is the regulation-making power we are looking at now in proposed section 202MD(1)(b). I put the caveat again that it is anticipated we would have no reason to deviate from the TGA's position, but paragraph (b) gives us the capacity to say in our regulations that, for the purposes of this definition, a "prescribing practitioner" who is an endorsed midwife or a nurse practitioner, can dispense and administer the drug up to nine weeks. We can put a limit around it. I do not want to go down a rabbit hole because the overall caveat is that there is no reason to think we would not follow TGA advice.

Hon MARTIN ALDRIDGE: Yes, I understand that. I wanted to understand whether we have effectively outsourced the decision to make it nine weeks because I cannot find nine weeks mentioned anywhere in the bill. Whether we simply outsource it to the TGA to make a decision or retain some decision-making power, the minister is saying that this proposed section, through the regulations, can qualify it. I assume the only provision is in proposed section 202MD (1)(b) —

> is prescribed by the regulations for the purposes of this definition.

The minister is saying that the government can qualify, for the purposes of proposed subsection (1)(b), the practitioner and also circumstances such as gestational limits on whether someone is a prescribing practitioner. That is not obvious from my reading of the bill but if the minister is saying the government has the ability to say "only these practitioners have the ability to prescribe up to certain gestational limits", then I accept that.

Hon NICK GOIRAN: Further to this line of questioning by Hon Martin Aldridge, I picked up an article in *The Australian* of 17 July. It is entitled, "Peak obstetricians' body warns women at risk after abortion pill access expanded". I will briefly quote from it —

> National Association of Specialist Obstetricians and Gynaecologists president Gino Pecoraro said allowing nurses to prescribe the abortion pill would see "lesser trained practitioners" handing out the medication.
>
> "You can't just start something like this, you have to have all the infrastructure in place to deal with all of the complications and it may simply be that it's just not safe to do this everywhere," he said.

The article goes on to say —

> Dr Pecoraro said he had been called in to help save the life of a 40-year-old woman earlier this year who was flown in from regional New South Wales after being prescribed …

The medicine—I apologise, minister. My notes are cut off at this point, so I will stop there in terms of quotes. My staff will be thrilled that the quote was cut off when they read this in *Hansard*. The point is, have any of those concerns about bringing in what is being described here by the specialist as "lesser-trained practitioners" been raised with the government in regard to proposed section 202MD?

Hon SUE ELLERY: While the advisers are considering advice, I will advise the member, and perhaps ask Hon Dr Brian Walker to close his ears. This is an old chestnut about what nurse practitioners, in particular, can do. I say that from the perspective of someone who worked for the Australian Nursing Federation. I was involved in debates about scope of practice for nurse practitioners and how there was a view amongst some in the medical

profession that the sky would fall down and the end of the world was nigh. It has long been the case that nurse practitioners, like a whole range of other clinicians, operate within the scope of their practice. They are required to be registered. They are required to be highly trained. They are required to do ongoing professional development. They are required to meet any number of standards. I can formally advise that nurse practitioners already demonstrate strength in clinical assessment and health history taking and are authorised to prescribe schedule 4 drugs. Sound sexual health and contraception knowledge are essential, as is the ability to undertake women-centred counselling around these topics. They have a good understanding of the medications used in abortion and provide clear education on their use, effects and side effects.

Additionally, nurses who care for women undergoing surgical abortions must have knowledge of the perioperative patient journey. Nurses from other clinical areas often facilitate women's access to abortions. It is worth noting that the idea of midwives being involved in the abortion process was brought up by the Senate Community Affairs Reference Committee of the Australian Senate at recommendation 20, that midwives should be allowed to prescribe MS-2 Step.

The member's actual question was whether it was raised by anybody. I am advised that it was raised by the AMA during the course of the consultations. I met with the AMA specifically and I do not recall them raising that with me. I invited the AMA to listen to the debate and I would like them to close their ears at this moment. This is an old chestnut. I do not mean to diminish or belittle the proposition put, but nurse practitioners have long been providing complicated and complex care within the scope of practice.

