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The Research Director
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
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Dear Research Director

Submission to the Inquiry into the Abortion Law Reform Bill and laws governing termination of pregnancy in Queensland

Executive summary

The authors of this submission support the decriminalisation of abortion in Queensland, and argue that the issue of termination of pregnancy should be dealt with as a health matter. Legalising abortion in Queensland would also achieve fundamental policy objectives including modernisation of the law to reflect community attitudes; provide clarity and certainty; protect and promote women's health and safety; ensure equity of access to abortion services and enable health professionals to practise in a legally-certain environment.

We make the following recommendations:

1. Sections 224, 225 and 226 from the *Criminal Code Act* 1899 (Qld) ('the Criminal Code') be repealed.
2. Section 226 be deleted from schedule 2 of the *Transport Operations (Road Use Management) Act 1995* (Qld).
3. That Queensland's abortion laws be governed by the legal principles of certainty; enforceability; justice; equity; autonomy; and avoidance of harm.
4. In determining whether termination of a pregnancy is lawful, the relevant principles should be those that govern medical procedures. Terminations where the foetus is 24 weeks or more, for non-*Gillick* competent young women and for women with impaired decision-making capacity involve different considerations, and should be regulated in different ways.
5. A two-tiered approach (similar to that in Victoria) be adopted to regulate termination of pregnancy by gestation periods, whereby:
   - Women may access an abortion on request up to 24 weeks gestation.
   - Abortions be available post-24 weeks gestation where a doctor reasonably believes that the abortion is appropriate having regard to all relevant circumstances, taking into account the woman's physical or mental health and/or the serious medical condition of the foetus.
6. The ability to make a conscientious objection to terminating a pregnancy be available to health professionals in non-urgent situations, but must incorporate an obligation to refer. We further

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recommend that a doctor with a conscientious objection must be required by law to perform an abortion where it is necessary to save the life of the woman, or prevent serious injury to her physical or mental health.

7. Accessing an abortion in Queensland should not be subject to a mandatory requirement for the woman seeking a termination to be referred to, or access, counselling and support services.
8. Legislation be introduced which provides that parental consent is sufficient authorisation for the termination of a non-*Gillick* competent minor's pregnancy, with the child's best interests being the relevant criterion. Court approval should not be required.
9. Access/buffer zones outside of facilities offering abortion services be implemented in Queensland.
10. Residency requirements to access an abortion should not be introduced in Queensland.

Background

We are the Directors of the Australian Centre for Health Law Research (ACHLR), a specialist research Centre within the Queensland University of Technology's Faculty of Law. The Centre undertakes empirical, theoretical and doctrinal research into complex problems and emerging challenges in the field of health law, ethics, technology, governance and public policy.

We commend the Queensland Parliament for conducting this Inquiry, which we hope will result in the transition of abortion from a criminal law to health law framework, thereby promoting women's health and reproductive rights, and providing clarification and modernisation of the Queensland law in relation to this challenging and sensitive issue. We provide this submission in response to the Inquiry terms of reference and the questions for consideration noted in the Inquiry Information Paper.

Response to questions for consideration (Questions 1-7)

The following section addresses the questions for consideration provided in the *Inquiry into Abortion Law Reform Information Paper: Current law in Queensland and other Australian jurisdictions*.

1. Policy objectives which should inform Queensland law governing termination of pregnancy

The policy rationale for decriminalisation of abortion and treating the issue as a health matter is well recognised, and has been discussed at length in relevant literature and by governments, policymakers, community groups, and both supporters and opponents of abortion. We therefore do not propose to discuss policy objectives in depth in this submission, except to note some critical policy considerations which, in our view, demonstrate the need for reform to legalise abortion in Queensland so that it is treated as a health matter:

- **Modernisation of laws to reflect community attitudes**: The current Queensland laws are outdated and fail to reflect contemporary community attitudes, standards and medical

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practice.[1] A 2009 Auspoll survey of over 1000 Queenslanders found that 79% of the population supported decriminalisation of abortion.[2] A 2010 survey of obstetricians and gynecologists found that 89% of respondents supported induced abortion being made available within the public health system.[3] That survey also confirmed that 73% of respondents performed abortion as part of their practice.[4] These and other surveys[5] demonstrating high levels of public support for legalising abortion evidence the need for reform in this area.

- **Clear and certain laws**: The current laws are unclear, complex and generate considerable confusion and anxiety for the public and medical profession. These laws require reform to provide clarity and certainty about what the law is, and protection for both women and Queensland health professionals.

- **Promoting and protecting women's health and safety**: Termination of pregnancy affects a significant proportion of women in Queensland and across Australia. In 2003, a national survey reported that 22.6% of women aged 16 – 69 had received an abortion at some time in their lives.[6] A further study conducted in 2004 found there are more than 80,000 abortions in Australia each year, and that approximately half occur in Queensland and New South Wales, both jurisdictions in which procuring an abortion is a criminal offence.[7] Despite the high proportion of women who are likely to undergo an abortion, it continues to be treated as an unlawful procedure and a criminal offence. Legalising abortion would best promote the health interests and reproductive rights of women, and their autonomy in medical decision-making.

  Access to safe termination procedures is also essential for the preservation and promotion of women's health and wellbeing. Decriminalisation of abortion would discourage and reduce unsafe practices such as self-abortion attempts, illegal importation of abortion drugs (such as Mifepristone and Misoprostol), and abortions being performed by unqualified practitioners or others.[8]

[1] Kerry Petersen, 'Abortion laws and medical developments: A medico-legal anomaly in Queensland' (2011) 18 *Journal of Law and Medicine* 594 – 600, 595.
[2] Auspoll and Children by Choice, *Queensland voters' views on abortion* (May 2009) <https://prochoiceqld.files.wordpress.com/2013/07/auspoll-attitudes-to-abortion-report-queensland-2009.pdf> at 30 June 2016.
[3] Caroline de Costa, Darren Russell and Michael Carrette, 'Views and practices of induced abortion among Australian Fellows and specialist trainees of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists' (2010) 193 *Medical Journal of Australia* 13-16, 13.
[4] Ibid.
[5] See also the Galaxy poll of 800 voters in 2009, which identified that 64% of the Queensland community supported legalisation of abortion, and 5% were uncommitted: Jenelle Miles, 'Two thirds support abortion law change: poll', *The Courier Mail* (online), 15 September 2009 <http://www.couriermail.com.au/news/two-thirds-support-abortion-law-change-poll/story-e6freon6-1225773035076>.
[6] Anthony Smith, Chris Russell, Juliet Richters, Andrew Grulich and Richard de Visser, 'Sex in Australia: reproductive experiences and reproductive health among a representative sample of women' (2003) 27(2) *Australian and New Zealand Journal of Public Health* 204 – 209, 206.
[7] Heather Douglas, Kirsten Black and Caroline de Costa, 'Manufacturing mental illness (and lawful abortion): Doctors' attitudes to abortion law and practice in New South Wales and Queensland' (2013) 20 *Journal of Law and Medicine* 560-576, 560.
[8] Petersen, above n 1, 599.

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- **Recognition and treatment of abortion as a women's health issue:** Abortion should be recognised by the law as fundamentally a women's health rather than criminal law issue. Other Australian jurisdictions have already implemented reforms which have seen the shift of abortion from the criminal law realm towards health law.[9] This approach is also supported by practitioners. For example, the Royal Australian and New Zealand College of Obstetricians and Gynecologists considers that 'termination of pregnancy is an important health issue, and, as a medical procedure, should not form part of the criminal law'.[10]

  Continuing to classify abortion in Queensland as a criminal offence attracting condemnation, punishment and penalties, rather than a woman's health issue, is problematic, for a number of reasons. Abortion is the only medical procedure presumptively prohibited by the Criminal Code. No other medical procedure is regulated in this way within the Queensland criminal law. As a consequence the practice is perceived as a 'radical' intervention rather than a standard medical procedure.[11] This places women and their doctors in the difficult position of potentially being prosecuted and criminally penalised if they seek or perform an abortion.[12] The case of *R v Brennan and Leach*[13] provides evidence of this.

  Shifting Queensland abortion law from the criminal law to the health sphere would remove the problems inherent in criminalisation of these procedures, and ensure abortion 'is firmly within the general management of pregnancy and, as such, … governed by ethical medical practice as a whole'.[14]

  We consider abortion is fundamentally a woman's health matter, and that it is both timely and appropriate to modernise Queensland's law to transition abortion from the criminal to health law realm.[15]

- **Promoting greater equity in access to abortion services:** Legalising abortion would make the procedure more readily accessible across Queensland, particularly in the public health system.[16] It should therefore address current health inequalities experienced by women, particularly those in rural and regional areas, who lack access to abortion services and are compelled to engage in 'abortion tourism' by travelling interstate and to metropolitan areas to terminate their pregnancies.[17] It should also improve access to abortions for women who

[9] See for example the legal and regulatory models adopted in the Australian Capital Territory, Victoria and Tasmania which remove termination of pregnancy from the criminal law realm, and characterise it as a medical procedure.
[10] Royal Australian and New Zealand College of Obstetricians and Gynecologists, *Media statement: Position Statement: Official Statement on the Infant Viability Bill (Victoria) From The Royal Australian and New Zealand College of Obstetricians and Gynaecologists* (25 May 2016) <https://www.ranzcog.edu.au/media/statements/1719-official-statement-on-the-infant-viability-bill-victoria-from-the-royal-australian-and-new-zealand-college-of-obstetricians-and-gynaecologists.html>.
[11] Douglas, Black and Costa, above n 7, 574-576.
[12] Ronli Sifris, 'Tasmania's Reproductive Health (Access to Terminations) Act 2013: An analysis of the conscientious objection to abortion and the "obligation to refer"' (2016) 22 *Journal of Law and Medicine* 900 – 914, 902.
[13] *R v Brennan and Leach* (unrep, District Ct, Qld, Criminal Jurisdiction, 12-14 October).
[14] JK Mason, *The Troubled Pregnancy: legal wrongs and rights in reproduction* (2007), Cambridge University Press: Cambridge) in Danuta Mendelson, 'Decriminalisation of abortion performed by qualified health practitioners under the Abortion Law Reform Act 2008 (Vic)' (2012) 19 *Journal of Law and Medicine* 651, 658.
[15] For further discussion see our response to Question 3 below.
[16] Douglas, Black and Costa, above n 7, 561.
[17] Ibid, 576.

