ABORTION LEGISLATION REFORM BILL 2023

Committee

Resumed from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Dr Sally Talbot) in the chair; Hon Sue Ellery (Leader of the House) in charge of the bill.

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

Committee was interrupted after the amendments moved by Hon Kate Doust had been partly considered.

The DEPUTY CHAIR (Hon Dr Sally Talbot): Members, we are considering the Abortion Legislation Reform Bill 2023. We are in committee, we are on clause 8, and we are considering three amendments, 3/8, 4/8 and 5/8, moved by Hon Kate Doust.

Hon KATE DOUST: Members, I know that we have had a brief discussion, on another occasion, about the language in the series of amendments that I have just moved, and I remind members that one of these amendments was moved and passed in the South Australian Parliament in 2021 for the legislation that it was dealing with at that time. I am, basically, moving this because I have been asked to do so by a number of people in our community who have picked up on a couple of changes that were made in South Australia. I think I said the other day that this amendment is not about taking away from the bill that is before us; it is, hopefully, about providing some clarity and further guidance for the stakeholders involved in this bill.

When we look at the bill and some of the language under proposed section 202MEA, adding this amendment will expand upon the language that is already there. The amendment we are dealing with is the post–23 weeks phase. It is not the lead-up to; it is the after time frame. The set of words that are repeated throughout this clause are "in all the circumstances". The bill says that a practitioner can make the decision to perform the abortion "in all the circumstances" and they can take into account whether the woman is able to have an abortion "in all the circumstances". Subclause (2) provides a couple of examples of this, but they are very generic, if you like. I know that sometimes the intent of the legislation is to have very broad terms so that we have capacity to move, but I like the language that is in the South Australian proposal and its version of the amendment because I think it steps out and reinforces some of the discussions that we have had. We have all talked about how a woman gets to the point of making the decision to have a termination post–23 weeks, and the minister has referred to how horrific it would be for someone in that situation to make the decision about a child who was wanted, anticipated and loved—I may have modified her words, but I think that was the gist of it. I do not think any of us would want to be in the awful position of having to make that call. All the proposed new section will do is provide a range of scenarios and examples. It outlines lots of different types of real-life situations for the practitioner to work through to make the decision in all the circumstances, not just the couple that are listed there. It just steps them out. It would add clarity to the legislation.

I think I also made the point that in other bills in the past, there was not a lot of detail—the language I used was skeletal. The detail was found in other documents that were not necessarily open to parliamentary oversight or public access. I have always taken the view, particularly on issues like this, that it is much better to put as much detail as possible into legislation so that everyone knows where they stand. I know that my good friend sitting across from me Hon Dr Brian Walker will disagree. We have had the discussion a couple of times about feeling as though people are imposing additional layers on doctors, but I do not think we would be.

I also want to make the comment—I think I have made it in the past—that it is our job, as members of Parliament, to make these decisions on behalf of the community. We may not always be skilled in that particular set, but we certainly try to adapt and act in the best interests of everyone involved. Although members might think it is a constraint, I think that putting in place this level of detail would provide guidance on the way forward. Obviously, when members of the South Australian Parliament contemplated their legislation, they decided that this was a very good approach to take in providing guidance to practitioners as a mechanism to assist them in the decision-making about post–23 weeks abortions that they would be involved in with their patients.

I may very well have more to say on this as we work through it, and I am happy to go through each part. I just wanted to put it on the record again. I thank the chamber for enabling me to deal with all three amendments together. It makes more sense to manage them in that way. I look forward to the government response, and I might have a few words to say about that when I have heard it.

Hon BEN DAWKINS: I think that the way that Hon Kate Doust has drafted proposed new section 202MEA is perfectly suitable. I would have thought that these sorts of mandatory considerations would have been in the Labor bill from the outset. They seem to me to be very sensible. There are plenty of things in there that, once the medical practitioner has considered them, would allow access to a phase 2 post–23 weeks abortion for some people in the disadvantaged situations that we and the government have been speaking about. I see it as very sensible and I commend Hon Kate Doust for it. I stand to be corrected, but I cannot see why there would be any difficulty in

adding this level of sophistication to what otherwise, as Hon Kate Doust said, is not a particularly helpful set of provisions as they stand. I think this would be a very commendable addition.

Hon Dr BRIAN WALKER: Let me first of all acknowledge the words of my esteemed colleague Hon Kate Doust. Every word she said is quite correct, but I would like to reference what my colleague Hon Ben Dawkins has just said. He missed out a few things that should be said. For example, what is the current liver function status of the patient? What is her haemoglobin level like? Do we have a reasonable check on her calcium and potassium levels? Members might ask what is the point of that. That is what doctors do. We might then ask: what is the psychiatric status of the patient? What else has gone on? What about her history of sexual abuse, the PTSD she is suffering from, the side effects she has had from the medication to treat her PTSD and how will that impact on the risks of pregnancy in the future?

