# Abort Mission: A Recommendation for Reform of New Zealand's Abortion Law

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A dissertation submitted in partial fulfilment of the degree of Bachelor of Laws (with Honours) at the University of Otago.

October 2017

# Acknowledgements

To my supervisor and Dutch fairy godmother, the wonderful Professor Nicola Peart. Without your limitless patience, dedication and wit, this dissertation would not have been achieved at all.

To my family, particularly Mum, Dad and Budget: thank you for your unconditional support, unwavering belief in me, and constant encouragement. I appreciate the proof-reading, the all-hours phone calls and the stubbornness I inherited from you more than you know.

To my friends: for all the coffees, the beers, the laughs and the much-needed stress relief, thank you.

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## *I Introduction*

> The abortion debate is surely one of the most contentious in the history of law and ethics and its durability is based not merely on the inherent gravity of the issues concerned, but also on the depth of feeling which it generates. There are few areas in which individuals and groups are so firmly convinced of the rightness of their position and of their duty to ensure that their beliefs are translated into law.[1]

This paper makes no attempt to give any solution to the debate surrounding abortion, nor does it wish to take any moral position. It simply wishes to address the discrepancy between the practise of abortion in New Zealand and the law, and offer a suggestion for change. The law surrounding abortion in New Zealand is out of date, ineffective, and disconnected from the reality of medical practitioners and women seeking terminations in New Zealand. Many have urged for a review of the law, including the Abortion Supervisory Committee and the United Nations Committee on the Convention on the Elimination of All Forms of Discrimination Against Women.[2] Abortion is a medical procedure and a health issue, not a criminal one, and has long been treated as such outside the law. It is time the law was changed to reflect that.

To better understand how we can regulate abortion with the most effectiveness for the medical profession and for the women who need such procedures in the future, we must first understand the history of the laws and how they have developed. This paper looks at three different jurisdictions in the commonwealth who have adopted different approaches to the regulation of abortion, before recommending an approach similar to that of Victoria, Australia. Such an approach removes abortion from the Crimes Act, leaving the majority of the regulation surrounding the process to be dealt with under medical law and regulations.

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[1] Sheila McLean "Abortion Law: Is Consensual Reform Possible?" (1990) 17 *J L & Soc* 106 as cited in Kerry Peterson "Abortion Laws: Comparative and Feminist Perspectives in Australia, England and the United States" (1996) 2 *Med Law Int* 77 at 79.

[2] *Report of the Abortion Supervisory Committee 2001* AJHR E28 as cited in *Right to Life New Zealand Inc v Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) at [52] per Miller J; *Convention on the Elimination of All Forms of Discrimination against Women* LII CEDAW/C/NZL/CO/7 (2012) at 10.

## *II England*

### *A Historical Legislation*

Abortion has been regulated in the law for thousands of years,[3] but in England first from 1803.[4] Before this, the common law had no offence for ending a pregnancy where the foetus had not quickened.[5] This Act made attempting to do so a felony,[6] though still carried harsher penalties for the procurement of miscarriage after quickening.[7] Much issue was taken with the standard of 'quickening': a non-scientific term, quickening was the point in time after which the movements of the foetus became subjectively noticeable to the mother.[8] After quickening, the *unlawful* administration of any deadly poison, or any other noxious and destructive substance or thing was prohibited, while before quickening, the use of any instrument or other means whatsoever was included.[9]

The use of the word *unlawful* in this Act gave rise to a school of thought that there must be circumstances in which abortion was therefore lawful, but the idea did not gain traction for many years.[10] The 1803 Act was revised many times. In 1828 the use of instruments was also forbidden after 'quickening'.[11] In 1838 the much-disputed 'quickening' was removed, and the punishment no longer the death penalty.[12] These changes did not mark a change towards liberalising the practise, however. In 1846, it was suggested that women ought to be punished for procuring miscarriages,[13] and in 1861 the Offences Against the Person Act made this recommendation a reality.[14]

Section 58 of this Offences Against the Person Act detailed that: [15]

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[3] The Assyrian Code (12th Century B.C.) makes mention of a woman aborting her own child and sets the punishment for her as to be "impaled and not buried." See also John Powis Smith *The Origin and History of Hebrew Law* (The Lawbook Exchange, New Jersey, 2005) at 243.
[4] Malicious Shooting or Stabbing Act 1803 (UK) 43 Geo 3, c 58 (more often referred to as Lord Ellenborough's Act) forbade 'the malicious using of means to procure the miscarriage of women'.
[5] *R v Woolnough* [1977] 2 NZLR 508 (CA) at 519 per Richmond J.
[6] Malicious Shooting or Stabbing Act 1803 (UK).
[7] K. W. Masterton *The Law of Abortion in England and Northern Ireland* (1977) 50 The Police Journal 50 at 51.
[8] *Edinburgh Medical and Surgical Review* (1810) vol 6 at 249 as cited in Barbara Brookes *Abortion in England 1900 – 1967* (Taylor and Francis, Abingdon, Oxen, 2012) vol 7 at 25.
[9] Barbara Brookes *Abortion in England 1900 – 1967* (Taylor and Francis, Abingdon, Oxen, 2012) vol 7 at 22.
[10] John Keown *Abortion, Doctors and the Law: Some Aspects of the Legal Regulation of Abortion in England from 1803 to 1982 (Cambridge Studies in the History of Medicine)* (Cambridge University Press, Cambridge, 1988) at 24 as cited in Brookes, above n 9, at 22.
[11] Brookes, above n 9, at 25.
[12] At 23.
[13] Second Report of the Commissioners on Criminal Law *Parliamentary Papers* XXIV (1846) at 147, 148.
[14] Offences Against the Person Act 1861 (UK).
[15] Section 58.

> Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing or shall unlawfully use any instrument or means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or not with child shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be liable at the discretion of the court to be kept in imprisonment for life.

Section 58 covered two situations: where a pregnant woman unlawfully used any means with intent to procure her own miscarriage and where any other person unlawfully used means with a similar intent, whether the woman was pregnant or not.[16] It was not necessary that the substance be an abortifacient,[17] but must indeed have been a "poison or other noxious thing."[18] An instrument was held to mean anything from a quill,[19] to the defendants' hand.[20] It was no defence for an accused person that the instrument or means used could never have procured a miscarriage.[21] If the woman died as a result of the attempted miscarriage, the person committing the act was liable for murder.[22]

Section 59 made it an offence to unlawfully supply or procure any poison or other noxious thing, or instrument or thing whatsoever knowing it was to be used with intent to procure a miscarriage.[23] Such an offence was punishable with up to three years imprisonment. If the drug was noxious and was supplied with intent to procure miscarriage, the offence was complete, regardless of any actual intent to use the means.[24]

These provisions had issues with enforceability, not least given the near impossibility of proving such an act had taken place. The harsh penalty of life imprisonment was considered a farce by many who argued that everyone in the court room knew the sentence "would not be carried out," putting judges in an "absurd position."[25]

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[16] Masterton, above n 7, at 52.
[17] *R.* v. *Marlow* (1965) 49 Cr. App. R. 49.
[18] Masterton, above n 7, at 53.
[19] *R.* v. *Dale* (1889) 16 Cox 703.
[20] *R.* v. *Spicer* (1955) c.L.R. 772.
[21] *R.* v. *Spicer*, above n 20.
[22] James Fitzjames Stephen *A digest of the criminal law (crimes and punishments)* (1st ed, MacMillan, London, 1829) at 144 – 155 as cited in Brookes, above n 9, at 26.
[23] Offences Against the Person Act 1861 (UK), s 59: whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman whether she be or be not with child, shall be guilty of a misdemeanour and being convicted thereof shall be liable, at the discretion of the court, to be kept in imprisonment for the term of three years.
[24] *R.* v. *Hillman* (1863) L. & C. 343.
[25] Alfred Swaine Taylor *Taylor's Principles and Practise of Medical Jurisprudence* (John Churchill and Sons, London, 1865) at 144 as cited in Brookes, above n 9, at 26.