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experience financial disadvantage and may only be able to terminate an abortion if these services were more accessible through Queensland's public health and hospital system.

- **Ensuring health professionals practise in a legally-certain environment:** Doctors should not be in fear of prosecution for carrying out women's health procedures. Legalising abortion would remove current uncertainty about its legality, and provide greater confidence and protection for doctors who perform these procedures.

2. Legal principles that should inform the law governing termination of pregnancy

In the following section we identify the legal principles we consider should inform abortion law reform for Queensland.

a) The need for certainty in the current Queensland Law

A critical legal principle which must guide the development of the Queensland laws relating to abortion is that of clarity and certainty of the law. A fundamental problem with Queensland's current abortion law is its uncertainty, ambiguity and complexity, and the resulting confusion in its interpretation and application to women and doctors. This is primarily due to the unusual interaction between the Criminal Code offence provisions, and the common law.

Although the criminal law in Queensland is codified, the common law has been adopted by Queensland courts to interpret the section 282 defence when applying to abortion (surgical operations and medical treatment). Consequently, Queensland abortion law has morphed into an odd mixture of Criminal Code offences and common law authorities, rendering the legal position complex, messy and difficult to interpret and apply. It is beyond the scope of this submission to explain in detail the complexities of the existing Queensland laws on abortion, however the following is a brief summary of the relevant issues.

(i) *Offence provisions*

Sections 224, 225 and 226 of the Criminal Code create the relevant offences. A person will commit an offence if he or she does particular acts 'unlawfully' (i.e. 'unlawfully do certain things' (s224), 'unlawfully administer' (s225) and 'unlawfully supply' (s226)). This drafting suggests that some conduct will be 'lawful'. The common law cases from other jurisdictions have considered when conduct in this setting will be lawful.

(ii) *The section 282 defence*

The defence relied on in Queensland is contained in section 282 of the Criminal Code. It is available where:

- The termination was performed for the preservation of the mother's life; and

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- Was reasonable having regard to the patient's state at the time, and to the circumstances of the case.[18]

(iii) *The common law defence and its application in Queensland*

The 'Menhennitt ruling' in the Victorian case of *R v Davidson* (1969)[19] has been adopted by Queensland courts in interpreting the ambit of the section 282 defence. *Davidson* determined that a procedure will not be unlawful where the accused honestly believes on reasonable grounds that the act (of abortion) is:

- **Necessary** to preserve the woman from serious danger to her life or her physical or mental health; and
- The abortion was not out of **proportion** to the danger intended to be averted (by the abortion).

A series of Queensland judicial decisions have accepted that the common law defence relating to necessity and proportionality as set out above is relevant in determining whether section 282 is satisfied.[20] The operation of the Menhennitt ruling has subsequently been extended in New South Wales, a common law jurisdiction, by the following cases:

- *R v Wald* (1971) determined that consideration of economic, social or medical grounds which would result in a serious danger to a woman's physical or mental health, either at the time of interview with the doctor or at some time during the pregnancy, was relevant to determining lawfulness.[21]

- *CES v Superclinics Australia* (1995) where Kirby P found that danger to the patient's mental health after the birth of a child because of economic, social or other adversity was also relevant.[22]

- In *R v Sood*, the issue of proportionality of the danger was deemed to be an objective, rather than subjective test (contrary to *R v Davidson*).[23]

In the Queensland case of *Veivers v Connelly* (1995), Justice de Jersey confirmed (in obiter dicta) that a woman may be able to lawfully procure a termination if there is a serious risk to her mental

[18] *Criminal Code Act* (Qld) s282.
[19] *R v Davidson* [1969] VR 667.
[20] See for example *R v Bayliss and Cullen* (1986) 6 Queensland Lawyer Reports 8; *K v T* [1983] 1 Qd R 396, 398 (affirmed on appeal in *Attorney-General (ex rel Kerr) v T* [1983] 1 Qd R 404 and *Attorney-General (Qld) (ex rel Kerr) v T* (1983) 46 ALR 275, although neither appeal court expressed a settled view on the interpretation of Queensland's abortion law; *Re Bayliss* (unreported, Supreme Court of Queensland, McPherson J, 24 May 1985); *Veivers v Connolly* [1995] 2 Qd R 326, 329.
[21] *R v Wald* (1971) 3 DCR (NSW) 25.
[22] *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47.
[23] *R v Sood* [2006] NSWSC 1141.

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health.[24] His Honour did not specifically address the issue of proportionality or adopt the *R v Wald* and *CES v Superclinics* rulings.

This brief outline demonstrates that Queensland law, particularly the defence to a charge relating to a termination, is complex and uncertain. A major problem is that the common law in relation to the lawfulness or otherwise of a termination of pregnancy can and has evolved under the common law (i.e. especially the case law in New South Wales). However, it is unclear in Queensland whether the common law, as it evolves from time to time, is applicable in interpreting the scope of the section 282 defence, *or* if it is only the common law as is specifically adopted from time to time in the Queensland cases that is applicable.

A further (but related) issue is that of recognition of the common law in a codified state. The courts have recognised that the application of the common law in Queensland, a code jurisdiction, is limited.[25] Indeed, as Mr RS O'Reagan QC noted in his article on the section 282 defence:

> *Resort to common law principles to supplement and explain statute law … must be regarded as very unusual in Queensland, which has a comprehensive Criminal Code, and one which does not have common law defences*.[26]

Accordingly, the legal regulation of abortion in Queensland rests on shaky legal foundations, is complex and uncertain.

b) Enforceability of laws

A further legal principle for consideration is enforceability of laws. The rule of law provides that society should be governed by the law, obey it, and be able to be guided by it.[27] Laws must not be in disrepute, and are at risk of being so described if they are clearly flouted. This raises important points relevant to Queensland's abortion laws:

i) **The abortion offences are rarely enforced.** Prosecutions of women who procure an abortion, doctors who perform abortions, and other people who supply drugs or instruments to procure an abortion are extremely rare. The last Queensland prosecution of which the authors are aware occurred in 2010 in *R v Brennan and Leach*.[28] Prior to that, there had been no prosecutions of Queensland doctors since 1986 in *R v Bayliss and Cullen*.[29]

[24] *Veivers v Connelly* [1995] 2 Qd R 326 at 329-330.
[25] See for example *State of Queensland v Nolan* [2002] 1 Qd R 454 at [7] where Justice Chesterman stated: '[t]he doctrine [of necessity] is, however, a creature of the common law and finds only a very limited role in the Code'. See also McGuire DCJ in *R v Bayliss and Cullen* (1986) 6 Queensland Lawyer Reports 8, 34-35. See also Belinda Bennett and Kerry Petersen, 'Abortion' in Ben White, Fiona McDonald and Lindy Willmott, *Health Law in Australia* (2nd ed, 2014), 448.
[26] RS O'Reagan, 'Surgery and Criminal responsibility under the Queensland Criminal Code' (1990) 14 *Criminal Law Journal* 73, 80-81.
[27] Ian Kerridge, Michael Lowe and Cameron Stewart, *Ethics and law for the health professions* (4th ed, 2013) (Federation Press: Sydney) 56.
[28] *R v Brennan and Leach* (unrep, District Ct, Qld, Criminal Jurisdiction, 12-14 October).
[29] Victorian Law Reform Commission, *Law of Abortion Final Report*, Final report No 15, (March 2008) 21.

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Indeed prior to decriminalisation of abortion in other Australian jurisdictions, prosecutions were equally rare.[30]

ii) **The abortion offences are inherently difficulty to enforce**. From a law enforcement perspective, it is incredibly difficult to obtain sufficient evidence that a termination has occurred, particularly given the existence of physician-patient privilege, which protects the privacy, confidentiality and dignity of the patient with respect to her health matters. In *R v Brennan and Leach,*[31] the discovery that an abortion had occurred (as a result of Mr Brennan procuring RU486 and Misoprostol which were taken by Ms Leach) occurred purely by chance, following police searching the defendants' home on an unrelated matter. But for that search and the discovery of empty blister packs for those drugs, there would have been no evidence available to pursue that prosecution.

iii) **There is no public interest in pursuing abortions**. From the limited prosecutions which have occurred in Queensland, it appears (in addition to the difficulties in obtaining sufficient evidence to prosecute) there is very little interest from law enforcement authorities in prosecuting women or their doctors for these offences, even if it is known that a termination occurred.