What members have just said is trying to teach doctors to suck eggs. Everything that is written down on the supplementary notice paper is very sensible and I have personally taught it to medical students. This is the kind of conversation that all medical students go through at the very beginning when they are considering how to deal with this. As a supervisor of young doctors who would come to me with a problem that they had to deal with, I would talk them through the very same points that are listed here, because this is the essence of good medical practice. Do we want to put on top of this bill a thick medical text with all the details of how doctors have to behave? This is our profession. This is how we think. This is how we act. If members want to codify that into law, as my colleague has rightly said, I will oppose it. This is what we do already as a matter of course. This is what doctors do. This is our life.

Frankly, it is quite difficult for those of us in the medical profession to be lectured by people who have not once held a scalpel in their hands and taken a cut in a patient. Not once has anyone here had to switch off a patient's life support—not once. I remember the first time I was asked to switch off life support. It was for a man who had fallen from a roof and we were treating him on the ward. He was brain dead to all intents and purposes. This was a long time ago and we have made further advancements. I vividly recall standing there and thinking that I saw a spark of life in the person, knowing that I was going to switch off his machine and that once he stopped getting ventilated, he would no longer be alive—he would be buriable. I also vividly recall being called to an emergency. I was working in organ transplant at the time and an 11-year-old boy had been hit by a car. There was a bit of brain hanging from his right ear. I had been called from a shopping expedition with my family and my youngest son was there. There I was, at the operating table, and in was wheeled an 11-year-old who looked exactly like my youngest son. I was about to assist in taking out the heart, the lungs and the liver—every single organ. The last part was when he was exsanguinated, and what had been a living, breathing dead boy became an empty corpse. Is anyone here prepared to talk me through the ethics and the emotions of how to do that? This is our profession. This is what we do. It is probably difficult for people who are not in that position to understand what doctors actually do in their daily life, when they come home from work exhausted and want nothing to do with anybody else because of what they had done that day.

When dealing with a late-term abortion, it is not a case of "Next patient, please". We have a process to go through; we help people understand what they will go through. Why will they go through it? If I take an unborn life from them, for whatever reason, I have a person who will be grieving and I want to make it as smooth as possible. While they will grieve, they will feel pain, they will be distraught and it may take them a long time to recover. I need to ensure that I treat them in the most respectable, helpful, healing, loving and kind way. We do not rip life out of people willy-nilly and say, "Next patient, please" and carry on. This is what we always do; this is natural for us. The fact that the member wants to codify it tells me that she does not understand what doctors do. Although I appreciate what the member is saying, it is very respectfully meant and I fully respect where she is coming from, it is not necessary.

Hon NICK GOIRAN: The three-part amendment moved by Hon Kate Doust en bloc seeks to insert seven mandatory considerations that a medical practitioner must take into account before determining whether they think it is reasonably appropriate to perform an abortion. Proposed section 202ME(2) on page 9 of the bill lists three matters that should be taken into account. Are these three matters at (2)(a), (b) and (c) also mandatory considerations for performance of abortions by medical practitioners at more than 23 weeks?

Hon SUE ELLERY: Yes. "Must have" is the language that is used.

Hon NICK GOIRAN: The government has already decided as a matter of policy that it wants to mandate considerations for medical practitioners for late-term abortions. That is an uncontroversial point. The government has highlighted three of those mandatory considerations. Hon Kate Doust seeks to insert seven. I ask the minister to look at the amendment to proposed section 202MEA and the seven itemised mandatory considerations. Are any of those seven mandatory considerations listed by Hon Kate Doust captured by the three mandatory considerations in proposed section 202MEA(2)?

Hon SUE ELLERY: They might be. I have not responded to the amendment yet, but I will in due course. The drafting of (a), (b) and (c) in proposed subsection (2) is sufficient to capture all that is necessary for clinicians to make a decision. If I can rely on the contribution of Hon Dr Brian Walker, to be any more specific or any more prescriptive is to be stepping into the shoes of the clinician. Clinicians are already trained to take these things into account. The existing provisions in the bill before us are sufficient. That is not my full answer in response to the amendment but that is my answer to the member.

Hon NICK GOIRAN: For example, one of the mandatory considerations that the government seeks to impose can be found in proposed subsection (2)(c), which states —

> the professional standards and guidelines commonly accepted …

Those things are not in the ether; they are commonly accepted by members. Are they documented in any way?