The Infant Life (Preservation) Act was passed in 1929, ostensibly to bridge the gap between abortion and murder.[26] The Act provided that no person would be guilty of causing the death of a child capable of being born alive if the act which caused the death of the foetus was done in good faith *for the purpose of preserving the life of the mother*.[27] This finally gave statutory weight to the idea that therapeutic abortion was justified in certain circumstances, a claim some had been arguing since the use of the word unlawfully in 1803.[28] The legislature, however, would not amend the 1861 Act to concretely confirm the existence of an exception for therapeutic abortion despite the addition of this proviso. This left the law of abortion in a somewhat confused state. Abortion, still a crime, was widely performed,[29] yet few convictions ever resulted.[30] Women were reluctant to talk, particularly as judges warned women they could incriminate themselves and open themselves up to prosecution.[31]

A decade later, in an attempt to "obtain a further definition of the present law" a doctor deliberately invited a test case.[32] A fourteen-year-old girl had been sexually assaulted by a group of soldiers, and had fallen pregnant as a result. Mr Bourne, a prominent surgeon, performed a termination on the girl, and was subsequently prosecuted.[33]

Justice McNaghten's summing up to the jury extended the circumstances in which abortion was considered lawful. He stated the word 'unlawfully' in the original 1861 Act ought to be held to have the same meaning "expressed by the proviso in s 1(1) of the Infant Life (Preservation) Act 1929" and that section 58 "must be read as if the words making it an offence to use an instrument with intent to procure miscarriage were qualified by a similar proviso."[34]

Justice McNaghten held the meaning of the words "for the purpose of preserving the life of the mother" were not simply to be interpreted as "merely for the purpose of saving the mother from instant death," but ought to be "construed in a reasonable sense."[35] This meant if the doctor

[26] Infant Life (Preservation) Act 1929 (UK). The relevant section, s 1(1) provided that "any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to penal servitude for life. Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother."
[27] Infant Life (Preservation) Act 1929, above n 26. See also Hugh Woods "When is Abortion Lawful?" (1937) 1 *BMJ* 470 at 470.
[28] Keown, above n 10, as cited in Brookes, above n 9, at 22.
[29] Brookes, above n 9, at 65.
[30] Home Office *Criminal statistics, England and Wales, 1934* (HMSO, London, 1936) at 15, 35. In 1934, 73 cases of procured abortion were made known to the police: 50 made it to trial and only 33 ended in conviction.
[31] Evidence of Sir E. H. Tindal Aitkinson, Director of Public Prosecutions, to the Inter-departmental Committee on Abortion. Minutes, 28 July 1937. MH 71/21, PRO, Kew as cited in Brookes, above n 9, at 28.
[32] Aleck Bourne "Abortion and the Law" (1938) 2 *BMJ* 254 at 254.
[33] *R v Bourne* [1939] 1 K.B. 687 page 690.
[34] At 690, 691.
[35] At 691.

was: [36]

> … of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequences of the continuance of the pregnancy will be to make the woman a *physical or mental wreck*, the jury are quite entitled to take the view that the doctor who, under these circumstances and in that belief operates, is operating for the purpose of preserving the life of the mother.

The exceptional circumstances of this case meant its value was somewhat limited for less extreme cases. Justice McNaghten's direction did not support the notion that simply desiring to "be relieved of her pregnancy" was a justification for the procedure.[37] A haphazard combination of legislation and this liberal interpretation in the court would form the law in England until 1967, with the enactment of the Abortion Act.[38]

*B Current law*

The Abortion Act 1967 (UK) provides that anything done with intent to procure the miscarriage of a woman is unlawfully done unless authorised by section one of the Act. Section one makes legal the performance of abortion where two registered doctors honestly believe that continuing the pregnancy would involve risk to the life of the woman, or injury to her physical or mental health, or injury to existing children in her family, greater than if she has an abortion; or that there is a substantial risk that the child, when born, would suffer from such physical or mental abnormalities as to be seriously handicapped.[39] In deciding whether the continuance of a pregnancy would involve 'risk of injury to health' doctors may take account of 'the pregnant woman's actual or reasonably foreseeable environment.'[40]

The Act contains a conscience clause to allow those who object to performing abortions to do so, though subject to the proviso that it is not to relieve a doctor of any duty he may otherwise have to save the life or prevent grave permanent injury to the physical or mental health of the mother.[41]

By the end of 1973 only one doctor had been prosecuted under the Act, and only for failing to give notice of termination within seven days.[42] The liberal interpretation of the therapeutic abortion exception through the years means very few prosecutions have been successful under

[36] At 691.
[37] At 691.
[38] Abortion Act 1967 (UK).
[39] Abortion Act 1967 (UK), s 1.
[40] Section 1(2).
[41] Section 4(1).
[42] Masterton, above n 7, at 58.

the Abortion Act, usually reserved for only non-consensual or late term abortions.[43] At the time, the Abortion Act was called a "half-way house" in that "it handed the abortion decision to the medical profession" but not "to the woman herself."[44] Importantly, the Abortion Act did not replace the Offences Against the Person Act or decriminalise abortion, but stipulated specific circumstances where women and their doctors would not be prosecuted.[45]

*C Practise*

The number of lawful terminations in England increased steadily from 1968 when the Abortion Act came into effect. The number is stable around 200,000 in England, Wales and Scotland – a number consistent with the rest of the Western world.[46] In 2016 there were a total of 190,406 abortions, lower than in 2015.[47] 92% were carried out before 13 weeks' gestation; 81% before ten weeks.[48] Medical abortions consisted of over half of all abortions at 62%. The proportion of medical abortions has more than doubled in the past decade, from 30% in 2006, and since 2014 has been the most common method of abortion.[49]

The vast majority of abortions in England are performed under the grounds of risk to the woman's mental health, totalling 99.8%.[50] Despite the law, in practise doctors make use of the wide discretion afforded to them under the Act to allow women to essentially access abortion on demand.[51] Some state this reality in practise, along with changes in social attitudes since the enactment of the Abortion Act have rendered the legislation outdated and ineffective,[52] calling it a law "characterised by archaic language, overlapping offences, inconsistencies in available sentences and clinically unwarranted restrictions on best practise."[53] This attitude has been reflected in Parliament. A Bill for Reproductive Health (Access to Terminations) was introduced in 2017, passing its' first reading. As a General Election was called and Parliament dissolved, the Bill will not make it into law at this point in time, but the very existence of the

[43] Sally Sheldon "The Decriminalisation of Abortion: An Argument for Modernisation" (2016) 36 *OJLS* 334 at 349.
[44] Madeleine Simms "Legal Abortion in Great Britain" in Hilary Homans (ed) *The Sexual Politics of Reproduction* (Gower, Aldershot, 1985) at 94.
[45] British Pregnancy Advisory Service "5 reasons to decriminalise abortion" (2017) We Trust Women < https://www.wetrustwomen.org.uk/5-reasons-to-decriminalise-abortion/>
[46] 15.9 per 1000 resident women in England and Wales aged 15–44. Globally, the age standardised abortion rate stood at around 28 per 1000 in 2008, with 24 per 1000 in developed countries or 17 per 1000 with Eastern Europe excluded. See Gilda Sedgh and others "Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008" (2012) 379 *Lancet* 625 and Department of Health (UK) *Abortion Statistics, England and Wales: 2014* (June 2015).
[47] Department of Health (UK) *Abortion Statistics, England and Wales: 2016* (June 2017) at 5.
[48] At 5.
[49] At 19.
[50] At 15.
[51] Sheldon, above n 43, at 363.
[52] Sheldon, above n 43, at 335.
[53] At 346.

