New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

11 September 2019

Committee Secretariat
Abortion Legislation Committee
Parliament Buildings
Wellington

By email: alc@parliament.govt.nz

Abortion Legislation Bill

Dear Sir/Madam

The New Zealand Medical Association (NZMA) wishes to provide feedback on the above omnibus Bill. The NZMA is New Zealand's largest medical organisation, with more than 5,000 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. We recognise the principles of te Tiriti o Waitangi and the special obligations to Māori, particularly to ensure equity and active protection. The NZMA is committed to advocating for policies in health and the social and wider determinants of health that urgently address disparities and contribute to equity of health outcomes. An integral part of the NZMA's leadership role is our Code of Ethics, which sets out principles of ethical behaviour for the medical profession and recommendations for ethical practice.

Background and general comments

1. In May 2018, the NZMA made a submission to the Law Commission on abortion law reform.[1] While several of the considerations in that submission remain relevant, this submission is focussed on the specific legislative changes that are being proposed. To inform our response, we have sought feedback from our Board, Advisory Councils, Ethics Committee and wider membership. We acknowledge that the medical community holds a wide range of views on abortion and on the issues relating to abortion. To ensure the personal ethical integrity of doctors who consider abortion as a taking of human life, it is essential to retain robust provisions for conscientious objection (see paragraphs 15–17).

[1] Available from http://www.nzma.org.nz/__data/assets/pdf_file/0005/82994/NZMA-Submission-on-Aborton-Law-Reform.pdf

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2. It is useful to preface our feedback on the Bill by identifying the relevant ethical principles to consider and the extent to which these apply (if at all) to the fetus / unborn baby. With respect to the pregnant woman, key goals are to maximise autonomy, health / wellbeing (beneficence) and to minimise the risk of harm (non-maleficence). Also important are justice and equity issues, particularly as women tend to be left shouldering responsibility for the consequences of pregnancy (and potentially parenthood) to a far greater extent than the male party. With respect to the fetus / unborn baby, if there are any ethical obligations, these should be viewed as increasing as in-utero development proceeds. The rationale for this is twofold: i) the developing fetus / unborn baby has a greater capacity to experience sensations resembling pain and discomfort with advancing gestation.[2] If this is the case, there is an obligation to minimise any suffering along these lines; ii) as the fetus develops and nears term, it has greater potential and opportunity for life and development independent of the mother, which brings with it some degree of entitlement to be considered independently of the mother from an ethical standpoint.

3. Rather than an absolute, dichotomous, rights-based "right to life" versus "right to choose" lens to view abortion, we suggest a pragmatic alternative could entail attempting to carefully balance ethical obligation to both the pregnant woman and a continuum of ethical obligation to the developing fetus / unborn baby increasing with gestational age. Judgements about where the appropriate balance point lies (while being informed by personal values) should also be informed by an understanding of in utero development as well as an understanding of the potential harms and benefits to pregnant women under the various possible courses of action.

4. A key concern for the NZMA is that of equity in access to abortion services and support services. This must be central to any reform. Māori women account for one quarter of the total number of abortions in New Zealand yet experience a number of barriers to access. An important factor that needs to be addressed and that disproportionately impacts on Māori women is a failure to provide local abortion services, including medical abortions.

Specific comments

Decriminalisation of abortion

5. The NZMA is supportive of treating abortion as a health issue and we welcome the move to ensure the legislative framework aligns with, and supports, that principle.

6. We note that the legislative changes to abortion that are being proposed include repealing offences under the Crimes Act and the Contraception, Sterilisation, and Abortion (CSA) Act, such that abortion is decriminalised for the pregnant woman, and for health practitioners who perform an abortion or who supply products to induce an abortion. We note that the Bill retains important criminal offences for people who are not health practitioners who attempt to procure an abortion on a pregnant woman or who supply the means for procuring an abortion. The Bill also makes modifications to ensure that section 182 (killing of an unborn child) does not apply to abortion under the CSA Act. We note that health practitioners who do not comply with relevant standards or processes for performing an abortion may be sanctioned under the complaints and disciplinary regime for health practitioners, under the Health Practitioners Competence Assurance

[2] Thalamocortical fibres begin appearing between 23 to 30 weeks' gestational age while electroencephalography suggests the capacity for functional pain perception in preterm neonates probably does not exist before 29 or 30 weeks - see Lee SJ, et al. Fetal pain: a systematic multidisciplinary review of the evidence. JAMA. 2005 Aug 24;294(8):947-54 Available from https://jamanetwork.com/journals/jama/fullarticle/201429

(HPCA) Act 2003. We support this shift which brings abortion into line with other health procedures.