Hon SUE ELLERY: Yes. We have talked about scope of practice, for example, a number of times during the debate. That is defined. It operates within certain parameters. Those things are set out.

Hon NICK GOIRAN: In other words, someone would not be involved in something that they are not qualified to do. Is that what is meant by 2(c)? Presumably, it is something more than that.

Hon Sue Ellery: It could capture that; it could capture a range of things.

Hon NICK GOIRAN: I am not asking whether it could be. Is it captured or is it not captured?

Hon Sue Ellery: It could be, honourable member.

Hon NICK GOIRAN: So scope of practice is not necessarily captured as a mandatory consideration. It is definitely captured.

Hon Sue Ellery: It is.

Hon NICK GOIRAN: It is okay to say it is definitely captured. It is not a controversial point. If scope of practice is definitely captured, are any of the seven things that Hon Kate Doust included not incorporated in the professional standards and guidelines that are commonly accepted?

Hon SUE ELLERY: We think we can mount an argument that they are all covered.

Hon NICK GOIRAN: I appreciate that the minister flagged that she has not yet responded on behalf of the government to the amendment moved by Hon Kate Doust. I simply make the point that if the seven considerations are already covered—that certainly seems to be consistent with what Hon Dr Brian Walker is saying—Hon Kate Doust's amendment is unnecessary because this is already a matter of practice; this is what doctors do. My submission to the minister and other members is that there would be no harm whatsoever in accepting the amendment. We could include it as a matter of clarity, as we did earlier in the bill by defining the word "person". We could use it as a matter of not only clarity, but also safety as we did earlier in the bill, when we inserted the catch-all provision. These are things that were argued to be unnecessary but which the government said it would like to have in the bill anyway. Yes, there is an argument that it is unnecessary but as a matter of clarity and safety, the government has decided to include these things, like the definition of "person".

My respectful submission to members is that at the very least it does no harm to support Hon Kate Doust's amendment because, as Hon Dr Brian Walker said, this is what will happen anyway. As the minister said, it is part of the professional standards and guidelines commonly accepted by members of the medical profession.

Hon MARTIN PRITCHARD: First of all, I would like to congratulate Hon Kate Doust. I think her amendment comes from a very good place. Listening to Hon Dr Brian Walker, I am more inclined to accept that under proposed subsection (2)(a) "all relevant medical circumstances", a doctor would take these things into consideration. My contention is that if we put more words into the bill, we may create anomalies. I do not wish to pick the amendment apart but, for instance, section 202ME(2)(b) states —

> whether there are serious foetal abnormalities that were not identifiable, diagnosed or fully evaluated before the pregnancy reached 23 weeks …

It is possible and quite likely that if scans done between 18 and 22 weeks identify these things, people in remote areas in particular may get a diagnosis at 21 or 22 weeks and may not be able to receive an abortion until after 23 weeks. I understand that they only have to take note of this and that would probably not preclude them from going forward with the abortion. As I said, the more words we put in the bill, the more difficult it could be for a doctor to move forward. I am more inclined to accept proposed subsection (2)(a) of the bill, in which all medical circumstances are taken into account.

Hon BEN DAWKINS: There may be a fundamental misunderstanding of what this amendment will do. I do not see this amendment as limiting access to abortion. We might even call it an enabling amendment; it will actually

open up new avenues for women who are in hardship to access what we are calling late-term abortions. There is nothing wrong with being more specific in this instance, because it helps the individual patient. The doctor only considers this. We are not telling him what to do; we are asking him to consider things, so there is no impingement upon his professional freedoms. All we are asking him to do is consider the things that the minister referred to, such as abuse, socio-economic disadvantage and remote locations. By inserting these specific words, we would open up access for these women; we would not be narrowing it down. It may be that other amendments on the supplementary notice paper will have a narrowing effect, but to paint this amendment as something that will detract from the government's objectives of the Abortion Legislation Reform Bill 2023 is simply wrong. It will empower people and provide more criteria for people to be assessed on and therefore access a late-term abortion, in an overall sense. I do not think the chamber should look at this amendment as something that will detract from the overall objectives of the legislation; I think they will improve it. Sometimes it is good to be prescriptive, because this is prescriptive in an expansive way, if that makes sense, not in a narrowing way. I am just not sure that all members can see the good intent behind this amendment, because they are completely consistent with what the government has told us this legislation is all about.

Hon SUE ELLERY: The government will not accept the amendment. Amendment 5/8 on the supplementary notice paper seeks to insert proposed section 202MEA, which will require additional mandatory considerations that a medical practitioner must consider prior to the performance of an abortion at more than 23 weeks. These considerations are prescriptive, clinical, physical, social, economic and psychiatric criteria that we say are better and more generally encompassed under the existing proposed section 202ME(2) of the bill.