Hon NICK GOIRAN: The point is that the government is aware of the debate, the concern or views, and has considered it and has landed where it has. Later in that article, where I do have the further quote, the president of the National Association of Specialist Obstetricians and Gynaecologists said —

> Of all medical abortions, he estimated about 5 per cent resulted in complications.

The article goes on to say —

> "Someone could die because of this," he said.

Is there any data that has been collected in Western Australia? The context here is that he said he was called to save the life of a 40-year-old woman from regional New South Wales. Is there any Western Australian data with regard to the complication rate as a result of medical abortions? If so, I am particularly interested in any rates for the fewer than nine weeks' gestation period, in which we will be empowering this new cohort to be prescribers.

Hon SUE ELLERY: The answer to the question is no. We do not have any data, nor are we aware of any data on complications for medical abortions performed up to that gestation point. It is not that we do not have it and it is somewhere else, we are not aware of it being collected anywhere.

Hon NICK GOIRAN: Moving forward under this proposed regime, will data be obtained about complication rates and death rates in particular? I know there is going to be a different level of data provided to the Chief Health Officer based on their direction.

Hon SUE ELLERY: It is not intended for the information to be collected through the process of the directions—that we have already touched on—that the Chief Health Officer will issue. Information about deaths, for example, is collected elsewhere for other purposes, regardless of the procedure being performed. In respect of complications, it may well be, depending on the clinical setting that there are requirements around critical incidents. A critical incident or complication is not of itself a critical incident, but it depends on the circumstances. The immediate answer to the member's question is no. It is not the intention of the CHO to gather that material through the mechanism of the directions. Depending on the circumstances, it may be that that information is collected elsewhere as part of routine data collection around negative outcomes in respect of a whole range of medical procedures.

Hon NICK GOIRAN: Noting that the Chief Health Officer is yet to make a decision about what type of data will be collected, strong consideration should be given to this data being collected. We want to know if there will be serious complications that will arise. If this expert from New South Wales is saying that the complication rate is five per cent, that is not insignificant when we consider how many medical abortions are taking place. We have already ascertained that under the existing regime over the last 25 years that the significant majority of abortions take place in the earlier stages. By definition that means that the majority of them are taking place by way of a medical abortion. If five per cent have complications, I would have thought that it would be in the best interest of the Chief Health Officer and Western Australia to continue to monitor that. I make the case that that data ought to be collected. Given that some data will be collected, it should not to be too difficult to record any complications that arise—and it is even more important if a death were to occur. I make that case and I hope the Chief Health Officer in due course will give that due consideration.

My final question on proposed section 202MD, found at page 8 of the bill, is on the 23-week limit imposed on prescribing practitioners, who are registered health practitioners. What is expected to be the practice for them to be informed of the gestational age?

Hon SUE ELLERY: They will establish that by way of an ultrasound, honourable member. For them to prescribe, they need to have seen the ultrasound.

Hon Dr BRIAN WALKER: Just for clarification for the benefit of members, for every woman who presents to a medical practice and says "I have missed my period", the first thing we do is determine the date of their last period, which gives us an approximate date of confinement. That date is further qualified by the first scan. By the second scan, once we have a clearer view of the organ development, we can give a better idea. The age of gestation is found, but it is always plus or minus a few days. Every woman who has conceived will have a date attached to her name in her medical records. That is without exception.

Secondly, on a point of clarification, the honourable member mentioned that five per cent of the terminations might have a complication. One in 10 pregnancies ends in a miscarriage. They have rates of complication as well. These are things such as retaining products of conception. This is a normal process. When the implantation of the placenta separates with the loss of the pregnancy, the patient may retain products that can cause infection, inflammation and certainly bleeding. That would certainly be interpreted as a complication. When we say "complication", it is not something bad. It is simply one of those things that happens. For example, if someone gets a boil after a simple injection, it is a complication of the injection. It can be life threatening but it is something we would expect. Every single procedure in medicine has a potential for complication. That is a normal aspect of medical life, which is why we are so heavily regulated. Things can go wrong.