We also consider there is minimal public interest in the Crown pursuing such matters. There is no evidence that the small number of prosecutions to date have had deterrent effect on women obtaining and receiving terminations, and doctors performing these procedures. Such prosecutions serve only to exacerbate the distress, harm and humiliation of the women concerned and their families, and have the potential to cause stress, anxiety and damage to the reputation of their doctors.

c) Laws that are just and equitable

Queensland's laws should reflect the legal principles of fairness, justice and equity. In our view the current laws are inequitable, and disadvantage women seeking a termination. The practical application of the laws can also cause economic disadvantage for women in Queensland seeking an abortion. It is understood that the majority of terminations are performed in private, not public facilities.[32] This is likely to inhibit access for women who experience economic disadvantage, and cannot afford the out-of-pocket expenses associated with the procedure through a private clinic. A further example of inequity is the impact of these laws on women residing in regional or remote Queensland, who must endure travelling long distance to access an abortion if services are not available locally (imposing additional financial burden for those women). In our view, there should be equitable access to abortion for all women, regardless of location or economic or social status.

[30] For a full analysis of Australia's history of abortion-related prosecutions, see the Victorian Law Reform Commission's Final Report, above n 29, ch 2.
[31] *R v Brennan and Leach* (unrep, District Ct, Qld, Criminal Jurisdiction, 12-14 October).
[32] Dr Carol Portman, 'Therapeutic Abortion Provision' in Abortion in *Queensland conference report* (17 October 2008) <http://www.childrenbychoice.org.au/images/downloads/AbortionInQldConfReport2008.pdf>.

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Laws that recognise and promote individual autonomy

A fundamental principle that underpins laws in a liberal democracy and contemporary medical ethics is that of autonomy. In the context of abortion, this principle provides that women should be allowed to exercise autonomy and self-determination when making decisions about their bodies and health, including whether to continue with or terminate a pregnancy. Queensland's current abortion laws significantly undermine the autonomy of women by placing the decision about the lawfulness of termination in the hands of the woman's doctor and, therefore, the medical profession, rather than enabling the woman to decide for herself.[33] Women's autonomy should not be constrained or subject to external decision-making by the medical profession or courts, except in exceptional circumstances (discussed below).

d) Laws that promote well-being and avoid harm to the community

Our legislative framework should avoid causing harm, whether physical, psychological, social or economic, to women seeking to terminate a pregnancy, or their doctors. In our view, criminalisation of abortion in Queensland has caused, and, if it remains unchanged, will continue to cause unnecessary harm to women, and to health professionals performing these procedures. Examples of such harm include:

- Continued restriction of women's autonomy in reproductive decision-making.
- Women and health professionals being exposed to potential criminal prosecution and penalties for procuring abortions.
- Continued barriers to access to abortions for women in rural and remote areas.
- The potential for women to seek 'backyard' abortions, or illegal abortions through importation of drugs.
- Harm, distress, humiliation and unnecessary delays for non-*Gillick* competent young women receiving a termination because of the need for court authorisation for an abortion, as well as confusion and anxiety for health practitioners.
- The impact of all of the above on a woman's physical and mental health (and the resulting effect on others i.e. existing children, partners, family members).

We consider that decriminalisation of abortion would in many cases eliminate or mitigate these harms.

3. Factors to be determined in deciding if termination of pregnancy is lawful

We consider the following factors relevant in determining whether termination of a pregnancy is lawful:

- As discussed above, in our view, termination of pregnancy should be treated as a health matter rather than a criminal matter. As such, the usual principles that govern the

[33] Kerry Petersen, 'Classifying abortion as a health matter' in Sheila McLean, *First do no harm: Law, ethics and healthcare* (2006) (Ashgate: England) 355.

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lawfulness of a medical procedure should operate in relation to termination of pregnancy. These include:

- obtaining the woman's consent to the procedure;
- abiding by a doctor's legal duty to exercise reasonable care and skill in examining, diagnosing and treating patients;
- providing relevant information and/or medical advice particularly about material risks.[34]

- The decision whether or not to terminate a pregnancy should be made by the woman, in consultation with her doctor, on the basis of what she regards to be in her best interests.

- The law of abortion should operate differently once the foetus has reached 24 weeks gestation. This aspect of the submission is considered below.

- The law that should govern the termination of a pregnancy of a minor is more complex, and will depend on whether or not the minor has the capacity to make such a decision. This is explored in more detail later in the submission.

- The law that should govern the termination of a pregnancy of an adult who lacks decision-making capacity is also complex and governed by the *Guardianship and Administration Act 2000* (Qld). We make no separate submission in relation to this issue, except to observe that section 71 (termination of pregnancy) of that Act may need to be amended depending on whether there is reform of the Criminal Code to decriminalise abortion.

4. Regulating termination of pregnancy by gestation periods, and application of the law (term of reference 4)

We consider that regulating termination of pregnancy by gestation periods should be incorporated into relevant legislation, and recommend the 'two-tiered' approach of the Victorian law, whereby a woman may access an abortion on request up to 24 weeks gestation, and in certain circumstances following 24 weeks gestation. However, in contrast to the Victorian law, we submit that following 24 weeks gestation, there should be no requirement for a second doctor to agree to the abortion, and that one doctor is sufficient for this purpose.

a) *Abortions prior to 24 weeks*

There is evidence that at 24 weeks a foetus is potentially viable, that is, capable of being born alive and surviving independently from its mother, albeit with medical intervention.[35] Accordingly, we consider it justifiable to treat termination up to 24 weeks gestation differently from a termination

[34] Des Butler, Tina Cockburn and Jennifer Yule, 'Negligence' in Ben White, Fiona McDonald and Lindy Willmott, *Health Law in Australia* (2nd ed, 2014) (Thomson Reuters: Australia), 255-371.
[35] See for example the discussion in the VLRC report about relevance of viability, above n 29, 40 – 41.

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after this time. Up until 24 weeks gestation, we believe termination should be available to a woman who requests that procedure, and provides consent.

b) ***Circumstances in which an abortion post-24 weeks can occur***

It is our submission abortions should be available post-24 weeks if the termination is requested by the woman and the following can be established:

> "a doctor reasonably believes that the abortion is appropriate having regard to all relevant circumstances, taking into account the woman's physical or mental health and/or the serious medical condition of the foetus."

(i) ***Number of practitioners involved***

Where a woman is requesting a termination post 24 weeks, we consider that the agreement of a doctor who is satisfied that the relevant criterion has been met is needed. The decision to terminate a pregnancy is a serious and important one. Where the foetus is viable up until the time of birth, we believe that the competing interests of the woman and foetus exist. We also are of the view that a woman would not come to a decision about termination without having carefully considered all relevant issues. We also believe that doctors who participate in the process would be aware of the interests involved. Unless there is evidence that there is inappropriate conduct in the context of late-term terminations, we believe that law should interfere with the decision to terminate a pregnancy to the least extent possible. In our view, the gatekeeping role of one doctor is sufficient.

We also oppose any requirement for a clinical ethics or panel approach to decision-making. Such an approach is unecessarily onerous and burdensome, and would constitute unwarrranted intrusion and delay.

(ii) ***The woman's physical or mental health***

We consider that the woman's physical or mental health is an appropriate criterion for a woman to be able to obtain an abortion post-24 weeks. This criterion would promote the woman's health and safety, and would reduce risk and harm, whether physical or physiological, that may result if the pregnancy were to continue.

(iii) ***Serious medical condition of the foetus***

We note that termination on the grounds of a child's medical condition is a highly contentious issue. We consider that for an abortion on this ground to be lawful the condition of the foetus must be sufficiently grave. What constitutes a 'serious medical condition' is more appropriately a matter to be determined by Parliament, in consultation with the medical profession. Western Australia is the only Australian jurisdiction which makes a similar provision for abortions post-20 weeks, on the

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grounds that the 'unborn child has a severe medical condition', yet that terminology is undefined.[36] The United Kingdom also has not defined its analogous provision within the *Abortion Act 1967* (UK). Australian law academics Karpin and Savell note this is because the 'majority (in those Parliaments) understood that contextual matters would be significant in determining the meaning of 'severe medical condition' or 'serious handicap'….'.[37]

5. Conscientious objection by health professionals to termination of pregnancy

Jurisdictions that permit terminations of pregnancy generally provide for a health professional to conscientiously object to doing so in non-urgent situations. However, in our view any provision should include a legal obligation for a doctor exercising a conscientious objection to refer the woman to a doctor who does not have such objections. Referral in those circumstances is critical to ensure the patient is able to receive appropriate advice and information about termination, and to reduce delay in securing a termination.[38]

If a conscientious objection provision were introduced into Queensland law, the legislation must also prohibit a doctor who holds an objection from derogating his or her duty to treat the patient in an emergency situation. Specific provision must be made requiring a doctor to perform an abortion where is necessary to save the life of the woman, or prevent serious injury to her physical or mental health. Care must be taken to uphold the safety and health interests of woman at all times, and to avoid any situation where a woman loses her life, or sustains severe, permanent injury through a doctor's reluctance to terminate her pregnancy.[39]

6. Counselling and support services relating to termination of pregnancy (term of reference 5)

We submit that counselling and support services for women considering terminating a pregnancy, and who have terminated a pregnancy, can be an important source of support, information and resources for them and their families. However, we do not consider that the ability to receive an abortion should be contingent on accessing such services. A requirement for counselling presumes that women are incapable of making decisions without external guidance, and would further undermine their autonomy. Decisions to access such assistance prior to or following an abortion, as with any other medical procedure, should be a matter of personal choice for women, and should not

[36] Other jurisdictions make similar provisions, for example the United Kingdom. For a discussion of the position in that jurisdiction see the VLRC report, above n 29, and also Emily Jackson, *Medical law texts, cases and materials* (2006), 609-613.

[37] Isabel Karpin and Kristin Savell, *Perfecting Pregnancy: Law, Disability and the Future of Reproduction* (2012) (Cambridge University Press) 147. Comprehensive analysis of the relevant domestic and international debates concerning this issue are contained in this book.