Bill shows the growing movement towards decriminalisation seen throughout the Western world.[54]

England therefore has a legislative framework in which abortion is technically illegal, except when two medical professionals sign off that a continued pregnancy is likely to injure the woman, physically or mentally. Nearly one hundred percent of abortions are performed on the basis that continued pregnancy would harm the mental health of the mother. It seems doctors, therefore, have implemented a "consistently liberal interpretation" of the law, where "the requirement for two medical signatures becomes an entirely bureaucratic one, serving no obvious broader purpose."[55]

[54] Reproductive Health (Access to Terminations) Bill 2017 (UK). The Bill sought "to regulate the termination of pregnancies by medical practitioners and to repeal certain criminal offences relating to such terminations; and for connected purposes."
[55] Sheldon, above n 43, at 345.

## *III New Zealand*

### *A Historical Legislation*

New Zealand followed the English position on abortion, adopting the Offences Against the Person Act 1861 (UK) in 1866. In 1893, New Zealand passed the Criminal Code Act which reduced the penalty for the woman to a maximum of seven years imprisonment, while remaining life imprisonment for others involved.[56] The 1939 England case of *R v Bourne* encouraged a more liberal interpretation in New Zealand, but when the Crimes Act was revised in 1961, no changes were made regarding abortion.[57] The public became more supportive of abortion during the 1960's, as shown in England's 1967 Abortion Law.[58] Judicial decisions in Australia developed a more liberal abortion regime,[59] forcing some women in New Zealand to travel to those states to obtain an abortion.[60]

In 1977 the Contraception, Sterilisation and Abortion Act (CSA Act) was passed, amending the Crimes Act, seven other Acts, and creating the Abortion Supervisory Committee.[61] This legislation governing abortions in New Zealand has been in force, without adjustment, for forty years.[62]

### *B Current Law*

The act of terminating a pregnancy in New Zealand is illegal under the Crimes Act and the CSA Act unless one of the grounds for a termination applies and a certificate to that effect is authorised by two certifying consultants.[63] There are four separate offences that make up the law of abortion in New Zealand: section 183 of the Crimes Act 1961, section 44 of the Contraception, Sterilisation and Abortion Act 1977, section 186 of the Crimes Act, and section 182 of the Crimes Act.

The offences all require (a) the administration, use or supply of a poison, drug or noxious thing, an instrument, or any other means, (b) unlawfulness, and (c) an intention to procure a

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[56] "A brief history of abortion laws in New Zealand" (21 November 2014) Abortion Services in New Zealand < http://abortionservices.org.nz/information/history.html>. See also *R v Woolnough* [1977] 2 NZLR 508 at 514 per Richmond J.
[57] *R v Bourne*, above n 33.
[58] Abortion Act 1967 (UK).
[59] See *R v Davidson* [1969] VR 667 and *R v Wald* [1971] 3 DCR (NSW) 25.
[60] Megan Cook "Women's movement – Health, fertility and education" (5 May 2011) Te Ara – the Encyclopaedia of New Zealand < http://www.TeAra.govt.nz/en/womens-movement/page-8>.
[61] Contraception, Sterilisation and Abortion Act 1977. See Appendix 1 for relevant provisions.
[62] Contraception, Sterilisation and Abortion Act 1977; Crimes Act 1961.
[63] Crimes Act 1961, s 183, 186, 182, and 187A; Contraception, Sterilisation and Abortion Act 1977, s 44. See Appendix 1 for relevant provisions.

miscarriage.[64] It is not a requirement that the woman was actually pregnant, that she actually miscarried, or that she actually took the drug or used the instrument.[65]

Unlawfulness was not defined in the statute until 1977. Section 187A was inserted by Parliament which stipulated that for the purposes of section 183 and 186, any act described is unlawful in the case of a pregnancy of not more than 20 weeks' gestation *unless* one of the grounds provided is satisfied. These grounds do not necessarily have to exist as a matter of fact, rather, the person seeking to rely on the defence of s 187A must believe that such a ground exists.[66] The belief is not required to be held on reasonable grounds. The defence is not dependant on the abortion being successful, or that the means used were capable of inducing an abortion at all.[67]

*1 Pregnancy before 20 weeks' gestation*

If the pregnancy is less than 20 weeks, there are five grounds for lawfully terminating a pregnancy. These are a serious danger to the woman's life or physical or mental health; a substantial risk that the child will be severely handicapped; if the pregnancy has resulted from incest; if the pregnancy has resulted from an offence under section 131 Crimes Act; or if the pregnant woman is severely abnormal.[68]

(a) That the continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health, of the woman or girl.[69]

The phrase "not being danger normally attendant upon childbirth" originated from the judgement of Menhennitt J in Australia,[70] and was used by the trial judge in the case of *R v Woolnough*.[71] The Court of Appeal expressed concern about the phrase, Richmond J stating he "regard[ed] the words in question as at best redundant and in any event better left unsaid as they introduce the problem of just what is meant by "normal" risks."[72] However, the phrase

[64] Nicola Peart "Prevention and Termination of Life Before Birth" in Peter Skegg and Ron Paterson (eds) *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) at 599.
[65] At 599.
[66] At 602.
[67] Crimes Act 1961, s 187A.
[68] Crimes Act 1961, s 187A.
[69] Section 187A(1)(a).
[70] *R v Davidson* [1969] VicRp 85; [1969] VR 667 (3 June 1969).
[71] *R v* Woolnough, above n 5, at 513, per Chilwell J: "the test for whether or not the use of an instrument is unlawful is whether it is necessary to preserve the woman from serious danger to her life or to her physical or mental health, not being the normal dangers of pregnancy and childbirth."
[72] *R v Woolnough*, above n 5, at 519 per Richmond J.

was incorporated into the legislation for fear of being able to justify abortion on demand without it.[73]

This ground is further developed in s 187A(2) of the Crimes Act, with two factors set out that may be taken into account in determining whether the continuation of the pregnancy would seriously endanger the woman's life or health.[74] Firstly, whether the pregnant woman is near the beginning or the end of her childbearing years, and secondly, where there are reasonable grounds for believing that the pregnancy is the result of a sexual violation.[75] The fact that a pregnancy resulting from sexual violation is not in itself a ground for a termination is of grave concern to some people.[76]

Assessing whether or not a risk of serious harm exists requires an examination of both the probability and the severity of any harm.[77] The words are vague as to any one certain interpretation. Serious danger to the mental health of a woman has been historically widely interpreted. Nearly all abortions that take place in New Zealand are performed on this ground.[78]

(b) That there is a substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped.[79]

This ground being the sole reason for abortion has not risen above one percent of the total number of abortions performed.[80] The terms 'substantial risk' and 'seriously handicapped' are unable to be precisely defined, though unlike the ground of serious danger to the woman's mental health, have not been interpreted so widely or liberally.[81] Medical testing and scans which provide verifiable evidence for stating this ground is fulfilled is likely to be the reason for this.[82] It remains a possibility that this ground could see an increase in debate as more conditions and disabilities can be picked up earlier, and the sensitivity of the scans is ever increasing.[83]

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[73] New Zealand Royal Commission of Inquiry, *Report of the Royal Commission of Inquiry: Contraception, Sterilization, and Abortion in New Zealand* (Government Print, Wellington, 1977) at 271 and Explanatory Note to the Contraception, Sterilisation and Abortion Bill No 57-1 at ix as cited in Peart, above n 64, at 604.
[74] Crimes Act 1961, s 187A(2).
[75] Section 187A(2)(a) and (b).
[76] Siobhan O'Connor "A Precarious Position: The State of Abortion Law in New Zealand" *Salient* (online ed, Wellington, 7 August 2017).
[77] Peart, above n 64, at 604.
[78] Abortion Supervisory Committee *Report of the Abortion Supervisory Committee 2016* (2016) at 23.
[79] Crimes Act 1961, s 187A(1)(aa).
[80] Abortion Supervisory Committee, above n 78, at 23. In 2015 the number of abortions performed solely for this reason was 57, or 0.4%. When combined as a reason with mental and/or physical danger to the mother, that number raised to 174, or 1.3%.
[81] Peart above n 64, at 607.
[82] At 607.
[83] At 607.