We even have a measure of development within society of maternal mortality. The greater the maternal mortality, the less developed are the health services. Even in well-regulated and well-developed health services, we have a significant rate of maternal mortality. This is a normal part of pregnancy. This is why we need to be careful about this. Questions about abortion and death rates—this happens throughout normal pregnancy as well. The member makes a big deal of it, but it is a normal part of life. We need clinical considerations at all times regarding what we are doing with a woman at this time under these conditions. The complication rate may be a red herring. It is not something to be worried about but members should take note that these things can happen.

The member mentioned nurse practitioners, who do a fantastic job and I am very much in support of that. I must tell members that very often the nurses put out their hand and stop the doctor from doing something they should not do, because we can get some pretty stupid actions. By the grace of God go most doctors, and nurses hold them back from doing something stupid.

Hon Kate Doust: Just as well as there are some regulations in place.

Hon Dr BRIAN WALKER: Indeed, that is so. This is why we need qualifications and people maintaining standards and working as a team. People need to respect each other as part of a team all doing different jobs but working together. The concept here around abortion is not of one person making decisions; it is the whole team. Bearing in mind the natural progress of a pregnancy against the method here of abortion, each one would have particular problems that might be associated with a particular approach used. For example, with progestin to be given intravaginally to stimulate delivery, we get a normal delivery of a very underdeveloped foetus, but things can still go wrong. It needs to be regulated and that is why we have such strict controls.

Hon KATE DOUST: Minister, I am just going to start to ask a few questions leading up to moving a couple of the amendments I have on the supplementary notice paper. I am not planning on moving them right now, but I refer in particular to division 2 and proposed sections 202MC and 202ME. One of the amendments I have on the supplementary notice paper is in relation to sex selection. I made reference to that in my second reading debate contribution. There is a range of reports around sex selection as an issue in the world. I was looking at a report today from the United Nations Population Fund, Asia and Pacific region, 2012. It referred to the increase in sex selection being used and creating an imbalance in gender throughout the world in quite significant numbers. It references that globally there are about 117 million missing girls because of sex selection abortion and a preference for male children.

I know that sex selection has been banned in Australia, since, I think, the early 2000s. I am not sure whether it is just anecdotal information from doctors or whether formal data has come out of other states. I am wondering whether there is any type of information or data in the Western Australian health system. Have doctors reported formally or provided anecdotal information that women have sought an abortion for gender selection at the earlier stage, phase 1, which is currently up to 20 weeks? I want to be very clear, minister, that it is not for sex selection purposes when there may be an inherited family disease, because that is a different issue. Even the amendment that I have put on the supplementary notice paper includes that but not in a negative way. Really, it is about the question

of whether people have requested an abortion for the purpose of gender selection—whether they have a preference for males or females. I am interested to know whether there has been any reporting in Western Australia.

Hon SUE ELLERY: The short answer is no. Clinicians who provide abortion care, including those who provide it at later gestations, advise there is no evidence of that. The short answer is no.

Hon Dr BRIAN WALKER: Here I can give the member an answer directly because I have been approached by women who wanted sex selection.

Hon Martin Aldridge: Hmm.

Hon Dr BRIAN WALKER: "Hmm" indeed. We find that those who choose to do that come from a certain social grouping in which the birth of a boy child is far preferable to the birth of a girl child. I have refused to take this further, as I hope every single other doctor in this country also has. It is entirely unacceptable, but it points out an area of concern. I will refer, if I may, to another horror in our nation, which is female genital mutilation. I cannot think of a single doctor who would actually go through with that. However, there are doctors who come from a country where female genital mutilation is accepted and, in fact, demanded and supported, who, behind closed doors, might secretly perform that procedure, but when they are reported and found, they are disbarred from practice, as they should be, because that is entirely unacceptable. The same thing, I believe, is also true for anyone who would consider doing a secular abortion based on the choice of the sex of the unborn child. It is true that in places like India and China that has taken place, and it is to be condemned entirely; it is not part of Australian culture at all. As far as I am aware, our law is such that a request for such a selection would be refused by any gynaecologists that I know of.