7. The Crimes Act contains provisions designed to protect medical practitioners from criminal responsibility when performing surgical operations with reasonable care and for the benefit of the patient. There is a view that existing provisions for abortion in the Crimes Act also, in part, serve this purpose. We therefore again ask the Committee to examine the implications of removing abortion from the Crimes act in terms of the protections from criminal responsibility for practitioners providing abortion services.

8. Some of our members are opposed to the decriminalisation of abortion. This is primarily because of the understanding of abortion as the intentional taking of human life.

Authorisation for abortion

9. The NZMA is generally comfortable with the proposed changes to the authorisation for abortion for a woman who is less than 20 weeks pregnant, where there would no longer be a requirement for a statutory test that a health practitioner needs to apply. Removing this requirement for women less than 20 weeks pregnant is most consistent with a health approach to abortion and prioritises the autonomy of women to make an informed decision about what is appropriate for them in the circumstances. The Law Commission also reported that this measure may also improve access to abortion services and help reduce unnecessary delays, allowing abortion to be performed at earlier gestations, which is safer for women.

10. While a statutory test is proposed for abortion for a woman who is more than 20 weeks pregnant, there are strong concerns that this test is too weak. Currently, the grounds for performing abortion after 20 weeks are to save a woman's life or prevent serious permanent injury to her physical or mental health. The statutory test that will replace this under the proposed law changes is for a health practitioner to reasonably believe that abortion is appropriate with regard to the pregnant woman's physical and mental health, and well-being. Similar criteria have been used to provide abortion for pregnancy up to 20 weeks. There is therefore every likelihood that these criteria will enable on demand late term abortion. This would be inconsistent with the notion of increasing ethical obligation to the developing fetus / unborn baby as it gets closer to term.

11. We submit that the statutory test for abortion for woman who are more than 20 weeks pregnant needs to be narrower than what is being proposed. Furthermore, we contend there needs to be a further point of distinction in the legislation such that the threshold in terms of requirements for the statutory test is raised late in pregnancy. For example, there should be a distinction between the process at 21 weeks and at 38 weeks, yet the existing legislation makes no distinction between an unborn baby that is nearing term versus one that is 21 weeks gestation. We acknowledge that late term abortions are sometimes performed for congenital abnormalities and are distressing for all concerned. We suggest that strengthened statutory criteria could be designed in a way that accounts for situations where congenital abnormalities are discovered late in a pregnancy.

12. We acknowledge that some members are opposed to the liberalisation of the current legal grounds for authorising abortion. Some members also believe that 20 weeks is too late in a pregnancy for when a statutory test needs to be applied.

Self-referral

13. The NZMA is not opposed to the insertion of a provision to allow a woman to self-refer to an abortion service provider, primarily as the current referral requirements are thought to contribute to delays in access to abortion services. Nevertheless, we believe that seeing a GP can be a valuable first step for a woman considering abortion. GPs are well placed to provide support and discussion if wanted, and to facilitate referral to an abortion service provider. It is rare for women wanting an abortion to present at their GP and simply ask for a referral without first wanting to share and discuss their thoughts and feelings. It is important to ensure that women who do self-refer to an abortion service provider receive the same decision support, care and attention that they would receive if they had seen their GP. We seek clarification on how this would be achieved. It has been suggested that having a specialist GP at clinics where woman self refer could be useful.

Counselling

14. We believe that equitable access to fully funded counselling services is crucially important for women considering abortion. While women cannot be required to undergo counselling, counselling should be expressly part of the abortion services framework. It should be non-judgemental and cover all options that are available to women seeking abortion. We support the Bill's requirement for health practitioners to advise women of the availability of counselling services if they are considering an abortion or have had an abortion, though counselling is not mandatory. We welcome the specific clause requiring the Minister of Health to take reasonable and practicable steps to ensure that counselling services are available throughout New Zealand in relation to the provision of abortion services when entering into Crown funding agreements under the New Zealand Public Health and Disability Act 2000. Doctors need to have confidence that their patients are not going to face barriers in seeking counselling and that the process to access counselling, both before and after termination, is smooth, timely and actively facilitated. Counsellors should be professionally qualified. Ideally, particularly for late term abortions, counsellors should work off-site from abortion facilities to better maintain their autonomy and professional independence.