(c) That the pregnancy is the result of sexual intercourse between a parent and child; or a brother and sister, whether of the whole blood or of the half blood; or a grandparent and grandchild.[84]

This ground has less room for interpretation, stating that pregnancy may be terminated if it is the result of sexual intercourse with the woman's father, son, brother, grandfather, or grandson. It is a relatively clear provision, which has not seen much debate or litigation. This ground is a *belief* based justification. The abortion provider must *believe* that the pregnancy is a result of such a relationship, regardless of whether or not anyone in question is charged with any crime relating to incest.[85]

(d) That the pregnancy is the result of sexual intercourse that constitutes an offence against section 131(1).[86]

Section 131 creates an offence to have or attempt to have sexual connection with a dependant family member under the age of 18.[87] It does not matter if the relation was close or distant,[88] whether the girl consented, or whether the man knew the girl was under the age of 18 at the time.[89] As with the other grounds for abortion in New Zealand, it is the *belief* of the medical professional who is performing the termination that the pregnancy is a result of such an offence that matters for the use of the defence.[90]

(e) That the woman or girl is severely subnormal within the meaning of section 138(2).[91]

This ground justifies the termination of a pregnancy of a woman who is "severely subnormal" within the meaning of section 138(2) of the Crimes Act. However, legislative changes have rendered this definition obsolete. In 2005, section 138(2) was amended, with section 138(6) now defining sexual exploitation of a person with "significant impairment."[92] Significant impairment is defined as "an intellectual, mental, or physical condition or impairment."[93] This

[84] Crimes Act 1961, s 187A(1)(b)(ii) and (iii).
[85] Peart, above n 64, at 608.
[86] Crimes Act 1961, s 187A(1)(c).
[87] Crimes Act 1961, s 131.
[88] Crimes Act 1961, s 131A defines "dependant family member" with reference to the power and control exercised over a person under the age of 18 by another person within a family context, inserted by Crimes Amendment Act 2005, s 7.
[89] Crimes Act 1961, s 131 leaves the possibility that the mistaken belief about the girls age could be raised as a defence.
[90] Peart, above n 64, at 608.
[91] Crimes Act 1961, s 187A(1)(d).
[92] Crimes Amendment Act 2005.
[93] Crimes Act 1961, s 138(6): "an intellectual, mental, or physical condition or impairment that affects a person to such an extent that it significantly impairs the person's capacity to understand the nature of sexual conduct, understand the nature of decisions about sexual conduct, foresee the consequences of decisions about sexual conduct, or communicate those decisions."

makes the ground much wider than intentionally drafted: where the original definition was restricted to mental subnormality, this new definition includes physical and intellectual impairment.

There is no definition of severely subnormal in the Crimes Act, rendering this abortion ground "a nonsense."[94] The term itself is "outdated and offensive."[95] The Abortion Supervisory Committee suggests a change in the wording to a patient who "lacks mental capacity to consent,"[96] and advises reference to section 6 of the Protection of Personal and Property Rights Act 1988, which sets out the circumstances in which a person lacks capacity.[97]

*2 Pregnancy of more than 20 weeks' gestation*

If the pregnancy is of more than 20 weeks' duration, the scope for a termination is greatly reduced. The person performing the abortion must believe that the termination is necessary to either save the life of the pregnant woman, or to prevent serious permanent injury to her physical or mental health.[98] Abortions over 20 weeks make up a fraction of the total abortions performed every year in New Zealand: in 2015, 57 abortions of 13,155 were performed after the 20-week mark.[99]

*3 Killing unborn child*

While these justifications mean a person will not be convicted of an offence under section 183 and section 186 of the Crimes Act, a belief that one of the grounds for abortion exists will not necessarily eradicate all liability.[100] Section 187A arguably may not protect against section 182 of the Crimes Act 1961. The section creates an offence for causing the "death of any child that has not become a human being in such a manner that he would have been guilty of murder if the child had become a human being."[101]

This section was intended to cover the period of time during which a child is being born, but has not proceeded in a living state from its mother, the point at which babies are considered human beings.[102] By not including a time limit on the point at which before birth this section applied, the scope went much further than originally intended. The common law has developed in such a way that "child" can only apply to the foetus of a second trimester pregnancy. The

[94] Peart, above n 64, at 609.
[95] Abortion Supervisory Committee, above n 78, at 4.
[96] At 4.
[97] Protection of Personal and Property Rights Act 1988, s 6.
[98] Crimes Act 1961, s 187A(3).
[99] Abortion Supervisory Committee, above n 78, at 21.
[100] Crimes Act 1961, ss 187A(1) and (3) and CSA Act, s 44(3). See also *R v G* CA335/94, 3 November 1994.
[101] Crimes Act 1961, s 182(1).
[102] Peart, above n 64, at 616.

Court of Appeal has held that while a foetus past 20 weeks is well within the natural and ordinary meaning of child,[103] the section does not apply to a foetus in the first trimester.[104]

The relationship between section 182 and sections 183 and 187A is problematic and unclear. The Court of Appeal has attempted to clarify the position, stating "one whose acts are lawful under the provisions of s 187A and therefore under s 183 could not be convicted of an offence under s 182."[105]

*4 Procedural requirements in the Contraception, Sterilisation and Abortion Act 1977*

The CSA Act sets out the procedural elements of obtaining and performing a termination in New Zealand. Unless the abortion is performed in an emergency situation, not complying with these procedural elements carries a maximum penalty of six months imprisonment or a $1,000 fine.[106]

If a woman approaches a doctor for an abortion, they must be referred to another certifying consultant or, if the doctor is not one themselves, two certifying consultants.[107] One of these consultants in each case must be an obstetrician or a gynaecologist.[108] A doctor or medical practitioner is not under any obligation to perform or assist in the performance of an abortion if they have an objection to doing so on the grounds of conscience.[109] If they refuse, the doctor must still inform the woman that she can obtain such services from another doctor or a family planning clinic.[110]

These consultants must consider the case and assess whether they believe any of the grounds in section 187A of the Crimes Act have been satisfied.[111] If there is a disagreement about whether a ground for abortion exists at all, the case must be referred on to a third certifying consultant.[112] Once a decision is made as to the existence of a ground for abortion, the two certifying consultants must issue a certificate in a prescribed form. They must then advise the woman of her right to counselling.[113] Each abortion performed by a medical practitioner must

[103] *R v Henderson* [1990] 3 NZLR 174 (CA) at 179.
[104] *R v Woolnough*, above n 5, at 516.
[105] *R v Henderson*, above n 103, at 177.
[106] Contraception, Sterilisation and Abortion Act 1977, s 37.
[107] Section 32(1).
[108] Section 32(2)(b).
[109] Section 46.
[110] Health Practitioners Competence Assurance Act 2003, s 174.
[111] Section 33.
[112] Peart, above n 64 at 612.
[113] Contraception, Sterilisation and Abortion Act 1977, s 35.

be recorded, including the reasons for the abortion.[114] This report must be sent to the Abortion Supervisory Committee within one month.[115]

Abortions must only be performed in an institution licensed by the Abortion Supervisory Committee to do so,[116] unless in an emergency.[117] There is both a 'full license' and a 'limited licence': the former allowing abortions to be performed at any point during a pregnancy, and the latter allowing abortions to be performed only within the first 12 weeks.[118]

The Abortion Supervisory Committee points to the outdated language used in the legislation, such as referring to doctors as "he" throughout.[119] The term "woman's own doctor" is also used, which the Committee points out is obsolete as it becomes more common to not have a regular General Practitioner.[120] The legislation is clumsy and outdated, and does not align with developments in technology, healthcare, or social opinion.