Hon KATE DOUST: Thank you for that, member. That was very helpful.

I do not think a single person in this place would support gender selection simply for that preference model, if you like, in any way, shape or form. I pick up on the member's point that, sadly, it has been based upon particular ethnic groups. That, in fact, was the focus of the report that I looked at. I note that friends of mine who have come from some of those countries have talked about their own experience of having been taken to an ultrasound and pressure was applied to them if they were not carrying the right gender. The nature of technology has changed and advances have been made in both accessing scans and the imagery of the scans that assist in identifying the gender of a child earlier. It used to be roughly around 16 weeks when someone who asked could expect to be told what the gender was. I do not know whether that time has been brought forward because of the changing technology. I have raised that a couple of times over the last couple of days. The report that I looked at talked about the fact that because technology has advanced and is much cheaper to put into not only hospitals, but also smaller clinics and other places, that has enabled better access and it has become more affordable for individuals to get that information. My concern about changing the goalpost from 20 to 23 weeks when a woman can seek an abortion without having to provide a different justification when it is life threatening to the child or themselves—I will keep it in those simple terms—perhaps gender selection either will or is happening and we just do not know it and perhaps doctors are not reporting it. I have a series of questions around that. Is there a guideline in Western Australia, or a document from the Chief Health Officer or the department, that provides guidance to doctors or medical practitioners about how to deal with the question that is put to them by a pregnant woman who wants gender selection as a reason for an abortion? Is there information about how to manage that?

Hon SUE ELLERY: No, honourable member.

Hon KATE DOUST: I only ask that because I am pretty sure that Queensland and New South Wales have quite detailed guidance notes around a whole variety of termination issues. The gender selection issue was quite interesting to see, particularly in New South Wales. I might just find the document because it goes into a whole range of detail. It is titled *Prevention of termination pregnancy for the sole purpose of sex selection*. It is from the New South Wales government and was published in June 2021. It is a fairly straightforward document. It is only a couple of pages. It talks about the key principles in New South Wales pertaining to this particular issue. I will quote select parts of it. It says —

> The NSW Parliament has opposed the performance of termination of pregnancy for the sole purpose of sex selection.

The Parliament has been very clear, not just the government. I think we have seen that also in South Australia, which is one of the reasons I have put my amendment on the notice paper. The document goes on to say —

> This Guideline relates to when a termination of pregnancy is sought for the sole purpose of sex selection. This Guideline does not apply to a termination due to the possibility of a sex-linked medical condition in the fetus.

I have already said in my earlier comments that that is an entirely separate issue, in my view. The guideline goes on to say —

> Before performing a termination of pregnancy, it may be disclosed to the medical practitioner that the reason for the request is for the sole purpose of sex selection. If this is the reason for the request, the practitioner **must not** perform the termination, unless not performing the termination will cause significant risk to the woman's health or safety.

Towards the end of the document, it says —

> When a termination for the sole purpose of sex selection is refused, the medical practitioner must offer additional support and referral to counselling or other relevant services.

We are told that those situations have not been formally reported in Western Australia. If the New South Wales Parliament, and obviously the New South Wales government, has taken the hard decision on this aspect—I think there is a reference of a similar nature to it in Queensland—will the Western Australian government, given the shift in the time line to 23 weeks, clarify for medical practitioners what to do in that circumstance? It may be that our good friend Hon Dr Brian Walker is not alone in his experience, and for some reason it is just not something that doctors think they should report or can report or know how to report or seek guidance on. I imagine it would be a pretty tough position for a doctor to be put in when that question is put to them. I will wait for the answer to my question about whether the government will contemplate putting some sort of guideline in place in a similar vein to that which exists in New South Wales currently.

Hon SUE ELLERY: I am advised that there is no intention to issue a guideline along the lines the member referred to. There is an amendment on the notice paper, and we will be able to debate that when we get there, but there is no intention or plan to do that, which is not to say it will never happen.

