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Submission to Law Commission from

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I am an 82-year-old mother of two and grandmother of three granddaughters. I write in strong support of law and policy changes that will see abortion treated as a health issue.

I will focus on my own experiences both personal and professional. These experiences have shaped my beliefs which have evolved over time.

In 1956 I carried out my own abortion which was an illegal act with a penalty of 7 years imprisonment at that time. Although such cases as mine have for many years been a matter of public knowledge, the police, using their discretion, do not prosecute. Laws that are not enforced raise questions about their intention and indeed their necessity. Self abortion should not be a punishable offence. **I recommend that Section 44 of the CS&A Act be repealed, removing the offence of self abortion from the statutes.**

In 1961, when I was married with two young children, I was one of the first women in New Zealand to take the oral contraceptive pill. Since then I have been a strong advocate for all methods of contraception, including vasectomy and spent a significant part of my career working for Family Planning. If abortion is to be treated comprehensively as a health issue then law changes must not occur in isolation but must be a accompanied by preventive policies to reduce the incidence of unplanned and unwanted pregnancies. This will include sexuality education for young persons and improved access to all methods of contraception for both men and women. **I recommend that preventive strategies must complement and enhance any law change.**

In 1963 I graduated as a medical practitioner. In my medical training I had one lecture in Forensic Medicine on illegal abortion and one lecture in Obstetrics & Gynaecology on contraception. I was not equipped to deal with these issues in medical practice. I know that nowadays things are not as dire as this but abortion remains a neglected topic in medical training. Changing the law without putting in place improved training may be counter-productive. Workforce planning for the future is essential. **I recommend improved training in contraception and abortion at undergraduate and postgraduate level for medical practitioners and for nurses and midwives.**

In 1971 I was a general practitioner in the Student Health Service at Victoria University, Wellington. I introduced the “morning-after” pill, now termed emergency

contraception. Since 2002 emergency contraception has been more readily available over-the-counter through pharmacies but access issues persist – especially confidentiality, cost and health professionals not prescribing or dispensing emergency contraception because of a conscientious objection. To reduce the incidence of unplanned pregnancies **I recommend that emergency contraception be more freely available through general practitioners, trained nurses and pharmacists.**

The topic of conscientious objection must be examined, not just in regard to emergency contraception but for other matters of reproductive health care. The current requirement in the Health Practitioners Competence Assurance Act (HPCAA) is problematic. Merely telling a patient that he or she can obtain the service from another health practitioner of from a family planning clinic is not best medical practice. That puts the patient in the difficult position of "shopping around" for health care in an unfamiliar environment. If a health practitioner does not wish to be directly involved he or she should advise the patient why not and should be required to make a helpful and thoroughly professional referral to another who will provide that service. The present position is biased towards the rights of the doctor to exercise his or her beliefs versus the rights of the patient to appropriate health care. **I recommend that Section 174 of the HPCA Act be repealed, together with the relevant sections of the CS&A Act (Section 32 (2) (4) and Section 46).**

In 1971 I started sessions at the Wellington Family Planning Clinic to improve my knowledge and skills in this area. Very few abortions were approved at this time in New Zealand so I began to refer patients to Australia for a legal abortion. Court cases in Melbourne (1969) and Sydney (1971) found in favour of doctors performing abortions in good faith. Travelling to Australia was stressful for women and expensive. International travel is still necessary for a few women, especially in the later stages of pregnancy, because services are not always available in New Zealand. International travel should <u>not</u> be regarded as an acceptable option even for these few women. It is a matter of injustice that rich women have always been able to obtain abortions, if not in New Zealand, then elsewhere in the world. **I recommend that New Zealand must provide a quality abortion service for all stages of gestation. Abortion must remain one of the core services provided by all DHBs and adequately funded.**

In 1974 I began to refer patients to the Auckland Medical Aid Centre (AMAC) after it opened in May 1974. At the time of the police raid in September 1974 I had referred 10 patients - eight were accepted and two were refused. The latter were subsequently referred to Australia. One of my patients was selected as a witness in the Woolnough trial. Twelve patients, the referring doctors and AMAC staff were required to attend the magistrate's hearing and two High Court trials in Auckland. In the first trial the jury could not agree. In the second trial Dr Woolnough was found not guilty and this verdict was upheld after an appeal. It was an extreme ordeal for all witnesses who gave testimony, especially the patients drawn into this test case. Treating abortion as a crime further stigmatises what should be an accepted procedure, not one surrounded with secrecy, controversy and guilt. Such a negative climate is detrimental to the health and well-being of patients. **I strongly recommend that abortion be treated as a health issue and not as a crime.**