The bill sets out what medical practitioners must take into account when considering an abortion after 23 weeks. That includes all relevant medical circumstances; we do not need to list them, because we could not. It also includes the person's current and future physical, psychological and social circumstances; and the professional standards and guidelines that apply to the medical practitioner in relation to the performance of an abortion.

The amendment inserted into the South Australian bill provides, if you like, granular-level detail. It requires medical practitioners to take into account whether the patient had difficulty accessing timely and necessary specialist services before the pregnancy reached 22 weeks and six days, including, but not limited to, patients experiencing significant socio-economic disadvantage, cultural or language barriers; and those who reside in remote locations. We say that these things are already captured in the bill by requiring medical practitioners to have regard to the person's current and future physical, psychological and social circumstances. The level of detail captured in the South Australian version, which is what amendment 5/8 is, is inconsistent with our ordinary legislative practices. The suggested considerations are also invasive of both the patient and the practitioner, and would cause the practitioner to have to make a speculative judgement call as to whether the patient could have accessed an abortion service earlier, or whether they would have wanted to continue the pregnancy if they were in a better financial position. That places on the practitioner responsibility for subjective and unwarranted judgement calls about the patient. For those reasons, the government will not support the amendments.

Hon KATE DOUST: First of all, I want to say to Hon Dr Brian Walker that I take these issues extremely seriously. I always have and always will. It does not matter whether we are dealing with abortion, end of life or anything in between, we have to give our fullest consideration to any legislation that is going to terminate a life at any point, and in some circumstances we need to apply a rigid set of rules to be followed for those processes.

The idea of this amendment is not about implying that doctors do not know or do not understand what they are doing; it is about providing a much broader range of information and options. It is not the be-all and end-all, because I appreciate that there probably are other things, but it struck me that it was good enough for the South Australian Parliament to give serious consideration to adding value to its legislation and enhancing it. As I said earlier, this will not take away from the bill in front of us. When I was dealing with Parliamentary Counsel, some of my original amendments would have sought deletions and insertions. My thinking was that there was no value in that. The idea of adding value and an explanation was, I thought, a much better proposal. It is disappointing that the government will not give any consideration to this amendment. I say to members that, on the basis that this amendment will not take away from the bill before them, they will not reduce any of the proposals the government has put before members for their consideration. They are simply about putting in a range of options to provide the clarity we would ask a doctor to provide before that decision was made. As I have said before, the doctor would consider this for a very narrow—possibly less than one per cent—number of all abortions that occur in this state. It is for the very narrow group of the most diabolical, dreadful situations. I know my colleague does not like the use of the word "dreadful" or whatever; there is probably a range of other adjectives I could use. I think "heartbreaking" is probably the way to go. It is a heartbreaking decision for that woman to make. This amendment will just step that out and provide clarity. It is not just for the doctors; this is about the whole community understanding the circumstances in which this could play out. In what circumstances do we, as a society, think it is appropriate for this type of abortion to occur? I do not see this as being detrimental to the bill in front of us; I see it as an enhancement so that anyone

who opens up this legislation can find out what is going on, be they a doctor, a person on the street who is curious about the process, or the woman at the heart of the situation who wants to know where she stands and the options available to her, rather than just waiting before she goes to a doctor. I acknowledge that the member has said that this is the meat and bones for doctors and is at the core of their work in respect of how they conduct themselves. We do this with lots of different types of legislation. We put in place regimes to tighten up the legislation, provide clarity and transparency and offer a much clearer pathway to a decision. I do not see this as being any different. It is not there to cause insult or injury to the practitioner at all. It is there to provide some straightforward guidelines and options when it comes to decision-making. I say to members that this amendment will not be detrimental to the bill before us; it is simply about opening up information and providing guidance. I hope people give appropriate consideration to supporting the amendments before us.

Hon WILSON TUCKER: I felt myself being swayed, really, on both sides of the fence and supporting the amendments from listening to the passionate contributions of members. I take Hon Dr Brian Walker's point about telling doctors how to suck eggs—I think his words were—and being too prescriptive in codifying a set of rules for something doctors already do and that we trust them to perform. I imagine that in the vast majority of cases—if we want to put a percentage to it, it is probably 99.9 per cent—doctors do the right thing and follow the ethical and moral guidelines that we expect them to follow every day as part of their practice. As legislators, we should not necessarily take the happy path, which I think is easier, and put in a set of rules that we expect people to follow, but rather flesh out cases on the edge and cater for some of the bad actors in the system. There are always bad actors who look to undermine the rules in place. That is the tricky point, and as legislators in this chamber we should really think about it and try to tease it out. It is important that we attempt to codify some of those rules and set some guardrails for those cases on the edge.

