Submission of Dame Margaret Sparrow to the Abortion Legislation Bill Select Committee

16 September 2019

Submission to Select Committee on Abortion Legislation Bill

I write this submission from the point of view of an experienced abortion provider. See Appendix for details of experience.

I support the intent of this bill because:

It treats abortion as a health issue and not a crime.

It improves women's access to abortion, by removing some of the obstacles that result in delays obtaining abortion care.

It improves safety because the earlier the abortion the safer it is.

It allows women the autonomy to self-refer.

It provides for counselling to be available but not mandatory.

It allows qualified health practitioners other than doctors to provide abortion care.

It allows for abortion to be provided in a wider range of settings, beyond hospitals and clinics.

Up to 20 weeks it allows women to make the decision, not two certifying consultants.

It goes some way in protecting women from health care providers with a conscientious objection.

It goes some way in protecting women from harassment by the creation of safe areas.

I wish to make the following general comment:

My preference is strongly in favour of Model A of the Law Commission's Ministerial briefing paper. Women are capable of making a responsible decision and know their personal circumstances better than anyone else, however well qualified. Coercion and partner violence can be screened for. Some women may require special assistance in making a decision e.g. those who are very young, migrant and refugee women, women with pre-existing mental health issues, or women who are ambivalent – but ultimately it should be their decision.

I wish to comment on specific clauses in the Bill:

Clause 2 Commencement
There must be a sufficient time lapse to allow for the transition from the previous system to the new system and this will depend on advice from the Ministry of Health regarding the loss of the Abortion Supervisory Committee and certifying consultants and the establishment of new services incorporating counselling, self-referral and practitioners other than doctors.

Clause7 Sections 10 to 46 replaced

I recommend that ss 10-11 be amended to enact Model A of the Law Commission's Ministerial briefing paper. In my experience few women request an abortion after 20 weeks and those who do usually have serious health problems (sometimes life threatening) or are carrying a fetus with serious abnormality. In New Zealand there are very few medical specialists trained and qualified to provide surgical procedures at this stage of pregnancy, so most are done in hospital using medical techniques. The statutory test is unnecessary because practitioners always have regard to the woman's physical and mental health and well-being. This is already obligatory duty of care.

I have reservations about s 12 re availability of non-mandatory counselling services. It may take time to establish these and the words "reasonable" and "practicable" are contestable.

The term counselling in s 13 is not defined in the Bill and in practice it is subject to wide variation in interpretation ranging from the provision of basic information (required by everyone), to discussion with a nurse, social worker or doctor (of specific issues including options and contraception), to in depth counselling for underlying mental health issues with a professional therapist. It may be preferable to have this covered in more detail in standards of care.

I support self referral in s 14. While many women will wish to involve their general practitioner or family planning clinic the option of self referral is a major step forward. It will help to eliminate delays in the system and will give women greater autonomy. The influence of conscientious objectors is lessened.

I support the creation of safe areas in ss 15-17 but an improvement would be to simplify the procedure and make them universal. Safe areas protect both women and staff from harassment and if a case must be made before a safe area is established, this means harm that could have been prevented is allowed to occur. There are many other forms of harassment harder to rectify so providing safe areas is a good start. Over the years I have personally been subjected to various forms of harassment .

I support s 18 regarding the duties of the Director-General of Health

(a) Collecting, collating, analysing and publishing information is necessary to monitor abortion services and trends. In the past statistics published annually have been helpful in identifying issues. This should continue.
(b) Standards provide guidelines for optimal provision of services and these should be provided in cooperation with experienced abortion providers. The existing standards commissioned by the Abortion Supervisory Committee are useful and should be updated to comply with the new legislation.
(c) Make and maintain a list of abortion service providers. This is new although in the past the list of abortion certifying consultants has been public information. Such a list needs frequent updating and consideration should be given to providing the names of services rather than naming all individual health practitioners. The aim of such a list should be to make it easier for health professionals making a referral and for women who wish to self refer.

I support s 19 re conscientious objection but have reservations about how it will be implemented in practice. It is an improvement on the existing requirements which are balanced in favour of the objecting professional. For a discussion of this issue I refer the select committee to a recent paper by Ballantyne, Gavaghan & Snelling. Doctors rights to conscientiously object to refer patients for abortion service providers. NZMJ 26 July 2019 Vol 132 No 1499.

In s 20 regarding employment the term “unreasonable disruption” is contestable and the requirements are balanced in favour of the objecting person.

I wish to comment on sections of the Contraception, Sterilisation and Abortion Act not repealed.

s 4 Administering of contraceptives to mentally subnormal females. This language (also found in s 187A (d) of the Crimes Act 1961) was criticised by the Abortion Supervisory Committee in the Annual Reports for 2016 and 2017. In 2016 the ASC suggested the wording should be ‘patient lacks mental capacity to consent’ and referred to section 6 of the Protection of Personal and Property Rights Act 1988 which sets out the circumstances in which a person lacks capacity.

s 8 Reports on sterilisations. No accurate statistics on sterilisation have ever been collected and in 1994 the collection of notification forms ceased. As a Family Planning doctor performing vasectomies I was involved in complaints about this for many years from 1987 to 1997. Copies of this correspondence is available if more detail is required. The issue was brought to the attention of Parliament in 1993 during question time and in 1996 during the Inquiry into the Abortion Supervisory Committee. With the issues unresolved over such a long period I submit that the Director-General of Health should have recommended repeal of the legislation many years ago.

Principal Recommendations:

Due consideration must be given to the commencement date for the smooth transition of services.

Model A is the preferred option.

Counselling is not defined. It is a complex issue and the details are better dealt with in standards of care.

Safe areas must be automatic for all premises providing abortion services.

The term mentally subnormal females must be replaced by a more respectful term.

Repeal of s8 regarding the notification of sterilisation operations.

APPENDIX

ABORTION EXPERIENCE

1956	Self-abortion in New Zealand when it was a crime punishable by 7 years jail.
1969-74	Referrals to Australia.
1972-	Member of ALRANZ. National President 1975-1980, 1983-2011.
1974-77	Referrals to Auckland Medical Aid Centre which opened May 1974.
1975	Patient a witness in the Woolnough trials August/November 1975.
1976	London, assessing doctor BPAS (British Pregnancy Advisory Service).
1976	London, training as operating doctor, Fairfield Hospital.
1977-79	Referrals to Australia via SOS.
1979-80	Referrals to Wellington Hospital and to Auckland Medical Aid Centre.
1980-98	Operating doctor Parkview Clinic, Wellington Hospital, opened July 1980.
1998-2005	Referrals to Level J Unit and Te Mahoe, Wellington Hospital.
1995	Co-organiser of first national meeting of abortion providers, Wellington, in June.
1999-	Founding director of Istar Ltd, a not-for-profit company to import mifepristone.
2010-17	Published three books on the history of abortion in New Zealand.
2015-	Inaugural member APGANZ Abortion Providers Group Aotearoa NZ.

FAMILY PLANNING EXPERIENCE

1971-2005	Employed part-time by New Zealand Family Planning Association.
1976	London/Bombay, training in vasectomy.
1987-	Elected Honorary Vice President NZFPA.
1986-99	Published three books on contraception and vasectomy.