*5 Right to Life New Zealand v Abortion Supervisory Committee*

*Right to Life New Zealand v Abortion Supervisory Committee* was a landmark case for a multitude of reasons. Chief Justice Elias and Tipping and Blanchard JJ upheld a previous judgement of *Wall v Livingston*.[121] This confirmed that the Committee cannot make any inquiry or investigation into the decision making in an individual case, as "to do this would be to engage in a process of attempting to review the clinical judgement of the consultant in an individual case," something "not contemplated by the Act."[122]

In the lower court, Miller J made a thorough analysis, though perhaps some unwise comments, about the legality of many abortions in New Zealand.[123] The case illustrated what the Abortion Supervisory Committee had been attempting to for years: the disparity between the legislation and the practice of abortion in New Zealand.[124] It was reiterated through the courts that there is no right to life for the foetus in New Zealand,[125] and that many agree there is a need for

[114] Section 36.
[115] Section 45(1).
[116] Section18.
[117] Section 37.
[118] Section 19.
[119] Abortion Supervisory Committee, above n 78, at 4.
[120] At 4.
[121] *Right To Life New Zealand Inc v The Abortion Supervisory Committee* [2012] NZSC 68, [2012] 3 NZLR 762; *Wall v Livingston* [1982] 1 NZLR 734, (1982) 1 NZFLR 417 (CA).
[122] *Right to Life New Zealand Inc v The Abortion Supervisory Committee*, above n 121, at [40].
[123] At [52], Blanchard J said of Miller J: "The Judge did go too far when he appeared to question the lawfulness of abortions authorised by certifying consultants."
[124] *Right To Life New Zealand Inc v The Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) at [56].
[125] "We are satisfied that there is no basis either from the … abortion law to derive generally an express right to life in the unborn child." *Right to Life New Zealand Inc v Abortion Supervisory Committee* [2011] NZCA 246, [2012] 1 NZLR 176 at [54], [55] per Stevens J.

review of the abortion laws in New Zealand. The Supreme Court refused to "weigh in with its own opinion," but rather delicately suggested Parliament "consider … whether the Act is operating as it ought."[126]

*C Practise*

The latest abortion statistics show the trend in New Zealand is continuing downwards.[127] The total abortion ratio for 2015 was 177 abortions per 1,000 known pregnancies, the lowest since 1993.[128] At the time of an abortion, 88% of women are provided with contraception: a factor that may be behind this decrease in abortions.[129]

The most telling statistics are those which state the grounds abortions are performed upon. 12,810 of 13,155 of the abortions performed in New Zealand in 2015 were on the basis of danger to mental health alone: totalling 97.4%.[130] A further 110 were performed on the basis of a combination of danger to mental and physical health, and another 107 on a combination of a severely handicapped child, and mental health danger to the woman.[131] Only 57 were performed on the basis of foetal abnormalities, and 32 due to a serious danger to the woman's life.[132] Over 99% of abortions in New Zealand are performed with 'danger to the mental health of the woman' as one of the grounds for the procedure.[133]

The Committee itself has said the law is being "used more liberally" and "interpreted more widely" than Parliament intended when the legislation was enacted four decades ago.[134] The United Nations Committee on the Convention on the Elimination of All Forms of Discrimination Against Women condemns New Zealand's "convoluted abortion laws."[135] The United Nations Committee states this makes "women dependant on the benevolent interpretation of a rule which nullifies their autonomy," voicing concern that "abortion remains criminalised … which leads women to seek illegal abortions, which are often unsafe."[136] They urged New Zealand "to review the abortion law and practice with a view to simplifying it and to ensure women's autonomy to choose."[137]

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[126] *Right to Life New Zealand Inc v The Abortion Supervisory Committee*, above n 121, at [53] per Blanchard J.
[127] Abortion Supervisory Committee, above n 78, at 8.
[128] At 8.
[129] At 8.
[130] At 23.
[131] At 23.
[132] At 23.
[133] At 8.
[134] Comments of Dr Christine Forster in Sunday Star Times (5 November 2000) as cited in *Right to Life New Zealand Inc v Abortion Supervisory Committee*, above n 124, at [53].
[135] *Convention on the Elimination of All Forms of Discrimination against Women* LII CEDAW/C/NZL/CO/7 (2012) at 9.
[136] At 9.
[137] At 10.

## *IV Australia*

### *A Australian Capital Territory*

#### *1 Historical Legislation*

Until 1998, abortion was regulated under the Crimes Act 1900 (ACT). The abortion provisions were taken from the Offences Against the Person Act 1861 (UK), imposing a near complete ban on abortion services.[138]

At the time, the court decisions of New South Wales were understood to apply in the Australian Capital Territory. This meant while the laws of the time were restrictive, access to abortion was relatively easily gained.[139] From 1971, abortion could be accessed by women "where there existed any economic, social, or medical ground or reason" which a doctor could base upon "an honest belief that [continuing the pregnancy] would result a serious danger to her physical or mental health."[140]

In 1998 the Australian Capital Territory passed the restrictive Health Regulation (Maternal Health Information) Act 1998.[141] The Act purported to "ensure that adequate and balanced medical advice and information [was] given to a woman who is considering an abortion" and "to ensure that a decision by a woman to proceed or not to proceed with an abortion is carefully considered."[142] In reality, the Act served to "discourage medical practitioners from referring women for abortion," acted as a "disincentive for medical practitioners to perform abortions," delayed "the process of obtaining an abortion, thereby increasing the maternal health risks of the procedure," and ultimately sought "to remove any autonomy that the woman concerned may have had under the previous regime."[143]

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[138] Offences Against the Person Act 1861 (UK), ss 58 and 59.
[139] National Health and Medical Research Council *An Information Paper on Termination of Pregnancy in Australia* (1996); see also Lyndall Ryan, Margie Ripper and Barbara Buttfield *We Women Decide: Women's Experience of Seeking Abortion in Queensland, South Australia and Tasmania* 1985-1992 (Bedford Park, South Australia, 1994) 15-28.
[140] The decision of *R v Wald* [1971] 3 DCR (NSW) 25 in NSW held that some abortions were lawful: Judge Levine in this case said it was for a jury to decide "whether there existed in the case of each woman any economic, social or medical ground or reason which in their view could constitute reasonable grounds upon which an accused could honestly and reasonably believe there would result a serious danger to her physical or mental health. It may be that an honest belief be held that the woman's mental health was in serious danger as at the very time when she was interviewed by a doctor, or that her mental health, although not in serious danger, could reasonably be expected to be seriously endangered at some time during the currency of the pregnancy, if uninterrupted."
[141] Health Regulation (Maternal Health Information) Act 1998 (ACT).
[142] Section 3(b).
[143] Mark Rankin, 'Contemporary Australian Abortion Law: The Description of a Crime and the Negation of a Woman's Right to Abortion' (2001) 27 *MonashULawRw* 229 at 251.