Hon KATE DOUST: I know that the amendment has been proposed. The minister has already indicated that the government will not support any of those amendments. In light of that anticipated outcome, will the government give consideration, in the absence of a requirement in the legislation, to provide a guideline?

Hon SUE ELLERY: There is no intention to do that, honourable member. That does not mean it will not happen at some point in the future. The advice available to me here at the table right now is that there is no intention to provide that specific guideline. The advice available to me is that in the clinical advice sought on the bill, clinicians did not report that being an issue. That does not take away from Hon Dr Brian Walker's experience. I believe him when he said that is what a patient presented to him. However, the best available advice to me is that clinicians did not indicate that that was an issue for them and there is no intention from the Chief Health Officer at this point to issue any guidelines. That might change at some point in the future, I do not know, but there is no intention at this point.

Hon KATE DOUST: I understand the minister saying that clinicians did not indicate that this was an issue. Were clinicians actually asked the question? Was the question about this situation posed to clinicians?

Hon SUE ELLERY: Yes, honourable member.

Hon NICK GOIRAN: I will move the amendment standing in my name. Before I do, I will respond to the worthwhile dialogue that was just taking place there. I will say to Hon Kate Doust that as a point of hope, we need to remember that there has already been a principle established earlier in this bill that it is important to include things for the sake of clarity and safety, including things like defining the term "person". One would hope that when we get to the relevant amendment about sex selection, most members will support it as a matter of safety and clarity. It would do no harm because, apparently, this is not a practice that we need to be concerned about and it is a practice that nobody supports. There could not possibly be any harm in including the amendment for the sake of clarity and safety, given that we have gone to the extent of even defining what a person is. I move —

> Page 9, line 13 — To delete "circumstances." and insert —
>
> circumstances; and
>
> (c) the primary practitioner, or a medical practitioner consulted under paragraph (b), holds specialist registration in obstetrics and gynaecology under the *Health Practitioner Regulation National Law (WA) Act 2010*.

By way of explanation to members, proposed section 202ME deals with what can be described as late-term abortions. Members will be well aware that under this proposed regime, any two doctors will be able to, and will need to, be involved. My brief submission in support of the amendment that is currently before members is simply to quote from the AMA's position statement regarding this particular clause. It states —

> Clause 202ME—Specialist skills required to perform post-23 week abortions, should be prescribed in the Bill.

> Abortion after 23 weeks gestation is a highly specialised procedure which if performed without adequate expertise, can be dangerous and traumatic.
>
> **It should always involve at least one specialist obstetrician and gynaecologist and the Bill should be amended to expressly refer to this.**

Hon SUE ELLERY: I will indicate that the government will not be supporting the amendment. I think it is important to note at the outset that it is not common practice to stipulate specific specialties in any health-related legislation. We do not see abortion as being any different. All medical practitioners are required to act within the scope of practice at all times. In addition, medical practitioners are well versed in referring a patient to another practitioner if they are not able to provide the appropriate level of care. The current WA act does not stipulate a particular specialty. The majority of other Australian jurisdictions do not stipulate a specialty in their respective legislation. There is no evidence to suggest that non-specification has led to unqualified practitioners providing abortion procedures.

We are relying on the established mechanisms as we do for the provision of any other of any other health care to ensure that safe clinical practice is maintained. If there are concerns about a particular practitioner, they can be investigated by the relevant bodies such as the Australian Health Practitioner Regulation Agency and Health and Disability Services Complaints Office or, if it relates to criminal conduct, by the Western Australia Police Force.

The medical practitioner best placed to advise on a particular case may vary. It could include a whole range of practitioners such as oncologists, geneticists, psychiatrists or a person's known practitioner in another field. It may be useful to receive advice on a particular condition or on the relevant medical history of the patient. Rather than technical medical advice, detailed knowledge of the particular patient and their circumstances, medical history, responses to particular drugs and behaviours may be required. For these reasons, we will not be supporting the amendment.

Hon MARTIN PRITCHARD: I have seen some comments regarding the advice of the AMA. If this amendment went through, it would not necessarily require the person performing the abortion to have that. It could be the consulting practitioner. It will not actually address the concerns of the AMA, or am I looking at that wrong?