[38] VLRC report, above n 29, 47.

[39] See for example the case of 31-year-old Irish woman Savita Halappanavar, who died of septicaemia in 2013 after hospital staff refused to perform an abortion of her 17 week old foetus. She subsequently died: Associated Press, 'Irish Jury finds poor care in death of woman denied abortion', *The New York Times* (online, 19 April 2013 <http://www.nytimes.com/2013/04/20/world/europe/jury-cites-poor-medical-care-in-death-of-indian-woman-in-ireland.html?_r=0>.

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be mandated. We also believe any counselling offered should be through impartial, independent, appropriately qualified sexual health and reproduction counsellors and organisations.

7. Response to other aspects of the Bill and the terms of reference

In this section we provide responses to other aspects of the Bill, and identify further issues which require consideration as part of the Inquiry.

a) Consent to termination of pregnancy by *Gillick* competent children

A child is *Gillick*-competent if he or she has 'sufficient understanding and intelligence to enable him or her to understand fully what is proposed'.[40] Therefore, if a girl is less than 18 but has sufficient understanding and intelligence to make a decision in relation to the termination of her pregnancy, she is able to provide a valid legal consent to the procedure.

The authors support this legal position, and recommend no alteration of the law. If the legislature intends to pass law governing the termination of pregnancies, it may consider enshrining this proposition into the legislation to ensure this legal position clear.

b) Consent to termination of pregnancy by non-*Gillick* competent children

A further significant issue for consideration as part of this Inquiry is that of the requirement for judicial approval for termination of pregnancy for girls who are non-*Gillick* competent.

(i) *Flawed legal reasoning*

Since the Queensland Supreme Court's decision in *State of Queensland v B* (2008)[41] the legal position in Queensland appears to be that a non-*Gillick* competent child's parents are unable to consent to the termination of their daughter's pregnancy, and that such a decision can only be made by a court.[42] In *State of Queensland v B*, the Queensland Supreme Court relied on the reasoning in *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's case)* (1991)[43] where the court held that the sterilisation of a girl who lacked decision-making capacity was a 'special case' or medical procedure which was beyond the scope of parental decision-making authority. As a result, the Queensland Supreme Court in *State of Queensland v B* extended this reasoning to apply to the termination of a pregnancy.

While termination of pregnancy is a very serious matter, in our view the nature of the decision is not such as to deprive parents of the ability to provide consent in their child's best interests. Indeed, we consider that imposing a requirement of court approval for terminations of pregnancy for minors

[40] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.
[41] *State of Queensland v B* [2008] QSC 231.
[42] The recent case of *Central Queensland Hospital and Health Service v Q* [2016] QSC 89 reaffirmed this position.
[43] *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's case)* (1991) 175 CLR 218.

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who are non-*Gillick* competent is an unjustifiable and inappropriate extension of *Marion's case.* We submit that such procedures fall within the scope of parental decision-making authority for the following reasons:

- There are critical distinctions between the procedures of termination and sterilisation which justify these procedures being treated differently, and being afforded different levels of safeguards.

- A strict approach was adopted in *Marion's case* on the issue of when parents will not have power to consent to medical treatment on behalf of their child. The majority (of four judges) in that case strongly noted that incursion into parental power should only occur in a 'special case', and that sterilisation was such a case (they did not suggest termination of a pregnancy would also constitute a special case). The three dissenting judges were very reluctant to allow a court to remove a traditional consent power from parents. Courts have been, and in our view, should be slow to limit the powers of parents to act in their child's best interests.

- The need for court approval for the termination of pregnancy is incongruous with other powers of parents to make medical decisions that are in their child's best interests. For example, in an appropriate case, parents can decide to withhold or withdraw life-sustaining medical treatment from non-*Gillick* competent children, even where this may result in a child's death.[44] It is an absurdity, and inconsistent, to require court approval for a decision to terminate a child's pregnancy, yet not require it for a decision that will result in the child's death.

Our arguments and reasons are discussed more fully in the article Ben White and Lindy Willmott, 'Termination of a minor's pregnancy: critical issues for consent and the criminal law' (2009) 17(2) *Journal of Law and Medicine* 249-260, which we table before the Committee.[45] We further note that Queensland is the only Australian jurisdiction which appears to require judicial approval for termination of pregnancy of non-*Gillick* competent minors.

(ii) *Harmful consequences for the child*

Of further concern is the impact and effect of the current law on pregnant girls. It appears that the requirement for court authorisation of abortions for non-*Gillick* competent girls is causing them

[44] *Re Baby D* (2011) 45 Fam LR 313.
[45] Ben White and Lindy Willmott, 'Termination of a minor's pregnancy: critical issues for consent and the criminal law' (2009) 17(2) *Journal of Law and Medicine* 249-260, 251-256. Our position that parents, not courts, should be able to consent to the termination of pregnancy of a non-*Gillick* competent child is also supported by other leading Australian health law academics: Ian Kerridge, Michael Lowe and Cameron Stewart, *Ethics and Law for the Health Professions* (4th ed, 2013), (The Federation Press: Leichhardt, NSW) 594-595; Belinda Reeve, *Central Queensland Hospital v Q: Access to abortion in Queensland and children's ability to consent to medical treatment* (29 April 2016) <https://sydneyhealthlaw.com/2016/04/29/central-queensland-hospital-v-q-access-to-abortion-in-queensland-and-childrens-ability-to-consent-to-medical-treatment/> .

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harm, distress, humiliation and unnecessary delays in receiving a termination, as well as confusion and anxiety for health practitioners.[46]

Accordingly, we submit that this is a specific issue warranting particular consideration by the Inquiry. We further submit that legislation should be introduced to recognise that consent to termination of pregnancy for non-*Gillick* competent minors falls within the ambit of parental decision-making. Now that two Supreme Court decisions (*State of Queensland v B* and *Central Queensland Hospital and Health Service v Q*) have concluded that court authorisation is required in Queensland to terminate a non-*Gillick* competent minor's pregnancy, both health professionals and legal practitioners are likely to follow such an approach. For the current legal position to change, it would either be necessary for the Supreme Court to reach an alternate view in future decisions, or for the legislature to enshrine in statute the ability of a non-*Gillick* competent minor's parents, rather than the court, to consent to terminations. In our view, legislative intervention is needed to recognise this position and ensure the law is clear on this issue.

c) Proposed amendment to *Transport Operations (Road Use Management) Act 1995* (Qld)

We agree with the proposal in the Bill to amend schedule 2 of the *Transport Operations (Road Use Management) Act 1995* (Qld) to remove section 226.

d) Access zones

We urge the Committee to consider the issue of access/buffer zones outside of facilities offering termination of pregnancy, and support implementation of these in Queensland. Currently the Victorian, ACT and Tasmanian laws make provision for these zones.[47] In our view women considering or receiving an abortion should not be subjected to harassment, bullying, intimidation or harm through protests, communications, distribution of offensive materials or other acts of aggressive behaviour, and are entitled to sufficient protection of their personal safety and privacy, by the law, in such situations.

e) Residency requirements

We note that in South Australia an abortion can only be obtained where the woman has been a resident for at least two months.[48] We consider such an approach unnecessarily restrictive, and that it fails to take into account situations such as where a person is an international citizen travelling in Australia, or an Australian resident travelling or working interstate. As discussed earlier, termination of abortion is a medical procedure, and should be treated in the same way as all other medical

[46] Joshua Robertson, 'Queensland doctor in abortion case says more teenagers face "appalling choice"', *The Guardian* (online), 16 June 2016 <https://www.theguardian.com/world/2016/jun/16/queensland-doctor-abortion-more-teenagers-face-appalling-choice>.
[47] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s9; *Health (Patient Privacy) Amendment Act 2015* (ACT) Div 6.2 and *Public Health and Wellbeing Act 2008* (Vic) s2.
[48] *Criminal Law Consolidation Act 1935* (SA) s82A(2).

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procedures, none of which are subject to jurisdictional limitations. We oppose any similar provision being introduced in Queensland.

Thank you for the opportunity to contribute to this review. We would be pleased to assist the Committee further if additional information is required.

Yours sincerely

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Termination of a minor's pregnancy: Critical issues for consent and the criminal law

Ben White and Lindy Willmott*

The recent Supreme Court decision of Queensland v B [2008] 2 Qd R 562 has significant implications for the law that governs consent and abortions. The judgment purports to extend the ratio of Secretary, Department of Health and Community Services (NT) v JWB and SMB (1992) 175 CLR 218 (Marion's Case) and impose a requirement of court approval for terminations of pregnancy for minors who are not Gillick-competent. This article argues against the imposition of this requirement on the ground that such an approach is an unjustifiable extension of the reasoning in Marion's Case. The decision, which is the first judicial consideration in Queensland of the position of medical terminations, also reveals systemic problems with the criminal law in that State. In concluding that the traditional legal excuse for abortions will not apply to those which are performed medically, Queensland v B provides further support for calls to reform this area of law.

INTRODUCTION

Late in 2008, in *Queensland v B* [2008] 2 Qd R 562, the Supreme Court of Queensland considered an application in its parens patriae jurisdiction from a hospital to authorise the termination of a pregnancy of a 12-year-old girl, B. Because the girl was almost 18 weeks pregnant, the proposed method of termination was through the administration of a drug, misoprostol, rather than a surgical procedure. The girl wanted the termination to go ahead, as did both of her parents. This was also the course of action proposed by the hospital. Wilson J of the Supreme Court concluded that "the continuation of B's pregnancy would pose serious danger to her mental health and well-being, beyond the normal dangers of pregnancy and childbirth" (at [12]). Her Honour declared that the termination of the pregnancy by the "administration of the drug misoprostol would be reasonable in all the circumstances to avoid danger to the child's mental health". Declarations were also made permitting the child to undergo the termination and for hospital staff to perform it (at [1]).