This law was called the "most reactionary" abortion law in Australia and a "clear victory for the anti-choice movement."[144] Any medical practitioner was obliged to offer the woman referral to counselling.[145] The conscientious objection clauses allowed a practitioner not only the ability to refuse to perform an abortion, but also the ability to refuse to give any advice, information, or a referral to a practitioner who would do those things.[146] While the Act claimed to have no effect on the lawfulness of abortions in the Australian Capital Territory,[147] this was "nonsense."[148] The Act clearly had an effect on practise, and created criminal sanctions for contravention of certain provisions.[149]

*2 Current Law*

Despite the incredibly restrictive regime from 1998, the ACT was the first Australian jurisdiction to remove abortion from the "realm of the criminal law."[150] The process began in 2001 with the Maternal Health Information Regulations Repeal 2001, which repealed regulations brought in in 1999 under the restrictive Maternal Health Act, that among other things, had attempted to incorporate foetal pictures into requisite pamphlets.[151] The Crimes (Abolition of Offence of Abortion) Act 2002 (ACT) was passed in 2002 repealing the abortion provisions. It repealed ss 44-46 of the Crimes Act 1900, and substituted:[152]

> 44 Abortion – abolition of common law offence
> (1) Any rule of common law that creates an offence in relation to procuring a woman's miscarriage is abrogated.

This section repealed the abortion provisions previously found in sections 44, 45, and 46, and removed any common law offence of abortion that might have existed. As of today, the Crimes Act reads from section 43 to section 47 with no mention of sections 44 to 46.[153]

In one fell swoop, the Australian Capital Territory therefore removed the provisions in the Crimes Act maintaining abortion as an offence, and ensured no recourse to the common law by including section 44(1).[154] This simply removed any offences without creating any

[144] Rankin, above n 143, at 248.
[145] Section 8(l)(b)(i) and (ii).
[146] Section 12(c).
[147] The Act specifically states that 'the lawfulness or unlawfulness of an abortion ... is not affected by either the compliance by any person or the failure by any person to comply with a provision of this Act' - see Health Regulation (Maternal Health Information) Act 1998 (ACT), s 4.
[148] Mark Rankin "Recent Developments in Australian Abortion Law: Tasmania and the Australian Capital Territory" (2003) 29 *MonashULawRW* 316 at 329.
[149] Sections 6(1) and 6(2) prescribe imprisonment as the penalty for failure to obey that section.
[150] Rankin, above n 148, at 327.
[151] Maternal Health Information Regulations Repeal 2001 (ACT).
[152] Crimes (Abolition of Offence of Abortion) Act 2002 (ACT) s 3.
[153] Crimes Act 1900 (ACT), ss 43 – 47.
[154] Rankin, above n 148, at 330.

regulation. The Medical Practitioners (Maternal Health) Amendment Act 2002 (ACT) created new provisions.[155] These provisions have been relocated to the Health Act 1993 (ACT) as sections 80 to 84, dealing with who is allowed to perform abortions and where they may take place.[156] Section 84 retains that no one is under a duty to carry out or assist in carrying out an abortion, and a person is entitled to refuse to do so, though does not recuse a practitioner from their duty to provide advice to refer the patient to another practitioner, and if the woman's life is in danger, the medical professions ethical code requires assistance to be provided irrespective of any such objections.[157]

The performing of abortions in non-approved facilities and the performance of an abortion by anyone other than a registered medical practitioner are still offences.[158] They have the penalties of six months and five years' imprisonment respectively.[159] While the requirement that the premise be licensed could be used as a way to reduce access to abortion services in the Australian Capital Territory, the Minister must not "unreasonably refuse or delay a request for approval of a medical facility."[160] The only test the Minister may direct his or her mind to in making such a decision is whether or not a medical facility is "suitable on medical grounds for carrying out abortions."[161] Barely a year later, five such approvals had been granted.[162]

The Act makes it clear that abortion is no longer dealt with in the criminal realm in the Australian Capital Territory. It is managed under the Health Act, and there is no mention of circumstances for any woman that would make it illegal for her to obtain an abortion. There are no gestational limits specified, and no requirement for giving a legitimate reason or satisfying any grounds in order to receive one. Abortion was made completely legal. The Australian Capital Territory therefore "possesses the most liberal abortion law in the country."[163]

While, however, the 2002 amendments broadly removed any offences with respect to abortion, there are still offences in the Crimes Act 1900 (ACT) that might affect some abortions. Section 42 relates to the offence of child destruction, which retains the penalty of 15 years' imprisonment for any intentional or reckless act or omission occurring in relation to a childbirth and before the child is born alive which prevents that child from being born alive or contributes to the child's death.[164] While at first glance, the phrase "childbirth before the child is born

[155] Medical Practitioners (Maternal Health) Amendment Act 2002 (ACT).
[156] Health Act 1993 (ACT), ss 80 – 84.
[157] Medical Practitioners Act 1930 (ACT), s 55E.
[158] Health Act 1993 (ACT), ss 81 – 83.
[159] Medical Practitioners Act 1930 (ACT) s 55C.
[160] Section 55D(1), (3).
[161] Section 55D(1), (3).
[162] Rankin, above n 148, at 334.
[163] Rankin, above n 148, at 327.
[164] Crimes Act 1900 (ACT), s 42.

alive" seems to exclude abortion, upon scrutiny, could imply that some forms of very late term abortions could be construed as involving 'childbirth', therefore retaining an offence for such abortions.[165]

Commentators have suggested this implication of section 42 means that, although there are no gestational limits prescribed in the Health Act 1993 (ACT),[166] the upper time limit for abortion services in the ACT is viability.[167] This has been held to have substantially the same meaning as "child capable of being born alive,"[168] a remarkably unhelpful standard given the consistently changing face of medical advancements and scientific knowledge. In 1969, the South Australian Parliament held that viability occurred at 28 weeks,[169] while more recently in the past decades, the age of viability has been held to occur at 26 weeks.[170] A general consensus tends to hold that viability is reached sometime between 22 and 26 weeks, and no later than 28 weeks.[171] Most abortion services in Australia do not provide abortions if a woman is over 22 weeks pregnant,[172] even where the legislation expressly proscribes an ability to perform such procedures up until 28 weeks.[173]

Therefore, the Australian Capital Territory has "removed abortion from the criminal code and from the common law, and has provided for the medical regulation of the practise."[174] Subject only to the conditions that abortions are performed "pre-viability, and by registered medical practitioners in approved facilities, there now exists effective abortion-on-demand in the ACT."[175]

*3 Practise*

There is no legal restriction on when abortion can be provided in the Australian Capital Territory, but in practise, providers limit abortion to under the first 16 weeks of gestation. There are only two clinics which provide such services in the ACT, the latest of which will provide

[165] Rankin, above n 148, at 330.
[166] The provisions that were entered into the Medical Practitioners Act 1930 (ACT) have since been relocated to the Health Act 1993 (ACT).
[167] Rankin, above n 148, at 331.
[168] See *C v S* [l987] 1 All ER 1230 at 1240 - 1243 and *Rance v Mid-Downs Health Authority* [l991] 1 QB 587 at 621-622.
[169] Criminal Law Consolidation Act 1935 (SA), s 82A(8).
[170] *Rance v Mid-Downs Health Authority*, above n 168, at 616-617.
[171] J K Mason *Medico-Legal Aspects of Reproduction and Parenthood* (Ashgate Publishing, Farnham, 1990) at 104.
[172] Rankin, above n 148, at 329.
[173] For example, the Pregnancy Advisory Centre, which performs most abortions in South Australia, has a policy of only performing abortions up until 20 weeks, despite the fact that the South Australian legislation allows lawful abortions up until 28 weeks of pregnancy.
[174] Rankin, above n 148, at 334.
[175] At 334.

a surgical termination up to 15 weeks and 6 days' gestation.[176] Abortions are not provided in hospitals in the Australian Capital Territory, public or private, except in cases of emergency or foetal abnormality.[177]

As with the rest of Australia, there is no standardised, uniform data collection about pregnancy outcomes, other than recording births. This makes it difficult to determine any actual numbers of abortions or statistics to make a judgement on the impact the change in laws has had on the numbers of people obtaining abortions. Nationwide, current estimates are putting the Australian abortion rate at about 19.7 per 1,000 women.[178] The latest information available from the Australian Capital Territory puts the rate at about 18.6, using information obtained through Medicare claims.[179] The rate has been consistency dropping for years, 2013 being the lowest recorded rate in recorded history in the ACT, with a peak of 28 per 1,000 in 2000. While these figures are not close to being infallible, the general trend in Australia and New Zealand of consistently lowering rates seems to be holding true for the Capital Territory, despite essentially unrestricted legal access to abortion.

