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Committee Secretariat
Abortion Legislation Committee
Parliament Buildings
WELLINGTON

via: New Zealand Parliament submission portal

Tēnā koutou katoa,

Abortion Legislation Bill

Thank you for giving The Royal New Zealand College of General Practitioners the opportunity to comment on the Abortion Legislation Bill.

General practitioners comprise almost 40 percent of New Zealand's specialist medical workforce and The Royal New Zealand College of General Practitioners is the largest medical college in the country. Our kaupapa is to set and maintain education and quality standards for general practice, and support our members to provide competent, equitable care to their patients. We do this to improve health outcomes and reduce health inequities.

Submission

This submission reflects our members' and the College's own analysis of the draft Abortion Legislation Bill ('the Bill'). The College surveyed its members using an online questionnaire and received responses from 35 percent of members (n=1751).

The College makes no comment on the morality or ethics of medical and surgical abortion – we consider this to be a matter for individual members' own consciences, within the framework of the law. Our members hold a wide range of views on abortion and the College's submission should not be taken as endorsement or rejection of abortion.

The College's view

In general, the College:

- supports removing abortion from the Crimes Act;
- recommends the proposed law states that only appropriately qualified medical practitioners may perform surgical abortions;
- recommends any statutory test should occur earlier than 20 weeks pregnancy;
- recommends there should be a gestational limit after which time a woman could not obtain an abortion of a viable foetus;
- advocates that conscientious objectors should have full employment protections, without exception;
- recommends safe areas should be established for all facilities and should also include protection from online harassment;

- recommends the Minister of Health be given the authority to establish temporary safe areas while the Order in Council process occurs;
- recommends abortion counsellors should be independent, registered practitioners;
- advocates that priority must be given to widening the choice, access and funding for contraception and sterilisation options for women and men, to reduce the number of unwanted pregnancies; and
- recommends anonymised abortion data should be provided to the Health Safety & Quality Commission so it can report national variations in access and uptake, for the purpose of improving equitable access to services. It is essential that the data collected protects the identities of women, practitioners providing abortion services and referring general practitioners.

Definitions used throughout

Please note that our response distinguishes between medical abortion and surgical abortion, which are not explicitly defined in the Bill. For clarity, when our submission mentions:

- medical abortion, it means intentionally terminating a pregnancy by using a drug or combination of drugs;
- surgical abortion, it means intentionally terminating a pregnancy by using an instrument;
- late abortion, it means an abortion performed after the 20th week of pregnancy;
- viable foetus, it means a foetus that would survive outside the uterus, when supported by current medical interventions;
- health practitioner, it means a person who is registered with an authority as a practitioner of a particular health profession; eg doctors, nurses, pharmacists etc.
- medical practitioner, it means a person registered with the Medical Council of New Zealand, ie doctors only; and
- members, it means the members of The Royal New Zealand College of General Practitioners who completed the College's questionnaire to provide their feedback regarding the Abortion Legislation Bill. All College members have either achieved vocational registration with the Medical Council of New Zealand as specialists in the scope of general practice or are general practice registrars training towards specialist status.

Most members support decriminalising abortion

Members expressed a wide range of views on the decriminalisation of abortion. More than three-quarters of members responding to the survey supported removing abortion from the Crimes Act and treating it as a health issue.

> *"Every woman has their own reason for terminating a pregnancy; this should be respected and supported."*
>
> *"I do not believe a woman should be criminalised for requesting an abortion (although I am a conscientious objector to providing that service myself)."*

A smaller number of others felt that abortion on demand was essentially already available in New Zealand and the proposed legislation was merely catching up with current practice.

“I believe in [location] at least, it is widely considered and practised as though it is a health issue. This would just be making it official.”

A sizeable minority of members responding to our survey (one in five) expressed a strong view that ending a pregnancy is taking a life, so should remain in the Crimes Act.

“A health service should not cause harm to anyone, and there is no doubt at all that the unborn child is fatally harmed.”

Most members want some restrictions on who provides abortion services

All members agreed that abortion providers must be appropriately qualified and trained, but that the provision of surgical abortion must be restricted to medical practitioners. However, fewer than half of the members responding to the survey supported health practitioners being able to provide abortion services.