In August 1974 I was a member of the government delegation to the United Nations World Population Conference held in Bucharest Romania. Abortion was not a major focus of the conference but I met a number of world leaders in this field and was inspired by their advocacy for human rights and women's rights. I have since followed the trends through subsequent UN meetings and note that CEDAW (United Nations Convention on the Elimination of All Forms of Discrimination Against Women) made the following Concluding Observations (July 2012) in response to the New Zealand government report. CEDAW/C/NZL/CO/7 states:

"Health
34. The Committee commends the State party for its advocacy on the protection of women's sexual and reproductive health rights and prevention of maternal mortality. The Committee notes with concern, however, the convoluted abortion laws which require women to get certificates from two certified consultants before an abortion can be performed, thus making women dependent on the benevolent interpretation of a rule which nullifies their autonomy."

The previous government chose not to take action on this. New Zealand has obligations as a signatory to CEDAW and **I recommend that any changes in the law reflect a considered response to the UN observations.**

In 1976 I took sabbatical leave from Victoria University and in the UK I trained in the abortion procedure of suction curettage under local anaesthetic and also vasectomy. In London I did a weekly session for the British Pregnancy Advisory Service (BPAS). Women attended this clinic from anywhere in the world where abortion was difficult or impossible to obtain and I gained a greater understanding of the global politics of abortion and how repressive laws impact on the lives of women. At the other end of the spectrum I was impressed that Canada decriminalised abortion in 1969. **I recommend that an appraisal of jurisdictions where abortion has been decriminalised, such as Canada and ACT, be provided as background material to inform decision makers.**

In 1975 I was President of the Abortion Law Reform Association of New Zealand (ALRANZ) and presented the submission from ALRANZ to the Royal Commission. I was extremely disappointed at the adversarial approach taken by the Commission, which, in part, contributed to the resultant flawed report. Parliament used selective parts of this document to draft the current laws which in my opinion are seriously flawed. There needs to be a fresh start. **I recommend that the findings of the 1975 Report of the Royal Commission be disregarded.**

In December 1977 I was back in New Zealand and attended the all-night sitting at Parliament when the new laws were passed. They proved inoperable and very soon SOS (Save our Sisters) volunteer organisations sprang into action throughout New Zealand. I was a member of the Wellington Abortion Trust and weekly meetings were held on a Sunday in the home of Dr Carol Shand to coordinate the referral of women to abortion clinics in Sydney. Voluntary work is to be commended but it should not replace essential services. When and if new laws are passed, a repeat of what happened in 1977 must be avoided. The maintenance of safe services must be accorded greater priority than the changes to the law. **I recommend that in the event of significant changes those implementing the changes pay attention to a smooth transition from the current to the new system.**

In 1977 I was appalled at the barriers erected to take away the right for women to decide whether or not to continue a pregnancy and I am even more appalled that over four decades later I am making yet another submission! It is outrageous that 98% of abortions are done on the spurious ground of mental health, that a very personal decision is made by two state funded doctors, that fetal abnormality is not a ground for abortion after 20 weeks, and that sexual violation and age are not grounds in themselves. The hypocrisy and dishonesty of the current system is offensive. It should be replaced by a recognition that women of any age can be trusted to make the best decision that suits their circumstances. Specified grounds for abortion are not necessary. **I recommend repeal of the grounds for abortion in the Crimes Act.**

I was similarly appalled at the complicated procedures of the CS&A Act. When the Act passed I did not apply to become a certifying consultant because I considered my beliefs were too liberal. In July 1980 I was involved in the setting up of Parkview Clinic, a stand-alone clinic at Wellington Hospital. I applied and was appointed as one of the first operating doctors. Seventeen years later when a review of the clinic procedures was undertaken I was made redundant because it was decided that in the interests of efficiency, all operating doctors must also be certifying consultants. Admittedly this saved the patient seeing two doctors instead of three. As a matter of principle I did not apply (as suggested) to become a certifying consultant. The system of certifying consultants is an unnecessary complication.