*B Victoria*

*1 Historical Legislation*

The abortion provisions in the Crimes Act 1958 (Vic) were based on the Offences Against the Person Act 1861 (UK), resulting in a near-complete ban on abortion services. Section 65 of the Crimes Act 1958 (Vic) stated: [180]

> Whosoever, with intent to procure the miscarriage of any woman, whether she is or is not with child unlawfully administers to her or causes to be taken by her any poison or other noxious thing, or unlawfully uses any instrument or other means with the like intent, shall be guilty of a felony and shall be liable to imprisonment for a term of not more than 15 years.

[176] Maries Stopes International (based in Canberra City) will medical termination from 5 to 9 weeks gestation and surgical termination up to 15 weeks and 6 days gestation. Sexual Health and Family Planning ACT "Factsheet: Abortion in the Australian Capital Territory" (online factsheet, 20 June 2016).
[177] Sexual Health and Family Planning ACT, above n 176.
[178] Department of Health *Induced Abortions in Western Australia 2010-2012* (Government of Western Australia, July 2013).
[179] Robert Johnston "Historical abortion statistics, Australian Capital Territory (Australia)" (3 January 2015) Johnstons Archive < http://www.johnstonsarchive.net/policy/abortion/australia/ab-aust-act.html>
[180] Crimes Act 1958 (Vic), s 65.

Under section 65 a woman or any person who attempted to procure an abortion for a woman was liable to not more than fifteen years' imprisonment.[181] Section 66 prohibited supply of an instrument or substance knowing it would be used to unlawfully terminate a pregnancy.[182]

*2 Development of the Law*

The courts drove the development of the abortion law. In 1969, it was held that as the legislation defined only "unlawful" abortion there must therefore be a form of "lawful" abortion.[183]

In finding this, Menhennitt J relied heavily on the English case of *R v Bourne*.[184] In that case, the proviso that an act causing the death of a foetus was not an offence if done "in good faith for the purpose only of preserving the life of the mother" was extended to include serious danger to the mother's physical or mental health.[185] That express exception for preserving the life of the mother was not present in Victorian law, Menhennitt J observed, but the word "unlawfully" did appear, so "what is lawful and what is unlawful must be determined by other legal principles."[186]

Holding that "the defence of necessity applies not only to common law but even to statutory crimes,"[187] Menhennitt J stated that "necessity is the appropriate principle to apply to determine whether a therapeutic abortion is law or unlawful within the meaning of s 65."[188]

Justice Menhennitt quoted the principle of necessity as: [189]

> …an act which would otherwise be a crime may in some cases be excused if the person accused can show that it was done only in order to avoid consequences which could not otherwise be avoided, and … that no more was done than was reasonably necessary for that purpose, and that the evil inflicted by it was not disproportionate to the evil avoided.

Justice Menhennitt summarised this to mean in the context of abortion, "the accused must have honestly believed on reasonable grounds that the act done by him was necessary to preserve the woman from some serious danger."[190] That danger "should not be confined to danger to life" alone, rather "should apply equally to danger to physical or mental health, provided it is

[181] Section 65.
[182] Section 66.
[183] *R v Davidson*, above n 70, at [3].
[184] *R v Bourne*, above n 33.
[185] The proviso in the Infant Life (Preservation) Act 1929 (UK), s(1).
[186] *R v Bourne*, above n 33, at 690.
[187] J V Barry "The Law of Therapeutic Abortion" (1938) 3 *The Medico-Legal Journal* 211; Glanville Williams *The Sanctity of Life and the Criminal Law* (Faber and Faber, London, 1958) at 152.
[188] *R v Davidson*, above n 70, at [15].
[189] Stephen, above n 22, at ch 3, article 43.
[190] *R v Davidson*, above n 70, at [19].

a serious danger not being merely the normal dangers of pregnancy and childbirth."[191] These elements were "subject to the beliefs being held on reasonable grounds."[192] Justice Menhennitt directed the jury that:[193]

> …for the use of an instrument with intent to procure a miscarriage to be lawful, the accused must have honestly believed on reasonable grounds that the act done by him was:
>
> (1) 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 the pregnancy would entail; and
>
> (2) in the circumstances not out of proportion to the danger to be averted.

The jury returned a verdict of not guilty. The law following this case was remarkably and "firmly settled,"[194] but as time passed, advances in medicine and contraceptives posed a threat to this. Many were unsatisfied with the confused state of the law, where a haphazard combination of fifty-year-old legislation and a singular case formed the regulation of abortion.[195]

*3 Current Law*

In 2008, Victoria enacted the Abortion Law Reform Act. A simple piece of legislation, it totals barely more than 1,000 words. The purpose was simply to reform the law relating to abortion and regulate health practitioners performing them, as well as remove provisions relating to abortion from the Crimes Act and abolish any common law offences.[196] The law "was simple, well founded and effective. It took abortion out of the Crimes Act and did not put it anywhere else."[197]

The heart of the legislation is section four: a registered medical professional may perform an abortion on a woman who is not more than 24 weeks pregnant.[198] This section places only two restrictions on the legality of abortion in Victoria: that the procedure be performed by a medical practitioner, and the pregnancy must not be of more than 24 weeks gestation. There is no

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[191] *R v Bourne*, above n 33.
[192] *R v Davidson*, above n 70, at [22].
[193] At [22].
[194] Louis Waller "Any Reasonable Creature in Being" (1987) 13 *MonashULawRw* 45 at 49.
[195] Lachlan J de Crespigny and Julian Savulescu "Abortion: time to clarify Australia's confusing laws" (2004) 181 *Med J Aust* 201.
[196] Abortion Law Reform Act 2008 (Vic), s 1.
[197] Jo Wainer "Celebrate Sisters, The Battle is Won" *New Matilda* (online ed, New South Wales, 25 November 2008).
[198] Section 4.

requirement of necessity, as per Menhennitt J, nor did Victoria follow the English approach, requiring two doctors to agree there is serious danger to the woman's life or health.[199]

If the pregnancy is of greater gestation than 24 weeks, a medical professional may still perform a termination if he or she "reasonably believes that the abortion is appropriate in all the circumstances" and has "consulted at least one other registered medical practitioner who also reasonably believes that the abortion is appropriate in all the circumstances."[200] This broad statement of "all the circumstances" is qualified but not narrowed, stating the practitioner "must" have regard to "all relevant medical circumstances and the woman's current and future physical, psychological and social circumstances."[201] This legislation not only allows room for consideration of more factors than simple danger to mental and physical health, but explicitly demands it.

The Act also allows a drug or combination of drugs to be provided to a woman who is not more than 24 weeks pregnant to be provided by a registered pharmacist or registered nurse.[202] If the woman is more than 24 weeks, such a person may still provide the drug or drugs, but only on written direction from a registered medical practitioner who has consulted one other medical practitioner who both believe such an abortion is appropriate in all the circumstances. After 24 weeks, the nurse or pharmacist administering or providing the drugs to the woman must be employed at a hospital.[203]

The Act allows for conscientious objection, but the practitioner who is objecting must inform the woman and refer the woman to another registered health practitioner who the objector knows does not object to abortion.[204] Despite this allowance, the Act follows that despite any such objection, where the situation is an emergency and an abortion is required to preserve the life of the pregnant woman, a registered medical practitioner is under a duty to do so, and a registered nurse is under a duty to assist.[205]

Many amendments were proposed to what would become the Abortion Law Reform Act during its passage in Parliament. Some were aimed at compulsory counselling for women, providing information to women about the health risks of abortion, requiring anaesthetic to be provided to the foetus, and making the informing of parents of a minor seeking an abortion compulsory. No amendments were agreed to, and the Bill passed in the form presented.[206] A Bill titled the

[199] *R v Davidson* above n 70; Abortion Act 1967 (UK).
[200] Abortion Law Reform Act 2008 (Vic), s 5(1)(a) and (b).
[201] Section 5(2).
[202] Section 6.
[203] Section 7.
[204] Section 8.
[205] Section 8(3) and (4).
[206] Peter Westmore "Victoria: Behind Victoria's radical new abortion law" *News Weekly* (online ed, Victoria, 25 October 2008).