There were two major aspects to this decision, each of which raises significant legal issues that go well beyond the scope of the present case. The first is the issue of consent. In *Queensland v B*, Wilson J concluded (at [16]) that the girl did not have a full understanding of the nature of the proposed termination on the basis of evidence given by the girl's father, an obstetrician and a psychiatrist.[1] Accordingly, she was not able to give consent for herself. However, her Honour also concluded that this consent could not be given by her parents either: such a decision to terminate a pregnancy falls outside the scope of parental authority and therefore can only be made by a court. In reaching this view, Wilson J extended the ratio of *Secretary, Department of Health and Community Services (NT) v JWB and SMB* (1992) 175 CLR 218 (*Marion's Case*) to decisions to terminate the pregnancy of minors who are not yet *Gillick*-competent.[2] The implications of extending the ratio of *Marion's Case* are significant and this article seeks to argue that such a position should not be adopted.

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[1] A second psychiatrist disagreed and considered that the girl was competent to make the decision (at [16]).

[2] A child or young person has the right to make her or his own decisions as to medical treatment if he or she has "a sufficient understanding and intelligence to enable him or her to understand fully what is proposed": *Secretary, Department of Health and*

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The second major aspect of the decision in *Queensland v B* was whether the termination was lawful. Of significance here was that Wilson J concluded (at [21]) that the provision of the *Criminal Code* (Qld) traditionally relied upon as a ground for termination of pregnancies (s 282) did not apply. That provision refers only to "surgical operations" and so would not excuse terminations undertaken medically through the administration of drugs. With that option unavailable, Wilson J relied on s 286, which imposes on a "person who has care of a child under 16 years" a duty to:

> …
> (b) take the precautions that are reasonable in all the circumstances to avoid danger to the child's life, health or safety; and
> (c) take the action that is reasonable in all the circumstances to remove the child from any such danger;
> …

Wilson J concluded that the administration of the drug would be reasonable within the meaning of this provision and so the existence of this duty meant that the termination of pregnancy would not be unlawful.

This decision raises issues for the criminal law governing abortion. This is the first time that the position of medical terminations has been judicially considered in Queensland. The conclusion that the traditional excuse that is relied on for terminations does not apply in this context raises issues about the lawfulness of these procedures. The decision also reveals some inconsistencies in how the criminal law deals with termination of pregnancies for minors.

Although only a short judgment, *Queensland v B* has significant implications for two critical areas of medical law: consent and abortion. This article critically examines these two aspects of the judgment before making observations on how the problems identified should be addressed.

Extending Marion's Case to terminations of pregnancy

The authors argue that the ratio of *Marion's Case* should not be extended to the termination of a pregnancy for a non-*Gillick*-competent minor. To make this argument, it is necessary to recap briefly on the facts of that case, together with the reasoning of the majority, as revealed in their joint judgment, and of the three Justices who gave separate dissenting judgments.

Marion's Case involved a 14-year-old girl with an intellectual disability who was severely deaf, suffered from epilepsy, had an ataxic gait and exhibited behavioural problems. Marion's parents wanted her to be sterilised and the issue was whether that decision was within the power of her parents to make. The sterilisation was "non-therapeutic", which means that it was not needed to treat some malfunction or disease, but rather it was necessary to enhance Marion's quality of life. The parents wanted the procedures (hysterectomy and an ovariectomy) to occur to prevent "pregnancy and menstruation with its psychological and behavioural consequences" (at 229). The High Court held that the parents did not have power to consent to such treatment, and court authorisation was required for the procedure to be lawful.

The decision was by majority, with Mason CJ, Dawson, Toohey and Gaudron JJ delivering a joint judgment. The majority considered that the sterilisation procedure was a "special case" requiring court authorisation for two major reasons.

The first was the "significant risk of making the wrong decision, either as to a child's present or future capacity to consent or about what are the best interests of a child who cannot consent" (at 250). The Justices described the three factors that they considered contributed to the significant risk of a wrong decision as follows:

- The complexity of the question of consent: here, the Justices referred to the fact that a person may make an incorrect assessment that the child does not have the ability to consent. They also

Community Services (NT) v JWB and SMB (1992) 175 CLR 218 at 237-238 (*Marion's Case*). In this case, the High Court adopted the position taken in the House of Lords decision of *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, which is the source of the reference to "*Gillick*-competence".

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referred to the fact that historically, incorrect assumptions were made about the inability of a child with a disability to consent to, or refuse, such a procedure.

- The medical profession often plays a crucial role in the decision to sterilise as well as the procedure itself: the concerns of the Justices were that health professionals do not always make appropriate decisions. Further, there are many aspects of a sterilisation decision that are not of a medical nature, so are outside the expertise of the medical profession.
- There may be conflicting factors in making a decision: the decision to sterilise involves not only the interests of the child but also possibly conflicting interests of the parents and other family members.

Secondly, the consequences of making a wrong decision are particularly grave. The consequences referred to by the majority were both the inability to reproduce, and the fact of being acted upon contrary to the child's best interests.

The other three Justices dissented, but all for different reasons. Justice Brennan was of the view that the courts could not have any wider power to consent to a medical procedure than the parents. Further, his Honour was of the view that it was beyond the power of both parents and the court to consent to a non-therapeutic sterilisation. Justice Deane took a different approach. He was of the view that a parent could consent to a sterilisation procedure, including a non-therapeutic procedure, if it were "so obviously in the interests of the welfare of such a child" (at 289). Court approval would only be necessary if the need for the procedure was not obvious. Finally, McHugh J was of the view that parents could consent to such a procedure if it were in the best interests of the child.[3] His Honour did add the caveat that the power to consent should be exercised by the court *if* the interests of the parents conflicted with those of the child (at 322).[4]

There are two preliminary comments that should be made about the High Court judgments which are relevant to the issue considered in this article, namely whether the ratio of *Marion's Case* should be extended to the termination of a pregnancy of a non-*Gillick*-competent minor. First, there were four different approaches taken by seven High Court Justices. This fact alone demonstrates the complexity and difficulty of the issues considered by the court. Secondly, there was a clear reluctance by all members of the court to take matters out of the ambit of parental responsibility. The majority held that it would only be in an exceptional (or "special") case that such a step would be taken. Justices Deane and McHugh held that, in an appropriate case, parents would have such a power, while Brennan J was of the view that courts could not have greater powers to consent to treatment than parents.

It is against this backdrop that Wilson J extended the ratio of *Marion's Case* to a decision about termination of a minor's pregnancy. The authors advance three arguments as to why such an extension is not justifiable.[5]

Critical distinctions between the procedures of termination and non-therapeutic sterilisation

The justification for extending *Marion's Case* to decisions about terminating a pregnancy was contained in one paragraph of Wilson J's judgment. Because of the legal and practical significance of this decision, it is worth setting out that reasoning in full (at [17], emphasis added):

> In *Marion's Case*, Mason CJ, Dawson, Toohey and Gaudron JJ discussed why the parents of an intellectually disabled girl could not validly consent to her sterilisation, essentially because of the risks of their making the wrong decision and the grave consequences of their doing so. *For similar reasons*,

[3] McHugh J considered it could be in the best interests of a child to be sterilised for non-therapeutic reasons if the procedure is necessary to avoid serious jeopardy to the child's physical or mental health; to alleviate pain, fear or discomfort of such severity and duration or regularity that it is not reasonable to expect the child to bear it; to eliminate a real risk of the child becoming pregnant if she does not, and never will, have any real understanding of sexual relationships or pregnancy; or for an analogous purpose: *Secretary, Department of Health and Community Services (NT) v JWB and SMB* (1992) 175 CLR 218 at 321-322.

[4] His Honour noted (at 317) that sterilisation and termination of a pregnancy were two situations where such a conflict of interest could potentially arise.

[5] For a discussion of a model where the primary decision-making role rests with neither the parents nor the courts, see Herring J, "Children's Abortion Rights" (1997) 5 *Medical Law Review* 257.

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> B's parents should not be able to consent to the termination of her pregnancy. The court in its role as parens patriae must act in the best interests of the child, B, whereas her parents may ultimately make a decision which favours other and possibly conflicting interests of the family as a whole (albeit one bifurcated by their own divorce). And, like the decision to sterilise, which was under consideration in *Marion's Case*, the medical profession might be expected to play a central role in the decision to terminate the pregnancy as well as in the procedure itself. To terminate a pregnancy is to negate the possibility of the mother ultimately giving birth to a live baby.

The thrust of Wilson J's reasoning is that the two factors which were relied upon by the majority in the High Court in deciding that a non-therapeutic sterilisation was a "special case" applied equally to a termination: to use the summary of Wilson J, "because of the risks of their making the wrong decision and the grave consequences of their doing so". The difficulty with the Supreme Court decision is that it did not engage in any detail about how these two factors apply to the case of a termination. The authors consider there are some critical distinctions that mean terminations and non-therapeutic sterilisations should be treated differently.