Hon NICK GOIRAN: I am happy to assist the member. In its submission talking about late-term abortions after 23 weeks, the AMA stated that they should always involve at least one specialist obstetrician and gynaecologist and that the bill should be amended to expressly refer to that. In its submission, it did not say whether it should be the primary practitioner or the consulting practitioner. Accordingly, when I briefed parliamentary counsel, the member will see that the words proposed to be inserted are that the primary practitioner or a medical practitioner consulted under paragraph (b) hold the relevant specialist registration.

Division

Amendment put and a division taken, the Chair of Committees casting his vote with the noes, with the following result —

Ayes (8)

Hon Peter Collier	Hon Kate Doust	Hon Martin Pritchard	Hon Neil Thomson
Hon Ben Dawkins	Hon Steve Martin	Hon Tjorn Sibma	Hon Nick Goiran *(Teller)*

Noes (24)

Hon Martin Aldridge	Hon Lorna Harper	Hon Dr Brad Pettitt	Hon Dr Steve Thomas
Hon Klara Andric	Hon Jackie Jarvis	Hon Stephen Pratt	Hon Wilson Tucker
Hon Dan Caddy	Hon Ayor Makur Chuot	Hon Samantha Rowe	Hon Dr Brian Walker
Hon Sandra Carr	Hon Kyle McGinn	Hon Rosie Sahanna	Hon Darren West
Hon Stephen Dawson	Hon Sophia Moermond	Hon Matthew Swinbourn	Hon Pierre Yang
Hon Sue Ellery	Hon Shelley Payne	Hon Dr Sally Talbot	Hon Peter Foster *(Teller)*

Amendment thus negatived.

Hon KATE DOUST: I will just pick up one of the other points raised by the Australian Medical Association (WA) in the emails that I think most members received, as well as in its position statement. The link back to the bill is proposed section 202ME(4)(a), which states —

> the principal place of practice (as defined in the *Health Practitioner Regulation National Law (Western Australia)* section 5) of a medical practitioner with whom the primary practitioner consults need not be in Western Australia …

The AMA was quite clear in its email and document, stating —

> There is no sound clinical justification for permitting the medical practitioner with whom the primary practitioner consults for the purposes of Clause 202ME (1)(b), to have a principal place of practice outside Western Australia.

Can the Leader of the House explain whether it is a new arrangement to enable that person to consult outside Western Australia?

Hon SUE ELLERY: No, it is not, honourable member; it is just that the existing legislation does not refer to it at all. From time to time, a practitioner might need to consult somebody from a different jurisdiction. It has been inserted into the bill before us to make it clear that that is not prohibited. That does not mean that it has to be done; it just means that it is not prohibited. For example, I referred earlier to the need to understand a patient's history, so consultation might need to occur with somebody who used to provide care in another jurisdiction or who used to provide care here but is now in another jurisdiction. It could be for a range of reasons. It might be that the best person to consult in a particular area of speciality is in another jurisdiction. We would not want to limit getting the best advice based on the jurisdiction. I am advised that it is not new in the sense that it is precluded now and will be allowed in the future; the current legislation is silent on it.

Hon KATE DOUST: I know that the Leader of the House will correct me if I am wrong, but am I correct in thinking that situations in which a primary practitioner might seek advice from a different type of practitioner elsewhere will apply only for post–23 weeks abortions or will it also apply to pre–23 weeks abortions?

Hon SUE ELLERY: Under the bill before us, people will not need to consult two practitioners for abortions up to 23 weeks. That does not mean that a single practitioner might not seek advice from a colleague—they might, and they might be interstate. The provisions that we are talking about sit within proposed section 202ME, "Performance of abortion by medical practitioner at more than 23 weeks". Proposed subsection (4) at the bottom of page 9 is in reference to abortions performed at more than 23 weeks, because that is when two practitioners will be required. Proposed subsection (4)(a) specifies that the second medical practitioner will not need to reside in Western Australia. Nothing will prohibit a practitioner who is going to perform an abortion prior to 23 weeks from picking the brains of a colleague who resides elsewhere if they think they need assistance or clinical advice. Nothing will stop them from doing that.