Conscientious objection

15. The NZMA is concerned that sections 19 and 20 in the proposed legislation undermine a doctors' ability to exercise true freedom of conscience. Under the current law (section 46 of the CSA Act), no doctor is obliged to perform or assist with an abortion, and it is unlawful for an employer to discriminate against an employee or job applicant on the grounds of a conscientious objection to abortion. A person with a conscientious objection must inform a patient of his/her objection and inform them that they can obtain an abortion from another Health Practitioner, with no obligation to refer or provide any further details (section 174 of the HPCA Act).

16. The proposed legislation (section 20) states that an employer must accommodate the conscientious objection of a job applicant or employee unless it would "unreasonably disrupt the employer's activities", in which case the employer can refuse to employ someone, terminate their employment; offer them less favourable terms of employment / conditions of work / opportunities for training, for example. Legislating the ability for employers to discriminate on these grounds is a retrograde step. Furthermore, the phrase "unreasonably disrupt the employer's activities" could be open to wide interpretation. While this is likely to be tested in Court, we ask the Committee to rescind these draft provisions that allow employers to discriminate on the grounds of personal conscience. At the very least, it is necessary to specify that the term unreasonable disruption only

refers to disruption that would notably affect service provision, after all reasonable steps have been taken.

17. While the draft Bill does not require practitioners who object on the grounds of conscience to refer pregnant woman to another practitioner, it does introduce the requirement to tell a woman how she can access the contact details of an abortion service provider. The Bill requires the Director-General of Health to maintain a list of abortion service providers, and the practitioner must tell the woman how she may access the list. We believe this additional requirement is consistent with a recent position statement on conscientious objection by the AMA, our trans-Tasman sister association, particularly the requirement to "inform the patient that they have the right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right'.[3] However, it does raise important questions that the profession must be consulted on. For example, with respect to the provision of early (medical) abortion, does the government intend to have lists of every GP willing to prescribe the abortion pills mifepristone and misoprostol? Will the names be opt-in or opt-out of the current registers held by the relevant regulatory bodies? For practitioners who provide late abortions, will the state list the names and contact details of these practitioners? What are the privacy issues in accessing this information?

Safe areas

18. We are generally comfortable with the Bill's provisions to allow the setting up of safe areas around specific abortion facilities on a case-by-case basis. The purpose is to protect the safety and well-being, and respect the privacy and dignity, of women accessing abortion facilities, and practitioners providing and assisting with abortion services. There is, however, a counter view that the freedom to protest peacefully near abortion facilities should be lawful, and that creating zones to ban protests is contrary to democratic rights including freedom of expression and assembly. We note that proposed safe areas will not be more than 150 metres from the facility, and protests can still be conducted outside of this area. Overall, we believe that the proposal strikes a reasonable balance between protecting the rights of women and health practitioners as well as those of people who wish to protest.

Other matters

19. We recommend a suite of measures to improve access to culturally-informed abortion and comprehensive sexual and reproductive health services for Māori. It is important to ensure that Māori women have equitable access to medical abortions and can exercise their choice. Local first trimester abortion services should be made available in areas of the country with high Māori populations.

20. We believe that the prevention of unintended pregnancy should be a priority. The NZMA supports broad educational initiatives regarding sexual and reproductive health including contraception. We support ready access to a wide range of safe and reliable contraceptive measures and continue to advocate strongly for long-acting contraception. We welcome recent proposals by PHARMAC to widen access to funded levonorgestrel intrauterine systems such as Mirena.

21. To support improved access to early medical abortions, it is essential to ensure that abortion pills such as mifepristone and misoprostol are made available to GPs to prescribe.

[3] Available from https://ama.com.au/position-statement/conscientious-objection-2019

22. We suggest that it would be useful for the legislation to explicitly prohibit abortion on the basis of a fetus / unborn baby's gender.

23. As with any medical procedure, there needs to be appropriate accountability mechanisms in place to ensure competency and compliance with relevant legislation. Provision for some kind of audit of practice is appropriate. It has been suggested that judicial scrutiny of health practitioners that provide abortion after 20 weeks may be warranted to ensure that any statutory test is applied lawfully.

24. We seek clarification of the duty of care to a fetus / unborn baby that survives an abortion. Whichever way the clinician acts, there are legal and ethical considerations.

25. It is important to promote the message that all pregnant women should be encouraged to access full antenatal health care early on, regardless of their decision regarding termination.

26. We support policies that address the upstream determinants of health and well-being, including poverty and homelessness, to alleviate the financial stresses that contribute to some women seeking abortion.

We hope our feedback is helpful and would like the opportunity for an oral hearing to speak to this submission.

Yours sincerely

Dr Kate Baddock
NZMA Chair