First limb: Risks of making the wrong decision

Regarding the risks of making the wrong decision, the only justification or explanation in the relevant paragraph of Wilson J's judgment was that there was potential conflict between the interests of the family and of the child, and that the medical profession would play a role in the decision-making and in the procedure itself. With respect, this comparison is too simplistic. There are many types of medical treatment that satisfy both of these conditions. The decision for a minor to be prescribed oral contraception is one example. Parents may wish this to occur because they do not want their child to become pregnant and they, the parents, do not want the responsibility of raising the child's baby. However, to be prescribed an oral contraceptive from an early age may not medically be in the child's best interest. As such, the interests of the parents may conflict with those of the minor. On the other hand, it is also possible that the parents may wish their child to take oral contraception for a legitimate medical reason, such as managing difficult and painful menstruation. In the latter situation, a conflict of interest does not arise. However, depending on the parent's motives in a particular case, there is clearly a *potential* for conflict.

Similarly, the health professional is likely to be involved in the decision-making process about whether to prescribe oral contraception. He or she would provide medical (and possibly other) opinion about treatment options, and would ultimately prescribe the medication if that were the decision taken.

These two factors should not be sufficient to make the prescription of oral contraception a "special case" requiring court approval. Yet, applying the reasoning adopted in *Queensland v B*, that may be the result.

Importantly, in considering the risks of making the wrong decision, Wilson J did not refer at all to the risk of wrongly assessing either the child's present or future capacity to consent, or the child's best interests. However, both of these issues were extremely important to the conclusion of the High Court that a non-therapeutic sterilisation was a special case. Furthermore, these considerations demonstrate the significant difference between a non-therapeutic sterilisation and a termination. A determination of the ability of the child to consent now or in the future is a much more complex issue for a sterilisation than for a termination. In relation to the ability of the child to consent to a termination, an assessment of the child's capacity *now* is all that is relevant. Unlike a sterilisation, which could be carried out at some time in the future, there does not need to be an assessment of whether additional age or maturity will enable the child to make the decision herself in the future. Also, the factors that need to be understood in providing consent are much more straightforward for a termination than for a sterilisation. For the latter procedure, there are wider choices of treatment and different consequences of the different sterilisation options.

In terms of the best interests of a child who cannot consent, again a decision about termination of pregnancy is much simpler than one about sterilisation. For a termination, the options are fewer – either it occurs or it does not (although there is generally some choice regarding how a termination is achieved). By contrast, a decision as to whether or not a non-therapeutic sterilisation is in a child's best interests involves consideration of a greater number of factors. Those factors include the extent to

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which alternative options have been attempted or could still be attempted. A full investigation of such matters (including any potential side-effects of alternative treatment) will generally be necessary before a court will consider approving a non-therapeutic sterilisation. The factors to consider for a sterilisation also include the various possible surgical operations available and the critical issue of the timing of any such procedure.[6] As a result, issues of whether to sterilise, when to sterilise and how to sterilise make the assessment of a child's best interests more complex than for a termination of pregnancy.

In summary, the authors are of the view that the risks of making the wrong decision about a minor's ability to consent and what is in a minor's best interests are far greater for a non-therapeutic sterilisation than for a termination. It is therefore argued that the ratio of *Marion's Case* should not be extended to terminations, particularly having regard to the otherwise strict approach taken to limiting parental power (see below).

Second limb: Gravity of consequences of a wrong decision

The second factor relevant to making non-therapeutic sterilisation a "special case" for the majority of the High Court was the gravity of the consequences of making the wrong decision. The gravity of the decision for both a termination and a non-therapeutic sterilisation is obvious. However, the consequences of sterilisation are far graver *for the child* than the consequences of an abortion. Sterilisation means that the child can never reproduce. A termination of pregnancy means that the child will not reproduce *now*. The procedure is unlikely to affect her ability to reproduce in the future. Justice Wilson did not engage in this distinction and commented only (at [17]) that "to terminate a pregnancy is to negate the possibility of the mother ultimately giving birth to a live baby".

A strict approach to further incursion into parental powers

It was noted above that all members of the High Court in *Marion's Case* took a strict approach to when parents will not have the power to consent to medical treatment on behalf of their child.[7] The dissenting three High Court Justices were reluctant to allow a court to take over traditional consent power from parents. Justices Deane and McHugh considered that, in an appropriate case, the power to consent to a non-therapeutic sterilisation should form part of parental powers, and parents should be authorised to make decisions that are in their child's best interests. Justice Brennan, although deciding that neither a court nor a parent should be able to consent to a non-therapeutic sterilisation, expressed concern about the notion that a court could have wider consent powers than a parent (at 282). It was also clear from the lengthy and considered judgment of the majority that incursion into parental power should occur only in a "special case". The majority was at pains to point out what makes non-therapeutic sterilisation such a case. It should also be observed that in no part of their judgment did the majority suggest that the termination of a pregnancy would constitute a "special case".[8]

The limitations on parental consent powers that were imposed by the High Court in *Marion's Case* have subsequently been invoked, but only on a handful of occasions. In *Re A (A Child)* (1993) 16 Fam LR 715, the Family Court held that gender reassignment was a "special case" within the ambit described in *Marion's Case* for which court approval was required.[9] The same position was taken by

[6] In relation to the application process for approval by the Family Court of a non-therapeutic sterilisation, including the evidence that is required in support of the application, see Div 4.2.3 of the *Family Court Rules 2004* (Cth). See also Practice Direction No 9 of 2004, *Victorian and Queensland Registries: Medical Procedure Applications*.

[7] See above at 250.

[8] McHugh J acknowledged that a conflict between a child's interests and parental interests could arise in relation to a termination of pregnancy (as well as sterilisation) and if it did, then there would be no parental power to consent and court approval would be required: *Secretary, Department of Health and Community Services (NT) v JWB and SMB* (1992) 175 CLR 218 at 317, 322. However, these comments were made in the context of his Honour declining to mandate court approval for sterilisations and expressly recognising parental power to provide consent to all medical treatment in a child's best interests (at 321-322).

[9] The application in this case was for the assignment of male sex organs to the child. The court authorised the child's mother to consent to a range of medical procedures including bilateral mastectomies, hysterectomy and oophorectomy, unfolding of the clitoris, closure of the labia to create the appearance of a scrotum, the insertion of prosthetic testes and other consequential treatment.

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the Family Court some years later in *Re Alex (Hormonal Treatment for Gender Identity Dysphoria)* (2004) 180 FLR 89, a case in which the court approved hormonal treatment being administered to a 13-year-old girl who was diagnosed with gender identity disorder or gender identity dysphoria.[10]

As a result of two decisions of the Family Court, there is some doubt as to whether court approval is required in the case of the donation of regenerative tissue by a non-*Gillick*-competent child to a sick relative. While in *GWW and CMW* (1997) 21 Fam LR 612, the Family Court indicated that court approval was required, the more recent decision of *Re Inaya* (2007) 213 FLR 278 held that such a procedure fell within the ordinary parental power. In the latter decision, the Family Court noted the observation of the High Court in *Marion's Case* that most decisions about medical treatment fell within normal parental responsibility (at [60]). Cronin J also referred (at [61]) to the cost and inconvenience of having to apply for court approval, factors also acknowledged by the High Court.

It is submitted that courts should be, and have been, slow to limit the power of parents to act in their child's best interests. This sentiment permeates all of the judgments in *Marion's Case*, and is evident from the limited extension of what constitutes a "special case" in the 17 years since the landmark decision of the High Court. A decision to terminate a pregnancy for a child who lacks capacity is a serious one, and should be made only if it accords with the child's best interests. However, when assessing the nature of the surgery, it must be questioned whether the medical procedure is comparable with non-therapeutic sterilisation, gender reassignment surgery and treatment for gender identity dysphoria. With respect to Wilson J, compelling reasons were not advanced in *Queensland v B* as to why a termination of pregnancy should be regarded as a "special case" that falls outside the ordinary power of parents to consent in their child's best interests.

Parental power to consent in relation to more significant medical decisions

The decision to require court approval for the termination of pregnancy does not sit comfortably with other powers of parents to make medical decisions that are in the best interests of their child.[11] The decision to withhold and withdraw life-sustaining medical treatment from non-*Gillick*-competent children is an obvious example. Such decisions, though tragic, are not uncommon in the case of babies who are born with very serious disabilities and for whom the provision of medical treatment is considered to be futile. The common law has recognised that these decisions to withhold or withdraw life-sustaining treatment can be made by parents without the need for court approval, even though such a decision would result in the child's death.[12] Court intervention is generally required only when disagreement arises between parents and the child's medical team as to what is in the child's best interests.[13]

A decision to withhold or withdraw life-sustaining treatment is, in some respects, similar to a decision to terminate a pregnancy:

- there is potential for conflict between the interests of the baby and the family (as the family may have to make sacrifices in order to raise the baby who suffers from profound disabilities);
- the decision to withhold or withdraw treatment will involve medical professionals; and
- the consequence of the decision not to provide treatment is extremely grave, namely the death of the baby.

[10] This treatment has irreversible consequences including deepening of the voice, promotion of facial and body hair, encouragement of muscular development and the enlargement of the clitoris.

[11] The power of a parent to consent to (or refuse) treatment for their child stems from their "parental responsibility": see ss 61C(1) and 61B of the *Family Law Act 1975* (Cth). Note, however, that there are legal avenues that are available to protect a child if a parent exercises her or his power in a manner that is not in the child's best interests: see further Skene L, *Law and Medical Practice: Rights, Duties, Claims and Defences* (3rd ed, LexisNexis Butterworths, Sydney, 2008) at [4.7]-[4.14].

[12] *Portsmouth Hospital NHS Trust v Wyatt* [2005] 1 WLR 3395 at [3].