Hon KATE DOUST: Proposed section 202ME(4)(b) states —

> if a medical practitioner … does not believe that performing the abortion is appropriate in all the circumstances, this does not prevent the primary practitioner from consulting …

In what circumstances beyond 23 weeks will they not believe it to be appropriate? Is there any guidance? Is there a list of circumstances in which that might be the case?

Hon SUE ELLERY: No, there is not. It will be a clinical decision. It could be any number of things, as the honourable member can imagine. All kinds of reasons could lead to late-term abortions. It could be a situation with the health of the mother or the fetus, or it could be the two combined. We do not have a prescriptive list and we would not want to do that. It is about the best care for the patient in the circumstances in which the patient presents at that time.

Hon NICK GOIRAN: Further to this line of questioning, the Leader of the House has indicated on a few occasions that access is important. That has been part of the thrust behind this bill. Part of that has been the anecdotal evidence provided to the Leader of the House and others that some people go interstate. Under this regime, there will be no reason for anyone to go interstate for a phase 1 abortion, but there may be a reason for someone to go interstate for a late-term abortion if they cannot get two practitioners to agree that they reasonably believe that performing the abortion is appropriate in all the circumstances. That could be a possibility. I know that is a concern for the Leader of the House and the government; that is part of the reason the government brought this bill forward. Hon Kate Doust asked for examples of why a medical practitioner might consider that it is not appropriate. I would have thought that the government would have contemplated that. If that circumstance arises, the government will fear that people will go interstate. The Leader of the House can correct me if I am wrong, but she might say that one circumstance that the government feels passionate about is sex selection. She might say that the government's view is that neither the primary practitioner nor the consulting practitioner could or should reasonably believe that it is appropriate to perform an abortion for sex selection reasons. The Leader of the House and the government might hold that view, but that will mean nothing if no guidance is provided to practitioners. It will mean something if the amendment that will be moved in due course gets up. I would like to know what other scenarios the government is concerned might still lead to Western Australians purportedly needing to go interstate.

Hon SUE ELLERY: As I indicated to Hon Kate Doust, I do not have a list. We have not prepared a list. If the honourable member wants to put it in some context, we already know that only a very small number of abortions are carried out post–23 weeks in any event.

The prospect that within that small number there is a sufficient number of people who will not be able to find the two practitioners, including one who might be practising in another jurisdiction, is very small. Nevertheless, it might

exist. We have not contemplated the list because we have determined that this is about putting the patient at the centre. What are the circumstances that the patient presents with? That is what we need to consider, and a clinical judgement needs to be made about that every single time. I appreciate the line of questioning, but I am not in a position to come up with a list of examples. It would depend entirely on the clinical circumstances that the woman presents with.

Hon Dr BRIAN WALKER: Can I verify for the benefit of all members here that the current mood in the medical profession is that selecting sex as a reason for an abortion simply does not come into the equation. It is not something that we would contemplate or permit, or that would even come into our consciousness, because it is utterly irrelevant for the purposes of an abortion. It is not part of our social circumstances. It might have been said earlier that doctors have not raised this as a problem, but that is because it is actually not a problem. If a woman comes to us and says that their 16-week ultrasound showed that they are having have a girl and they want to have a boy so they want to have an abortion, not one of my colleagues would say, "Yes, we'll refer this woman for an abortion." It does not come into the equation. It is not something we would ever take into account. It does not feature within the medical profession because it is irrelevant, as far as I am aware. I am happy to stand corrected if anyone has another experience, but this is my experience within medical practice in not just Western Australia, but all the countries that I have worked in. It is just not the case. We do not refer mothers to have an abortion simply for the purposes of sex selection. That just does not happen.

Hon MARTIN PRITCHARD: In contemplating this, I am aware of the isolation that we have in this state and the reliance on telehealth. In the debate on clause 1, the minister touched on that issue. I am inclined not to support this amendment based on that. Can the minister expand on that at all?