Delays in the system are inevitable and this impacts seriously on safety. It is well recognised that the earlier an abortion is carried out the safer it is. The complicated procedures only work because dedicated staff make them work. **I recommend repeal of the complicated procedures in the CS&A Act.**

Harassment of patients and staff at Parkview Clinic was frequent and deplorable, increasing the stigma and guilt especially for patients. The protest activity continues but is less targeted now that the clinic is part of the main hospital. There is a recognised conflict between the rights of patients to legitimate care and the rights of protesters to free speech. In a democratic society there should be tolerance for all viewpoints but those opposed to abortion must not be allowed to impose their views on others through the law. Some jurisdictions overseas have found it necessary to enact laws to protect the rights of patients to access the services they are entitled to, free from harassment. **When there is conflict I recommend that priority be given to protecting the rights of patients.**

In June 1995 I was one of the organisers of the inaugural conference for New Zealand Abortion Providers, held in Wellington. As a group of professionals, doctors, nurses and counsellors acting largely in isolation it was beneficial to meet with colleagues to share experiences, gain new knowledge and improve standards of patient care. The following conferences were held by this dedicated group, with a large voluntary component:
Christchurch, June 1997
Auckland, October 2000
Wellington, March 2006
Auckland, March 2008
Rotorua, March 2012

After 20 years meeting as an informal group, on 19 February 2015, the Abortion Providers Group Aotearoa New Zealand Incorporated (APGANZ) was registered as an Incorporated Society. Members have contributed significantly to standards of abortion care in New Zealand. **I recommend APGANZ be consulted on standards of abortion care.**

In February 1999, I, together with four other doctors, formed Istar Limited as a not-for-profit company specifically to import Mifegyne® (mifepristone) from France. We were all experienced abortionists and wished to give New Zealand women the option of a medical versus surgical abortion but because of the stigma and controversy surrounding abortion, no established pharmaceutical firm was willing to import the drug (mifepristone). Our application to the Ministry of Health was successful and on August 2001, Mifegyne® (mifepristone) was approved for use.

The introduction of an early medical abortion service in most clinics was delayed because of an ambiguity in the law which was not resolved until April 2003 when a High Court judge determined that both drugs (mifepristone followed by a prostaglandin) must be given in a licensed premise. The woman did not have to stay in the licensed premise between the two doses or until the abortion was complete. Until this decision by Justice Durie, Level J Unit, Wellington Hospital was the only clinic offering an early medical abortion service, with the proviso that in the few cases that did not abort within 6 hours, the women consented to a surgical procedure. This was necessary as the clinic did not have the flexibility of providing an overnight stay.

The underlying problem is that the current law is seriously out of date in a number of respects including medical advances since 1977. The law was written on the assumption that all abortions would be surgical. However medical abortion became a reality in France in 1988. It is not possible to provide an efficient, patient-friendly, optimum, early medical abortion service with the current law. Patients do not need an expensive hospital to take one of the safest pills in the pharmacopoeia. Women should be able to take the first medication (mifepristone) in a clinic or consulting room or even at home and the second medication (misoprostol) at home, as is possible in Australia, Scotland, Canada and the USA.

Because of the extra number of appointments at a licensed clinic or hospital the uptake of medical abortion is comparatively low when compared to other places such as Scotland. In the Abortion Supervisory Committee's Annual report, for the year ended December 2016 15.4% abortions were medical (for all gestations) and 11.7% for gestations under 9 weeks.
In 2016 in Scotland 82.9% were medical (for all gestations) and 89.4% for gestations under 9 weeks.

Medical abortion pills are available on the internet and some New Zealand women are known to use this source (personal communication with Dr Rebecca Gomperts). This is illegal under present abortion laws but desperate women will use this if they do not have access to safe affordable care. The solution is obvious – we must ensure that safe affordable care is readily available.

I recommend that any new legislation takes cognisance of medical advances both actual and potential. Potentially, trained nurses could play a much greater role in the provision of an early medical abortion service.

I recommend that accurate statistics be collected so that trends can be monitored.

The history of abortion in New Zealand has been largely neglected and since my retirement from clinical medicine I have had time to explore the past, a past that is dominated by the abortion laws we inherited from Great Britain in 1866.

Through Victoria University Press I have published three books on the history of abortion in New Zealand:

- *Abortion Then and Now: New Zealand abortion stories from 1940 to 1980* November 2010. 304pp ISBN 978 0 86473 632 1
  This includes my own abortion story.

- *Rough on Women: Abortion in 19th-Century New Zealand* July 2014. 195pp ISBN 978 0 86473 936 0

- *Risking Their Lives: New Zealand abortion stories 1900-1939.* September 2017 383pp. ISBN 978 1776561636

These books explore the unpleasant experiences of illegal abortion in the past and are a salutary reminder as to why, in my opinion, we must advocate for compassionate, safe, affordable, legal abortion services. Abortion is universal in all cultures and in the absence of 100% effective contraception can be regarded as a fact of life. For modern women it is a common and safe procedure and must be treated as an essential component of comprehensive reproductive health care.

If necessary I would be pleased to provide further information to support the recommendations made in this submission.