[13] See eg *Portsmouth Hospital NHS Trust v Wyatt* [2005] 1 WLR 3395; *An NHS Trust v MB* [2006] 2 FLR 319; [2006] EWHC 507 (Fam); *Re K (A Child) (Medical Treatment: Declaration)* [2006] 2 FLR 883; [2006] EWHC 1007 (Fam); *Re OT (A Child)* [2009] EWCA Civ 409. For a general consideration of decisions in New Zealand and some other overseas jurisdictions concerning the ability of parents to refuse treatment on behalf of their non-*Gillick*-competent children, see Manning J, "Parental Refusal of Life-prolonging Medical Treatment for Children: A Report from New Zealand" (2001) 8 JLM 263.

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These were the factors that Wilson J relied upon in *Queensland v B* to justify the requirement for court approval. Yet, despite sharing these features, the courts have recognised that parents do have power to refuse consent to life-sustaining medical treatment.[14] It seems incongruous to require court approval for a decision to terminate a pregnancy of a child, yet not to require it for a decision that will result in the child's death.

IMPLICATIONS FOR THE CRIMINAL LAW

Queensland v B also has significant implications for the criminal law on terminations. This article examines the impact of this decision on surgical terminations involving children and also the law in relation to medical (rather than surgical) abortions. First, however, the law governing terminations in Queensland is outlined.

Criminal law on terminations in Queensland

In Queensland, the termination of pregnancy is governed by the *Criminal Code* (Qld). It is an offence to procure the miscarriage of a woman (s 224), including by the woman who is pregnant (s 225),[15] and to supply drugs or instruments to procure the abortion (s 226). Section 224 is the principal offence and provides as follows:

> Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a crime, and is liable to imprisonment for 14 years.

Despite not originally being designed to provide an excuse in relation to termination of pregnancies,[16] s 282 of the *Criminal Code* (Qld) is the provision principally relied upon to avoid criminal responsibility. It provides:

> A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for the patient's benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all circumstances of the case.

For the Crown to secure a conviction, it would need to negative beyond reasonable doubt one of the elements of this excuse and most relevantly for this circumstance would need to show either that:

- the termination was not performed "for the preservation of the mother's life"; or
- the termination was not "reasonable having regard to the patient's state at the time and to all the circumstances of the case".

Interestingly, the interpretation of this Code provision has been heavily influenced by the common law. In the Victorian decision of *R v Davidson* [1969] VR 667, the relevant offence provision considered was contravened only if the termination of pregnancy was "unlawful". It was therefore argued that not all terminations would be unlawful and the common law defence of necessity was identified as a source for making a termination lawful. This was captured in what became known as the "Menhennitt ruling" (which was the name of the judge in this case) that a termination will be unlawful where it can be proved beyond reasonable doubt that the accused did not honestly believe on reasonable grounds that:

- the act was *necessary* to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of her pregnancy would entail; or
- in the circumstances, the act was not out of *proportion* to the danger to be averted.

[14] *Portsmouth Hospital NHS Trust v Wyatt* [2005] 1 WLR 3395 at [3].

[15] See the recent prosecution of a 19-year-old woman for procuring her own abortion after importing the drug misoprostol into Australia from the Ukraine: "Queensland Abortion Prosecution", *The Law Report* (ABC Radio National, 28 April 2009).

[16] Section 282 was intended to be a defence to the offence of child destruction under s 313: O'Regan RS, "Surgery and Criminal Responsibility under the Queensland Criminal Code" (1990) 14 Crim LJ 73 at 77. This was also noted by McGuire DCJ in *R v Bayliss; R v Cullen* (1986) 9 Qld Lawyer Reps 8 at 34-35.

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Despite the different wording of s 282, it appears that the *Davidson* test has been accepted as the law in Queensland.[17] There have been a series of Supreme Court decisions that have accepted this view[18] and it was also the basis upon which the District Court trials in *R v Bayliss; R v Cullen* (1986) 9 Qld Lawyer Reps 8 were held. It is noted that the common law test, as expressed in *R v Davidson*, has been subsequently liberalised and it is suggested that this should also be reflected in the law of Queensland.[19]

Surgical terminations and children

Queensland v B involved a termination for a child who was 12 years old and not *Gillick*-competent.[20] It is worth considering, however, the implications of this decision for children more generally in the context of surgical terminations. It is noted at this stage that medical terminations will not be considered here: they are examined below. Children can be placed into four categories for the purpose of this discussion:[21]

- those under 16 who are not *Gillick*-competent;
- those under 16 who are *Gillick*-competent;
- those over 16 who are not *Gillick*-competent; and
- those over 16 who are *Gillick*-competent.

Turning first to a termination for a child who is under 16 and who is not *Gillick*-competent, if *Queensland v B* represents the law, approval of the court that the operation is in her best interests is required. Justice Wilson also held that the court would need to be satisfied that the decision was lawful because it could not be in a child's best interests to be subject to a criminal act and because the court could not authorise what would otherwise be criminal conduct (at [19]). As noted above, in *Queensland v B*, Wilson J relied on s 286 of the *Criminal Code* (Qld) to conclude the termination would be lawful. That provision imposes a duty on a "person who has care of a child under 16 years" to safeguard that child from danger to her life, health or safety.

Although, in that case, s 282 was not applicable because it did not involve a surgical operation (this is discussed below), in situations involving surgical terminations it may also be available to the court. If so, s 282 presents an alternative basis upon which a court could find that a termination was lawful. The result of this analysis is that consideration of whether a surgical termination may occur for a child who is under 16 and not *Gillick*-competent potentially involves the consideration of three different tests:

- the child's best interests (which is the criterion for obtaining court approval);
- lawfulness under s 286 if the termination is reasonable in all the circumstances to avoid danger to the child's life, health or safety; and
- lawfulness under s 282 if the termination is necessary to preserve the child from a serious danger to her life or her physical or mental health which the continuance of her pregnancy would entail, and that the termination is not out of proportion to the danger to be averted.

[17] Compare O'Regan, n 16 at 80-81. O'Regan considered that "resort to common law principles to supplement and explain statute law … must be regarded as very unusual in Queensland, which has a comprehensive *Criminal Code*, and one which does not have common law defences" (at 81). He considered that in Queensland it should be s 282, perhaps in combination with s 24 (honest and reasonable mistake of fact), that renders abortion lawful (at 81).

[18] *K v T* [1983] 1 Qd R 396 at 398 (affirmed on appeal in *Attorney-General (Qld) (Ex rel Kerr) v T* [1983] 1 Qd R 404 and *Attorney-General (Qld) (Ex rel Kerr) v T* (1983) 57 ALJR 285, although neither appeal court expressed a settled view on the interpretation of Queensland's abortion law); *Re Bayliss* (unrep, Sup Ct, Qld, McPherson J, 24 May 1985); *Veivers v Connolly* [1995] 2 Qd R 326 at 329.

[19] Dixon N, *Abortion Law Reform: An Overview of Current Issues* (Queensland Parliamentary Library Paper, Research Brief No 2003/09, 2003). Note also the comments of de Jersey CJ in *Veivers v Connolly* [1995] 2 Qd R 326 at 329, which suggest that a wider approach should also be taken in Queensland.

[20] For a discussion of *Gillick*-competence, see n 2.

[21] A child is an individual under 18: *Acts Interpretation Act 1954* (Qld). Once a child turns 18, if she lacks capacity to make a decision about terminations, that decision would then fall within the jurisdiction of the Guardianship and Administration Tribunal: *Guardianship and Administration Act 2000* (Qld), ss 65, 68, 71, 82(1)(g) and Sch 2 (definition of "special health matter" and "special health care").

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A similar position arises in relation to a child under 16 who is *Gillick*-competent, except that the requirement for the court to provide consent on behalf of the child in her best interests does not arise.

In relation to a child who is over 16 and *Gillick*-competent, consent from the court is also not required and s 282 will be available. However, s 286 is not, as its terms are limited to a duty imposed on those with the care of a child under 16. A termination for a child over 16 who is not *Gillick*-competent would also be limited to s 282 (and not s 286), and it would also require court consent on the basis of the child's best interests.

This analysis reveals the following anomalous situation for surgical terminations involving children as set out in Table 1.

TABLE 1 Law governing surgical terminations for children

Child's characteristics	Under 16 years of age	16 to 18 years of age
Lacks competence	• Consent: from court in best interests • Lawful: s 282 or s 286	• Consent: from court in best interests • Lawful: s 282 only
Has competence	• Consent: from child • Lawful: s 282 or s 286	• Consent: from child • Lawful: s 282 only

The current state of the law is clearly problematic. This complexity presents problems not only for lawyers but also the child involved and her family as well as the doctors considering undertaking such procedures. It is also undesirable for the lawfulness of the same procedure in relation to children to be governed by different tests. For example, at least in relation to how the tests are actually worded, it is likely that lawfulness under s 286 will be more easily met than the relevant test under s 282. Under s 286, all that is required is that the termination be reasonable to avoid danger whereas s 282 refers to a necessity to preserve the child from serious danger provided such action is proportionate.

A further anomaly in the criminal law governing terminations arises from the requirement proposed in *Queensland v B* that the court must sanction such a decision due to a lack of parental power. In sterilisations, a failure to get the court's consent will mean that any operation will be an assault, making those responsible liable under both criminal and civil law.[22] The position for terminations is different. A lack of the judicial consent required in *Queensland v B* will certainly lead to civil liability for the tort of assault, but it may not lead to criminal liability. If the termination occurs in circumstances in which s 282 would apply, the excuse means that a person is "not criminally responsible". Where this leaves the requirement of court approval so far as it is supported by effective sanctions is unclear. It certainly seems odd that a failure to obtain court approval could result in civil action but that doctors and others could at the same time be protected from criminal liability despite that failure to follow the mandated court approval process.