They noted that proposing all health practitioners could provide abortions does not consider the limits placed on various professions’ scopes of practice, and this broad authority does not consider the different levels of medical expertise needed to perform abortions at different stages of pregnancy.

“A nurse or pharmacist could provide abortion services? Pharmacists can't prescribe most things without a script and most nurses can't prescribe either – unless they are nurse practitioners. This seems like a very liberal and dangerous provision.”

“I believe that the scope of who can procure an abortion is too broad. Does this mean that pharmacists can carry out surgical termination of pregnancies (TOPs)? I would also have concerns with pharmacists carrying out medical TOPs. Doesn't seem to specify that the health practitioner would need to be appropriately trained within the scope of practice of abortion medicine.”

The College recommends that the Bill be amended to separately specify which practitioners can perform medical abortions and which can perform surgical abortions, for example:

- an appropriately qualified health practitioner may provide medical abortion services to a woman who is not more than 9 weeks’ pregnant; and
- surgical abortion services may only be provided by an appropriately qualified medical practitioner.

Most members support a statutory test at 20 weeks – with caution

The College notes that the Bill proposes the provision of abortion services be differentiated at 20 weeks’ gestation.

Because any abortion performed after 20 weeks would be classified as a late abortion, it is essential that the Bill specifies that only an appropriately qualified medical practitioner may perform the statutory test to consider whether a late abortion is performed. A medical practitioner, and not a health practitioner, is far more qualified to determine and quantify the risks for or against performing an abortion if continuing the pregnancy would be detrimental to the woman’s physical health.

Although two-thirds of members agreed that 20 weeks would be an appropriate time at which to apply a statutory test, many expressed concerns that 20 weeks is close to the foetus being viable. They expressed

preferences for a statutory test to be applied at either 13 weeks (end of the first trimester) or at 16 – 18 weeks (following diagnostic testing), and several weeks before viability.

> *"[A statutory test] makes a lot of sense. Ideally it would be at 13 weeks, ie: the end of the first trimester. However, many women do not realise they are pregnant or seek advice until they are 6 / 8 / 12 weeks' pregnant which makes it very pressured to obtain the services in the current timeframe. Also, diagnostic tests for foetal abnormalities do not take place until 8-12 weeks or 15-18 weeks. If the cut off is 20 weeks, it allows women having these tests to go ahead with them and then abortion without heavy scrutiny. However there needs to be protection in place against abortion for gender reasons."*

A few members commented there should be no requirement for a statutory test at any stage of pregnancy.

> *"There is no need for any test at any gestation. As part of normal medical practice all medical or surgical procedures require full informed consent by the patient and good medical practice requires that procedures are not carried out unnecessarily but only when appropriate. This extra 'test' is not required. It is already covered by current codes of practice. There is no medical rationale/logic behind a test at >20 weeks."*

The College notes that the statutory test proposed in section 11 of the Bill only allows abortion by any method past 20 weeks if the practitioner reasonably believes is it appropriate, considering the woman's physical health, mental health, and well-being.

It appears to exclude late abortion (after the 20th week of pregnancy) if the foetus has an abnormality incompatible with life, yet this is currently grounds for a lawful abortion under section 187a of the Crimes Act 1961.

Of those members that supported late abortion, most cited foetal abnormality, along with the risk to the mother's health as appropriate reasons for late abortion.

The College recommends that:

- section 11(1) of the Bill be amended to replace 'qualified health practitioner' and 'health practitioner' with 'qualified medical practitioner'.
- the Committee seeks expert clinical advice regarding a medically appropriate point at which to require a statutory test; acknowledging that it may be earlier than the proposed 20 weeks.
- the Committee consider whether the foetus' health be explicitly included or explicitly excluded as part of any statutory test.

Gestational limit on abortion

The College notes that the Bill does not propose any gestational limit after which time a woman could not obtain either a medical or surgical abortion.

Members strongly disagreed with the Bill not including an upper limit for a surgical abortion to be performed, and specifically commented that abortion of a viable foetus should not be allowed.