I take the view that if these provisions do not impose any friction on women seeking an abortion or add any additional friction to something doctors already do and that we expect them to do, there is no harm in including them. Given that provisions in these amendments are included in the South Australian legislation and the Parliament there thought it appropriate to include them, I am curious to understand whether the government has looked at the South Australian Parliament's rationale for including these provisions in its legislation, as well as the rationale that preceded the debate that culminated in them being included. It is curious that we all live in Australia and one Parliament has thought it fit to include these rules, but we are having this debate and the government's position is to not support them because it feels they are too prohibitive. I am curious to hear any response from the government on that point.

Hon SUE ELLERY: I am happy to provide the member with one. During the course of the debate earlier, we had an exchange, I think during the debate on clause 1. We talked about how there were particular curiosities, if I can describe them in that way, in the existing legislation that were put in place 25 years ago because they reflected the position of the Parliament of the day. For example, there was the extraordinary circumstance of the definition of "informed consent" meaning one thing for every other medical procedure, but in respect of abortion it had two—if members remember—very bespoke, very specific definitions, because that reflected what I referred to earlier as politics being the art of what you can achieve. That reflected the views and the make-up of the Parliament at that time. I have no doubt that that is the case in South Australia; that is, the provisions that were adopted reflected the debate and circumstances of what it would take to get that legislation through.

Before my adviser provides me with more information, I want to make this point as well: it is important to understand what the bill would look like if we passed these amendments. The page of the bill I am referring to will be a bit messy if members have marked it up themselves, as I have, to note where the amendments on the supplementary notice paper would fit. There are four amendments proposed on the bottom half of page 9 of the bill, so it is a little bit messy. To follow through the three amendments that Hon Kate Doust proposes, go in the first instance to line 23, at the bottom of proposed section 202ME(2). Proposed subsection (2) is the provision that refers to the matters that must be had regard to. It states —

> (a) all relevant medical circumstances; and
>
> (b) the person's current and future physical, psychological and social circumstances; and
>
> (c) the professional standards and guidelines commonly accepted by members of the medical profession that apply to the medical practitioner in relation to the performance of the abortion.

The amendments before us would have us delete the word "abortion" there and put in its place "abortion and", so something is about to be added. Let us say that that amendment gets up. The end of proposed subsection (2)(c) would read "in relation to the performance of the abortion and". Without limiting what has just been referred to in proposed paragraph (c), which are the broad general descriptors that have been set out, mandatory considerations, there is also the requirement to consider all seven matters listed in Hon Kate Doust's amendment. A doctor or a clinician will be required in the first instance to consider all of the relevant medical circumstances; the person's

current and future physical, psychological and social circumstances; the professional standards and guidelines commonly accepted; and, if we accept the amendment, the seven things listed in it. I have great faith in clinicians but that is quite a confusing regime to expect them to operate under. Which step takes primacy?

Medical practitioners are already required by law to consider all relevant medical circumstances; that is already established. Therefore, they would have to second-guess themselves. They will wonder whether they have covered the list of seven things when they consider all relevant medical circumstances. I do not question for a minute Hon Kate Doust's intent in moving the amendment, but the upshot of it is a very confusing regime for those practising and a very confusing regime for the woman who is 23 weeks pregnant or more and needs to access an abortion. She will have to understand all of the things that the clinicians will ask about, and she will need to look at this legislation and say, "There is that list and there is this list." It is confusing for the consumer and the clinician. For those reasons, we say that the language drafted for proposed section 202ME(2)(a), (b) and (c) will provide clinicians with the required set of measures, arrangements, facts and information that they need to satisfy themselves with, and that is the better proposal before the chamber now.

Hon Dr BRIAN WALKER: I want to give an example of what happens when detail is put into legislation and decisions are left in the hands of clinicians. This is a true story. I was working at a hospital, and in the geriatric department was a geriatrician who was terrified of getting sued by relatives of someone who died. For example, if someone has had a stroke or has some other major disability and they are lying in bed unable to feed themselves, we should technically let them pass away because their time of life has ended. I am cutting the story a bit short, but in the end, we should let things go naturally. The doctor was terrified. Every single geriatric patient was lying there, non–compos mentis—lying in bed, unable to move or blink or do anything. They had a tube put down the gastroscope and shone light in there, and a needle was put into their stomachs and a percutaneous endoscopic gastrostomy tube was inserted. Those patients were then given PEG feeding. They may have lasted two years, being turned for their ulcers and being cared for. Relatives visited the patients. There was no response but they came to visit. These patients were lying in bed. They could not do anything. They could not demand the tube be taken out because the doctor said he could be sued for killing a patient. It was terrible. The natural course of things at the end of life is that you die. We can artificially prolong life quite a lot. If you are frightened of being sued by patients' relatives, you are going to do what you can. There is the classic example of when someone aged 86 years has been hit by a car and is in the ICU. They are very frail, but they are kept alive for as long as they can, because they can be.