This situation could also arise in relation to terminations regarded as lawful through the operation of s 286. It is noted that that section is a duty provision and does not refer to a person being excused from "criminal responsibility". Nevertheless, that obligation to safeguard a child from danger is being relied upon in this context to excuse criminal liability and so the same anomalous situation could arise.

Medical (rather than surgical) terminations

While s 282 may have application to termination of pregnancies done by way of surgical operation, it will not apply to excuse medical terminations. The provision refers only to "surgical operations" and would not include the taking of medication. Although the issue has been raised previously in the

[22] *Secretary, Department of Health and Community Services (NT) v JWB and SMB* (1992) 175 CLR 218 at 232 (Mason CJ, Dawson, Toohey and Gaudron JJ).

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literature,[23] this was judicially considered for the first time in *Queensland v B* where Wilson J concluded (at [21]) that s 282 was not applicable because there was no surgery involved in the termination.[24] What, then, are the implications for the lawfulness of medical terminations if this excuse does not apply? What, if anything, makes medical terminations lawful?

Another specific provision in the Code

One possibility is that there may be another provision in the *Criminal Code* (Qld) that makes medical terminations lawful in certain circumstances. This was the approach taken in *Queensland v B*. As noted above, Wilson J relied on s 286, which imposes a duty to safeguard a child under 16 from harm on a person who has care of that child. Justice Wilson concluded that the administration of the drug would be reasonable within the meaning of this provision and so the existence of this duty meant that the termination would not be unlawful. That provision, however, only applies to children under 16 and so would not be otherwise available. What, then, in those other cases?

The authors have reviewed the duty provisions of the Code and consider two other provisions could possibly apply: ss 285 and 290. Section 285 imposes a duty on a person to provide the "necessaries of life" to another who is in her or his charge and "who is unable by reasons of age, sickness, unsoundness of mind, detention, or any other cause, to withdraw from such charge, and who is unable to provide himself or herself with the necessaries of life". Section 290 imposes a duty on a person who "undertakes to do any act the omission to do which is or may be dangerous to human life or health". If it could be argued that a medical termination in the particular circumstances could meet either of these criteria, a similar approach may be taken to *Queensland v B* and criminal responsibility excluded on the basis of a duty provision. This argument is, however, speculative as the authors are not aware of these two provisions ever being used in this way.[25]

Not "unlawfully": Common law defence of necessity

Another possibility is that the common law approach as first stated in *Davidson* could be applied to excuse medical terminations. Sections 224, 225 and 226 all make certain acts offences if they are done "unlawfully" and it was this qualification that permitted Menhennitt J in *Davidson* to conclude that if justified by the common law defence of necessity then a termination could be lawful.

It is suggested, however, that such an approach would not be permissible in Queensland. Because the criminal law is governed by a Code, a reference to "unlawfully" would not permit the wholesale importation of the common law defence of necessity.[26] Although s 282 (dealing with surgical terminations) has been interpreted to be consistent with that common law position, that approach has been criticised.[27] That is also a far less significant step than incorporating a common law doctrine to operate within the Code but without it being attached or referable to a specific provision, as is being mooted here. As such, this argument is unlikely to be accepted.

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[23] de Costa C and de Costa N, "Medical Abortion and the Law" (2006) 29 UNSWLJ 218 at 220; Douglas H, "Abortion Reform: A State Crime or Woman's Right to Choose?" (2009) 33 Crim LJ 74 at 79.

[24] Despite this decision, it has been suggested that s 282 could be interpreted widely so that a reference to "surgical operation" could include a medical termination with reliance being placed on either the "purposive" or "always speaking" approaches to statutory interpretation: Douglas, n 23 at 81-82. However, as Douglas acknowledges (at 82), the principal obstacle to these arguments is that the relevant offence provisions already contemplate terminations through non-surgical means; eg, s 224 refers to "administers to her or causes her to take any poison or other noxious thing". The authors consider that, in light of this, and the significant distortion of meaning that would be required for "surgical operation" to include the taking of medication, the interpretation of Wilson J in *Queensland v B* is likely to be accepted.

[25] Indeed, the authors are only aware of the duty provisions being used in this way in two cases. The first was *Queensland v Nolan* [2002] 1 Qd R 454, where the Supreme Court authorised an operation to separate conjoined twins that would lead to the death of one of the twins. The second case is the present decision being considered: *Queensland v B* [2008] 2 Qd R 562.

[26] In *Queensland v Nolan* [2002] 1 Qd R 454, Chesterman J stated that the doctrine of necessity is "a creature of the common law and finds only a very limited role in the Code" (at [17]). See also *Ward v The Queen* [1972] WAR 36, where it was held that the *Criminal Code Act 1913* (WA) required that unless common law doctrines are expressly adopted, the Code should not be construed with an assumption that they still apply. This position was cited with approval in *Roberts v Western Australia* (2007) 34 WAR 1 at [108]. See also O'Regan, n 16 at 81 which states that Queensland does not have common law defences.

[27] See above n 17.

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Not "unlawfully": Lawful prescription

An alternative argument based on the reference to "unlawfully" has been mounted that where the Therapeutic Goods Administration "has approved use of a drug, prescription of that drug is lawful in Queensland pursuant to the *Health (Drugs and Poisons) Regulation 1996* (Qld)".[28] In other words, the lawfulness of the action derives from the legal authority to prescribe the drug granted by the Therapeutic Goods Administration and this is sufficient to displace criminal responsibility. It appears this was the position adopted by the Queensland Government after advice from the Solicitor-General.[29] However, this view has not been tested nor was it considered, still less endorsed, by Wilson J in *Queensland v B*. Further, if this view is correct, then is there a need to meet the *Davidson* test set out above as adopted in s 282? It would appear not and this would lead to different legal tests depending on whether the termination was undertaken surgically or medically.[30]

CONCLUSION

The decision of *Queensland v B* raises problems in the law of consent and the criminal law. Some of the problems stem from the judgment itself; others arise from what the decision reveals about the existing state of the law.

In terms of consent, the authors have argued against the conclusion that a termination of pregnancy for a non-*Gillick*-competent minor requires court approval and cannot be consented to by parents. The requirement to obtain court approval has been imposed in a very limited category of cases, all of which share particular features. A closer analysis of terminations reveals that those features are not present in the same way in decisions of that type. While a termination of pregnancy is a very serious matter, the nature of the decision is not such as to deprive parents of the ability to provide consent in their child's best interests.

Accordingly, it is argued that *Queensland v B* should not be followed. As a decision of a single judge of the Supreme Court, it does not bind other members of that court. Nevertheless, individuals including parents and doctors who are considering a termination in these circumstances may be concerned as to the lawfulness of doing so without court approval. It may be prudent, unless and until the matter is reconsidered by the Supreme Court, that court approval be obtained prior to such a termination occurring.

In relation to the criminal law, the above analysis reveals that the law governing terminations in Queensland is inconsistent and uncertain. In relation to terminations for children, the different legal positions discussed above that operate depending on the characteristics of the child involved are illogical. An abortion which is legal a week before a child's 16th birthday should not then be unlawful a fortnight later when s 286 of the *Criminal Code* (Qld) is no longer available.

Nor can the ongoing uncertainty as to the lawfulness of medical terminations be justified. None of the arguments advanced above as to why medical terminations may be lawful are compelling and it is unsatisfactory that this uncertainty remains. Calls for reform of the law of abortion have been made for some time.[31] The problems revealed by *Queensland v B* and the analysis undertaken here demonstrate further the urgent need for law reform in this area.

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[28] de Costa and de Costa, n 23 at 220. See also Joint Statement by the Premier and Attorney-General of Queensland, *Queensland Doctors and the Prescription of RU486* (24 April 2006), http://www.statements.cabinet.qld.gov.au/MMS/StatementDisplaySingle.aspx?id=45774 viewed 31 August 2009.

[29] de Costa and de Costa, n 23 at 220.

[30] de Costa C, Carrette M and Russell D, "Why Abortion Law Reform is Also Needed in Queensland", *Crikey Online* (22 January 2008), http://www.crikey.com.au/2008/01/22/why-abortion-law-reform-is-also-needed-in-queensland viewed 31 August 2009. For a discussion of the legal requirements of the Therapeutic Goods Administration in terms of being able to use the abortifacient mifepristone (RU486) as an "authorised prescriber" see de Costa C, Russell D, de Costa N, Carrett M and McNamee H, "Early Medical Abortion in Cairns, Queensland June 2006 – April 2007" (2007) 187 MJA 171.

[31] See eg de Crespigny L and Savulescu J, "Abortion: Time to Clarify Australia's Confusing Laws" (2004) 181 MJA 201; de Costa and de Costa, n 23; Douglas, n 23 at 86. In Queensland, see also Taskforce on Women and the Criminal Code, *Report of the Taskforce on Women and the Criminal Code* (1999) p 366.

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POSTSCRIPT

On 21 August 2009, Queensland's biggest hospital, the Royal Brisbane and Women's Hospital, suspended its medical termination service due to concerns about legal liability.[32] Patients in need of these services are being referred interstate. In response, the Queensland Government will extend the protection of s 282 of the *Criminal Code* (Qld) to medical abortions but it has ruled out undertaking more comprehensive reform.[33]

[32] Walker J, "Ruling to Shift Abortions Interstate", *The Australian* (21 August 2009), http://www.theaustralian.news.com.au/story/0,25197,25959538-601,00.html viewed 31 August 2009.

[33] Walker J, "More Queensland Hospitals Drop Abortion", *The Australian* (25 August 2009), http://www.theaustralian.news.com.au/story/0,25197,25976894-2702,00.html viewed 31 August 2009.