> *"[The situation] gets very blurred when we are resuscitating 24-week babies but can terminate up to 40 weeks."*

"There should be restrictions imposed from 24 weeks. Situations can arise right up to delivery where an abortion may be necessary to save the life of the mother or salvage a multiple pregnancy where one foetus is not viable with the other(s). Also, medical events can occur during the pregnancy which were not foreseen. However, a foetus after 24 weeks is viable and should have some robust protections against termination. The statutory test … needs to be robust enough to provide these protections."

"I think a serious conversation needs to be had and led by a maternal foetal medicine specialist realistically discussing foetal viability. Working back from this we can establish a timeline for appropriate abortion services and the need for specialist input."

The College recommends that the Bill should specify an upper gestational limit for the surgical abortion of viable foetuses.

Members support a requirement to tell women how to access abortion providers, but many would like clarification on conscientious objection

The College acknowledges it is difficult to balance the rights of women to obtain a legal service without hindrance, and the rights of practitioners whose beliefs and/or values proscribe them from having any degree of involvement in medical procedures to which they object.

More than 80 percent of members agreed that all health practitioners must tell women how they can access the contact details of an abortion provider, regardless of whether the practitioner conscientiously objects to abortion.

"I strongly agree with this. All health practitioners are professionals. They need to put their own values aside and look after the patient. They are not being asked to do the termination, just to supply info. Currently women face horrific experiences seeing doctors who shame them even if they're nice about it. The experience is horrible for them, especially as there's no way for them to tell who conscientiously objects prior."

"The status quo is adequate and has been tested at law in the Hallagan vs NZMC case – the patient can be told that they can see another doctor of their choice or go to any Family Planning Clinic. Thousands of women have been freely able to access abortions in NZ since 1977. Any other system, eg: contacting the MoH for a list of providers, is intrusive, threatens privacy and would overcomplicate the process."

However, those members who identified as conscientious objectors disagreed with this proposed requirement. They stated that, in their view, referring women to other health practitioners to obtain an abortion was inherently contradictory to the principles of conscientious objection.

"Any discussion around abortion is distressing for a conscientious objector. Effectively referring the patient to an abortionist would feel unethical. I think abortion providers should be listed in the phone book/ contact details made publicly available."

While the College notes those conscientious objectors' views, its position is based on the views of the great majority of members to support the proposed requirements that health professionals must tell women of their conscientious objection *and* how to access the list of abortion service providers.

This position is also based on the High Court's judgement in Hallagan vs Medical Council of New Zealand[1] which clearly states that doctors with conscientious objection to abortion have a statutory duty to give the information to women. Further, the College's position is consistent with that of the Australian Medical Association's (AMA) position statement on conscientious objection[2], which states that a doctor with a conscientious objection should inform the patient of their objection, preferably in advance or as soon as practicable, and, take whatever steps are necessary to ensure the patient's access to care is not impeded (section 2.3).

However, the College does not agree with section 20(2) of the Bill, which allows an exception to the employment protections for conscientious objectors.

Conscientious objectors responding to our survey acknowledged that the Bill provides specific employment protections for them, but commented that section 20(2), allowing employers to dismiss conscientious objectors on the grounds that their moral/ethical stance would "unreasonably disrupt the employer's activities", was vague, and in practice would negate the protections outlined in section 20(1) of the Bill.

The right to conscientious objection is contained in section 13 of the New Zealand Bill of Rights Act 1990, which states that, "Everyone has the right to freedom of thought, conscience, religion, and belief, including the right to adopt and hold opinions without interference".

The College believes that the exception in the Abortion Legislation Bill's employment protections for conscientious objectors may be incompatible with the Bill of Rights' freedom of thought, conscience, and religion provisions.

The College recommends that section 20(2) of the Bill be removed.

Most members want safe areas established for all facilities

The Bill proposes that safe areas should be established on a case-by-case basis. However, two-thirds of members wanted safe areas established for *all* facilities. One member commented:

> *"I do not provide abortion services, but I get told I am going to be raped or killed fairly often as a [redacted]. There is no help for us doctors or nurses to stay safe at the bankrupt DHBs. We are really vulnerable to extremists. I've had to hide my address on the electoral roll. This is very real."*

Only one-third of responding members believed safe areas should be set up on a case-by-case basis noting that safe areas may not be required or practical in all cases. Those who opposed safe spaces did so because they considered it would impinge on their right to protest peacefully against any form of abortion.