I will tell members another story. A patient of mine was taken to surgery. It was a simple thing. It was to take out his spleen. There was a massive problem with the spleen. I assisted with the surgery and all was going well. The spleen was taken out and the sutures went in and off I went. That night, about 2.30 in the morning, I got a call. As the assistant to the surgeon, I raced up to the hospital with the surgeon and opened him up again. He had a bleed. One of the sutures had got loose. He had an arterial bleed after the operation, which had seemed fine but these things happen. As a result, he was hypovolaemic and he suffered brain death. He was resuscitated and ended up in ICU. There he was, non-responsive and clearly brain dead but the bureaucratic requirements—this was in Hong Kong—stated that as he had recently had surgery with anaesthetic, the test for brain death was no longer valid and therefore they had to wait seven days. After seven days in the ICU it could be declared that the anaesthetic was gone and any effects on the brain from the EEG were now valid. They could then say he was definitely brain dead. When he went to post-mortem, of course his brain had already begun to dissolve because for seven days we had kept him alive in the ICU at great cost. It was because they were frightened of being sued for having murdered a patient by switching off his machine too early.

These are the consequences when we put words into legislation, thinking we are doing good, but there are unintended consequences at the end. I would caution against putting too many words in legislation regarding how doctors should behave, if they are behaving ethically, morally and humanely, because it could end up with a false outcome. It could mean bad outcomes. The intent is to do good, but the unintended consequences may result in people suffering—not just the patients who are dying, but also their families who are watching. I caution against too many unnecessary words.

Having said that, I thoroughly appreciate all the words that Hon Kate Doust mentioned. I support them all. She is quite right: every single word is true but it is not necessary to mention them in this legislation.

Hon NICK GOIRAN: The argument from the government in opposing the amendments moved by Hon Kate Doust is that it would be confusing for medical practitioners to have the list set out here at proposed section 202ME(2) and then to have the seven considerations offered by Hon Kate Doust. I have said all along in this debate: test everything you hear. I remember saying it first in the Liberal Party room when this bill came in. If members hear me say something, test it. If they hear something said by the Minister for Health, test it, especially if she says that there is no such thing as a baby born alive after an abortion. If Hon Sue Ellery says something, test it. If Hon Sue Ellery says that, on behalf of the government, she is opposing the amendments because they are going to

be confusing for practitioners, consider this. Hon Dr Brian Walker said that the seven considerations are already done by medical practitioners. That is what they do all the time. I respectfully suggest that there is nothing confusing for a medical practitioner at all because they are doing it all the time. Hon Sue Ellery said that the seven considerations are part of the professional standards and guidelines commonly accepted by practitioners, so there is nothing confusing for a medical practitioner in fulfilling the seven requirements that Hon Kate Doust has put forward. Why? It is in the South Australian legislation. If these are good enough mandatory considerations for the South Australians, they should be good enough for Western Australians.

Hon PETER COLLIER: I had no intention of speaking on these amendments at all. I know where I stand. I am going to support this bill. I want to make that perfectly clear. That is not the issue here. Being a doctor would not mean I am an expert. I am not a doctor. I am not an expert. All I know is that I have been in this place for 18 years and I find that as we work through these things, sometimes we can enhance and improve legislation. It takes me back to the Voluntary Assisted Dying Bill, which people will remember. In a lot of instances, it was an extraordinarily long bill. My honourable colleague Dr Brian Walker suggested putting in too many words can sometimes make it too complex, prescriptive and difficult. I take members back to the VAD bill. I worked personally over time with the Australian Medical Association and a number of my colleagues with that bill to ensure we enhanced a number of areas to make it a better bill. It passed this Parliament. It did not pass in the format in which it entered. When it came out the other end, I think it was a significantly enhanced piece of legislation, even though I did not support it. It was as a direct result of communication that went on during the duration of consideration of that bill. The minister, Hon Stephen Dawson, handled the bill with aplomb. He was really receptive to input from various members of the chamber. There was a concern at that time about palliative care. As a direct result of what happened in this chamber, that bill was an enhanced piece of legislation at the end, even though some people did not support it. I still think it was a better bill when it came out the other end than when it went in.