Hon SUE ELLERY: If I understand the honourable member correctly, his question is: to what extent does this impinge on the question of access? Every time we add another layer of regulation, we add to the complexity of the process for people living outside metropolitan Perth. That is one of the factors that would impact on access. One of the main drivers of the government's opposition to this particular amendment is that if we do not require this for other forms of health care, why would we require it for this particular kind of health care? But the member is right to raise it as an issue. Every time we add another layer of something that someone has to do, we know that it is harder to do the further a person is from the metropolitan base.

The CHAIR: Just so that everyone is aware, we are dealing with clause 8 of the bill. I will allow some latitude for debate to occur around foreshadowing amendments, but if we are going to get into detail on an amendment, my preference is that we move to debate the amendment. The question is that clause 8 do stand as printed.

Hon KATE DOUST: We will not have much time as something else is coming along shortly, but the first tranche of amendments that I have on the supplementary notice paper—have I missed something?

The CHAIR: You have the floor, Hon Kate Doust.

Hon KATE DOUST: Sorry; I was just being distracted by hands waving and people talking.

Hon Sue Ellery: Ignore them.

Hon KATE DOUST: Thank you. As I was saying, the first formal amendments that I have on the supplementary notice paper are very much linked together, so I was hoping, minister, to seek the chamber's indulgence to move them en bloc and to talk to them. The first amendment is a linking amendment to enable the second one to be moved, and the third one is the substantive change that is being proposed. I refer to amendments 3/8, 4/8 and 5/8. I am happy to move them and read them out if people are happy to deal with them en bloc. I will do that to deal with them perhaps more expeditiously and because it makes more sense to manage them in that way.

The CHAIR: The first step of the process, Hon Kate Doust, is to seek leave of the committee to move the three amendments together and if leave is granted, you can move the three amendments.

Hon KATE DOUST — by leave: I move —

Page 9, line 23 — To delete "abortion." and insert —

abortion; and

Page 9, after line 23 — To insert —

(d) without limiting paragraphs (a) to (c), the matters referred to in section 202MEA.

Page 10, after line 12 — To insert —

202MEA. Mandatory considerations for performance of abortion by medical practitioner at more than 23 weeks

For the purposes of section 202ME(2)(d), the matters to which a medical practitioner must have regard are as follows —

(a) whether it is essential to perform an abortion of an affected foetus in a multiple pregnancy at a gestation that does not risk severe prematurity and its attendant consequences for the surviving foetus;

(b) whether there are serious foetal abnormalities that were not identifiable, diagnosed or fully evaluated before the pregnancy reached 23 weeks, including but not limited to abnormalities involving the brain, heart, renal and skeletal systems, or whether the foetus has been exposed to infective agents which may damage or limit the gestation and development of the foetus;

(c) whether the person on whom the abortion is to be performed (the ***patient***) has had difficulty accessing timely and necessary specialist services before the pregnancy reached 23 weeks, including but not limited to patients experiencing significant socio-economic disadvantage, cultural or language barriers and those who reside in remote locations;

(d) whether the patient has been denied agency over the decision to continue a pregnancy or not, including (but not limited to) the abuse of minors and vulnerable adults to sexual and physical violence including rape, incest and sexual slavery;

(e) whether the abuse outlined in paragraph (d) includes circumstances in which such abuse is not apparent, or the pregnancy is not diagnosed until an advanced gestational age;

(f) whether medical or psychiatric conditions of the patient may become apparent or deteriorate during the pregnancy to the point where they are a threat to the patient's life;

(g) whether the patient has a deteriorating maternal medical condition, or late diagnosis of a disease requiring treatment incompatible with an ongoing pregnancy (such as malignancies).

The CHAIR: Hon Kate Doust has moved amendments 3/8, 4/8 and 5/8 standing in her name en bloc. The question is that the words to be deleted be deleted. Noting the time, I am going to leave the chair for the taking of questions.

Committee interrupted, pursuant to standing orders.

[Continued on page 4512.]