The College notes the Bill proposes safe areas can only be established after the Minister of Health consults with the Minister of Justice, and the Governor-General then approves an Order in Council.

In practice, an Order in Council requires Cabinet confirmation and approval by the Executive Council before being submitted to the Governor-General. The College believes this is an onerous process because of the

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[1] High Court of New Zealand. 2010. *Reserved judgement of Mackenzie J*. Accessed 6 September 2019. https://forms.justice.govt.nz/search/Documents/pdf/jdo/74/alfresco/service/api/node/content/workspace/SpacesStore/dc9f3e24-dbf9-4f70-9022-023c36c78a63/dc9f3e24-dbf9-4f70-9022-023c36c78a63.pdf

[2] Australian Medical Association. 2019. *AMA Position Statement on Conscientious Objection 2019*. Accessed 16 September 2019. https://ama.com.au/position-statement/conscientious-objection-2019

time it could take to approve the Order in Council, therefore it is not a feasible option if there are serious threats or immediate dangers to women and practitioners at a clinic.

The College recommends the proposed legislation also allows the Minister of Health to temporarily establish safe areas to protect women and staff while the Order in Council process occurs.

The College also asked members whether they thought safe areas should be extended to other physical or digital spaces.

All members agreed that women and practitioners should be safe and free from harassment and/or violence everywhere, not only at specified facilities. Two-thirds wanted to see wider protection provisions, particularly online protections, included in the Bill.

The College notes that, in addition to its general protections, the Harmful Digital Communication Act contains sections specifically related to aiding and abetting suicide, racial disharmony, sexual harassment, and racial harassment. It would be appropriate to include specific protections in this Act against online harassment of women who want or have had an abortion, and abortion service providers.

The College recommends that the Committee consider making specific provision in the Harmful Digital Communication Act to prohibit online harassment and/or harm to women who request or have had either a medical or surgical an abortion, and the practitioners and staff who provide abortion services.

Members support counselling and stipulated providers

No matter their position on abortion, all members agreed that counselling is an important component of the medical or surgical abortion service. However, there was consensus that New Zealand lacks counselling services in general[3], and not only for abortion services.

> *"New Zealand needs more counselling/mental health services for every area and this need is no different. Would the number of people requiring this service be so much greater than currently?"*
>
> *"I have struggled to get patients counselling before their abortion clinic date. I think this counselling service needs to be created."*

Although members were divided about whether the changes to abortion law should be delayed in order to enable additional counselling services to be available, a slightly greater number (55 percent compared to 45 percent) did not think the Bill should be delayed because of this.

We also asked members whether the Bill should stipulate who could provide abortion counselling services. Nearly three-quarters of members agreed that the law should legislate who could offer counselling services, in the same way that the Bill legislates who can provide a medical or surgical abortion.

Members expressed a strong preference for counsellors to be qualified and independent.

> *"Such persons should be registered counsellors, psychologists or medical practitioners."*
>
> *"[The system] needs well-regulated and accredited providers with specific/relevant training to this area."*

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[3] Government Inquiry into Mental Health and Addiction. 2018. *He Ara Oranga*. Accessed 6 September 2019. https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

The College recommends that the Bill stipulate who may provide counselling services.

Other comments

The College would like to make comment on two other matters associated with the Bill:

1. Contraception and reproductive health services in New Zealand are poorly funded which creates equity issues for women and men trying to access to these services.

   Many members commented that if a range of contraception options were fully funded for women, then there would fewer unplanned pregnancies and potentially fewer medical and surgical abortions. The College recommends that full funding for contraceptive drugs, devices, and consultations, and sterilisation services, be approved as an appropriation in all future government Budgets.

2. The College supports the mandatory collection of anonymised, consistent, reliable, and useful data from all public and private abortion providers. However, it is essential that the collected data protects the identities of women, the practitioners providing abortion services, and referring general practitioners, and we would expect the current data anonymity protocols in place to continue.

   The College also recommends that this anonymised data is provided to the Health Quality & Safety Commission so it can create a national Atlas of Variation to enable equity issues to be addressed.

We hope that you find our submission helpful. We would like the opportunity to make an oral submission to the Committee to answer any questions it may have.

Nāku noa, nā

Dr Samantha Murton
President