On these amendments, I have to be honest. At this stage, I can say to Hon Kate Doust that I am still not sure how I am going to vote. I think there is some real merit in them. I do not think there is an issue with being too prescriptive, to be perfectly honest. That is the only reason I stood. I think it is important that in such legislation we are not fearful of making amendments if they will enhance the legislation. As we have heard already, if it is already happening and will not in any way or circumstance diminish the legislation, and if it will provide some clarity and certainty, I would be prepared to support the amendments. That is how I honestly feel. I come in here with eyes wide open on these amendments. I have listened intently to debates on both sides. Yes, I am not a medical practitioner, but I am an experienced legislator and I know there is nothing wrong with accepting an amendment, particularly something like this, which to me seems quite frankly eminently sensible. The Leader of the House said it is already happening. Hon Dr Brian Walker said it is already happening. I am sorry about this, Leader of the House, because I know she has already covered it, but can she confirm this with me to help me make up my mind: will the amendments in any way diminish the legislation or in any way alter the intent of the legislation? If not, why will the government not accept them?

Hon SUE ELLERY: I appreciate the honourable member's contribution. I do not think anybody is saying that people should not move amendments. People are entitled to. The government's position is that the particular set of circumstances are bespoke to South Australia. No other jurisdiction in Australia adopts them. The other jurisdictions are Queensland, New South Wales and Victoria, which adopted the provisions we put in this bill—that is, the three bits captured at the bottom of proposed section 202ME(2). The other jurisdictions do not. I genuinely believe that what happened in the South Australian Parliament is what was required to get the bill through. That does not necessarily make it best practice or easy to work with.

No clinicians, clinician peak bodies or clinician leaders have asked for more prescription on what matters they should take into account when they make a decision about a 23-week termination. They have not asked us for more prescription or for another list. As I said before, I believe that more prescription would make it harder for clinicians to understand what weight they should place on one element or another, and I think it would confuse consumers about what they need to satisfy in order to get the termination, bearing in mind where they are in the gestation. They are at the 23-week mark. They do not have a hell of a lot of time to make what is an awful decision for them. Bearing in mind all those things, honourable member, we say it is a detriment to the bill before us; it would make it harder to make it work, and it would make it harder at a point at which women do not have a hell of a lot of time to make that decision.

Hon MARTIN PRITCHARD: I thought of this very same issue that the minister has just identified towards the end there. I think that any educational program that is put out for people in this situation will basically reprint that clause. If a layperson at 23 weeks' gestation were to read that clause, I think that they would read through all the relevant medical circumstances and then see a list of specifics, and I believe that they would try to fit within those specifics. If they did not fit within those specifics, they may feel that they cannot raise that with a doctor or they cannot have an abortion. We either try to be prescriptive, and that is very difficult, because the list would be endless,

or we try to be a bit more generic so that the person they ask and who provides the advice is the person they go to—the health provider, the health professional, the doctor. The more I think about it, the more I think it is better that it is generic so that they get the actual information from the doctor.

Hon NICK GOIRAN: In Western Australia at the moment, how many medical practitioners make a determination on a late-term abortion?

Hon SUE ELLERY: It is the ministerial panel that is made up of six members, and the chair will contact two to make a decision. We have covered that many times.

Hon NICK GOIRAN: How many medical practitioners will be eligible to make a decision on a late-term abortion after this legislation passes?

Hon SUE ELLERY: It will be two.

Hon NICK GOIRAN: Only two Western Australian medical practitioners will be able to make a decision?

Hon SUE ELLERY: No, honourable member; there are more in the profession than two. I thought that the member was asking me how many were required.

Hon NICK GOIRAN: No, I want to compare apples with apples. To be clear, under the current law, six Western Australian doctors are eligible to make a decision, of whom two need to make a decision in order for a late-term abortion to be performed. Moving forward, two will still be needed, but how many will be eligible to make that decision?

Hon SUE ELLERY: We do not have that information available here. It would depend entirely on who was registered at the time in Western Australia. The number might be this today but that tomorrow. I am not in a position to give the member an actual number.

Hon NICK GOIRAN: The government does not know how many medical practitioners are registered in Western Australia?

Hon SUE ELLERY: I am still not in a position in which I can give the honourable member a number. I am sure the member is aware—we will probably get to debate it at some point later in the debate—that there is a right to refuse provision.

Hon Nick Goiran: I am saying eligible.

Hon SUE ELLERY: Yes; I cannot give the honourable member that number. There may be some who are eligible but who may refuse. Maybe they will refuse today; maybe they will not refuse tomorrow. I cannot give the member a precise number.

Hon NICK GOIRAN: The government does not know how many medical practitioners are registered in Western Australia, because that is the actual answer to the question I have asked, but I put it to the minister that we are talking about hundreds. In Western Australia, hundreds of medical practitioners will be eligible to make a decision on late-term abortions once this bill passes. At the present time, there are six. In other words, in Western Australia, we have six experts making these decisions on late-term abortions, but as soon as this bill passes and comes into force, every medical practitioner in Western Australia will be eligible to do so, irrespective of whether they have any experience in this area at all. I could absolutely understand the objection by members to the so-called prescriptive list proposed by Hon Kate Doust if we were leaving it as the six experts, because there would be no need to provide them with any guidance. But we are opening the door here to every single medical practitioner, some of whom may not have the level of experience of Hon Dr Brian Walker. They might have been a medical practitioner for five seconds. What would possibly be the harm in making sure that we include this prescriptive list that we have heard from one expert is normal medical practice and we have heard from the honourable Leader of the House is part of the commonly accepted professional standards and guidelines?

Hon KATE DOUST: Hon Nick Goiran raises a very interesting issue, to which I must admit I had not given a lot of thought. Given that we anticipate that with the change in this legislation there will be a shift from the six specialists who are currently able to make those calls, and we will be opening the doors up to a significant number of practitioners who, as Hon Nick Goiran said, may not have the experience or expertise, what arrangements have been put in place or will be put in place to skill up or train up those medical practitioners who will then be able to make decisions about whether a post–23 weeks abortion could occur or participate in a post–23 weeks abortion, and to ensure that they fully understand the requirements that are set out in those three points already articulated in this bill on how they manage the medical and other circumstances before they make that decision?

Hon SUE ELLERY: I thank the honourable member for the question. The member will recall—I think it may have even been in answer to a question from her—that we dealt with the proclamation date and why we would need I think six months before certain parts of the bill come into effect. I set out in my answer then the things that

need to be put in place around training, our policies and procedures, changing clinical guidelines et cetera. What I said then and I rely on now is that we will be developing processes and training within a number of internal and external bodies; for example, the Women and Newborn Health Service will need to review and modify current care for women considering abortions and their aftercare.

When I gave the answer in the debate earlier, I think I was talking about a range of education and training that will need to be provided to clinicians and health service providers. The six-month period is there to ensure that that work can be done.

Hon MARTIN ALDRIDGE: It has been an interesting discussion on this amendment, and I think it has been quite helpful. Certainly, from my perspective, when trying to weigh up the advantages and disadvantages of supporting the three amendments, this was probably one that, when considering the supplementary notice paper, I did not have a starting position. It certainly has been good to hear the discussion that has occurred. Some of it has been more useful than others. I am probably not convinced at this point about the merits of the value that will be created by inserting these additional seven provisions. My position at the moment favours the status quo over the amendments. Although I do not necessarily accept all of the government's reasons for opposing the amendments, due to the complexity and risks presented by supporting them, it is a difficult decision and I agree with Hon Peter Collier in that regard.

One thing I also say on this amendment is in response to Hon Dr Brian Walker. We have heard this a few times through the course of the debate and I think his clinical experience and background has been quite useful. I am challenged by some of what is said by the honourable member when there is an insinuation that his view is worth more than others because of that experience. By all means, I encourage the member to impart his knowledge and experience and try to convince others, in the course of a respectful debate, why something should be supported or not. It is illogical to suggest that only doctors or healthcare providers deserve, or ought to have, a view one way or another on these issues. I am not sure how many medical doctors there are in the cabinet who approved the drafting of this bill. As I understand it, there are two doctors in the Parliament, one in this house, one in the other. They could meet in a very small room and discuss the desirable outcome and come back and tell us what the result is. We could apply the same logic to many other topics that the Parliament has to consider. We are all one of 36, we are all equal members. We all get one vote. Not one of us gets any more than another. I encourage members when considering this bill that their experience is different from mine and my experience is different from theirs. Members should use the power of their voice to convince others how they should vote. However, please do not suggest that somehow one individual's experience or background is more important than someone else's.

The ACTING PRESIDENT (Hon Dr Sally Talbot): Members, we are considering three amendments, 3/8, 4/8, 5/8. I will put the first of those amendments in the form of the question that in regards to 3/8, that the words to be deleted be deleted.

Division

Amendment (deletion of words) put and a division taken, the Deputy Chair Sally Talbot casting her vote with the noes, with the following result —

Ayes (7)

Hon Ben Dawkins	Hon Steve Martin	Hon Neil Thomson	Hon Kate Doust *(Teller)*
Hon Nick Goiran	Hon Tjorn Sibma	Hon Wilson Tucker	

Noes (25)

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

Amendment thus negatived.

Progress reported and leave granted to sit again, pursuant to standing orders.