Infant Viability Bill was introduced in 2015, marking the first legislative attempt to overhaul the abortion law reforms.[207] The Bill proposed that abortion after 24 weeks would be prohibited in all circumstances, requiring instead a forced premature delivery, and the practitioner to take "all reasonable steps" to provide the neo-natal care to preserve the child's life.[208] The Bill was resoundingly defeated in May 2016, the same month safe access zones of 150 metres outside any hospitals, GP clinics and health services providing any abortions came into effect.[209] Despite its failure, some took the Bill as evidence of the change in attitude of policy-makers perceived by many towards a more regressive approach to abortion.[210] Many believe that the actual access to abortion in Victoria is still hindered by what some call "wavering support" by politicians.[211]

*4 Practise*

There is no standardised data collection on abortion in Australia, making indications on the impact of such law reform a guessing game more than much else. Some inferences can be made from the procedures reported through Medicare: though such procedures are also recorded in circumstances of treating miscarriage and other gynaecological procedures, making the data indicatory at best.[212]

Abortion rates are generally decreasing over time, peaking at over 20,000 in 1993, and consistently lowering, with 2014 being the last and lowest year on record, with only 12,890 reported abortions.[213] A 2009 report claimed 16,084 Victorian woman had abortions in 2008-2009, which follows the general commonwealth trend of a reduction – this being a 12% decrease since the 2005-2006 figures.[214] 90% of terminations were before 13 weeks, showing neither the "flood in total number of abortions" nor the "number of controversial late term abortions" as opponents of the law reform predicted.[215]

There is available data in Victoria for abortions performed for psychosocial reasons after 20 weeks, as they are required to be recorded as births and subsequently so, perinatal deaths.[216]

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[207] Infant Viability Bill 2015 (Vic).
[208] Section 6.
[209] Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015 (Vic).
[210] Autumn Pierce "Abortion Reform in Victoria" (8 July 2016) Positive Women <http://www.positivewomen.org.au/blog/abortion-reform-in-victoria>.
[211] Pierce, above n 210.
[212] Annabelle Chan and Leonie Sage *Estimating Australia's abortion rates* (2005) 182 *Med J Aust* 447.
[213] Robert Johnston "Historical abortion statistics, Victoria (Australia)" (3 January 2015) Johnstons Archive < http://www.johnstonsarchive.net/policy/abortion/australia/ab-aust-act.html>
[214] Fiona Hudson "Thousands of young women had abortions in Victoria last year" *Herald Sun* (online ed, Victoria, 21 November 2009).
[215] Hudson, above n 214.
[216] The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) *Victoria's Mothers and Babies 2014 and 2015* (Victoria State Government, Victoria, 2016) at 84 defines perinatal as

The latest information available is for the years 2014 and 2015, where in total there were just over 500 in the two years combined.[217] The abortion law reform was well established when this data was collected, at least six years in practice. If such broad laws were indeed to give incentive for women to terminate after 20 weeks, such terminations would have certainly been occurring by 2014.

There are claims that "scores" of women, totalling nearly half of the procedures performed, are travelling to Victoria for abortions due to restrictive laws in their own state.[218] This practise is deemed "abortion tourism" by Professor Caroline De Costa, who blames inconsistent and inadequate state-based laws for such a trend.[219]

Decriminalisation in Victoria has had "clear intended and achieved positive effects,"[220] and "increased clarity and safety" for abortion providing doctors.[221] However, recent studies have shown a consistent discontent with the continuing anti-abortion stigma in Victoria. Some believe there has been no decrease in the stigma attached to abortion for either women or providers.[222] Experts in abortion believe "access to public services [has] shrunk," rather than increased, especially for pregnancies of more than 20 weeks' gestation.[223] There is only one clinic in Melbourne that offers abortions after 20 weeks, and that clinic stopped offering abortions for pregnancies of more than 24 weeks in 2012.[224] The public hospital in Melbourne (RWH) will only provide abortions for non-medical reasons up to 18 weeks.[225] Keogh identified that the conscientious objection clauses in the Act were allowing "whole institutions" to justify refusing to provide abortion services.[226]

Access to abortion is not guaranteed by simple legislative change. However, in March 2017 the Victoria State Government released a report detailing key priorities for women's sexual and reproductive health.[227] The Minister acknowledges that despite the legislation "there remain barriers and service gaps that affect women's access to affordable healthcare,

infants of greater than or equal to 20 weeks' gestation, or if gestation is unknown, a birth weight of greater than 400 grams.
[217] CCOPMM, above n 216, at 50.
[218] Julia Medew "'Abortion tourism' brings scores of women to Victoria for late terminations" *The Age* (online ed, Victoria, 26 October 2015).
[219] Medew, above n 218.
[220] Barbara Baird "Decriminalisation and Women's Access to Abortion in Australia" (2017) 19 *Health Hum Rights* 197 at 201.
[221] Louise Keogh and others "Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia" (2017) 43 *J Fam Plann Reprod Health Care* 18 at 18.
[222] Keogh, above n 221, at 21 -22.
[223] At 22.
[224] Baird, above n 220,at 202.
[225] At 202.
[226] Keogh, above n 221, at 21 -22.
[227]Department of Health and Human Services *Women's sexual and reproductive health: Key priorities 2017-2020* (Victorian State Government, Melbourne, 8 March 2017).

contraception and termination services across the state."[228] Three of the key priorities focus on improving awareness of and access to abortion.[229]

[228] Department of Health and Human Services, above n 227, at 1, foreword by the Hon Jill Hennessy, Minister for Health.
[229] Department of Health and Human Services, above n 227, at 12.

## *V Reform*

### *A Justifications for Removing Abortion from the Crimes Act*

#### *1 Those affected when abortion is criminal*

##### (a) Women

It is accepted by people on both sides of the debate that there is a marked difference between the legislation and the way abortion is practised in New Zealand. Some suggest "the appropriate response is … to demand that [the laws] be more rigorously enforced," but forty years of inaction has rendered the law inappropriate and outdated. Changing the practise to align with the law would "result in preventing some (but by no means all) abortions," but at the cost of "gender equality, reproductive health, and autonomy [and] potentially, maternal mortality and morbidity."[230] Restricting access to legal abortion "makes no significant difference to the number of women who choose to seek them."[231] It simply means that women "turn to unsafe practitioners, whose methods range from counterfeit drugs to industrial poisons or wire coat hangers."[232] A 2012 World Health Organisation study found that regions with restricted abortion access have *higher* rates of abortion than areas which have easier access to abortion, and much higher incidences of unsafe abortion.[233]

Unsafe abortion is not the case in New Zealand purely through "benevolent interpretation" of the law.[234] The only reason most abortions are approved is that "the ASC and the current certifying consultants have taken a broad view of the law."[235] The legislative framework in New Zealand is one that could easily be used to restrict abortion, requiring only a "slight political shift for it to tighten up and become that much harder [to access abortion]."[236] Women are the victims when abortion is illegal. 21.6 million women yearly experience an unsafe abortion, and 47,000 women die from complications of unsafe abortion every year.[237]

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[230] Sheldon, above n 43, at 357.
[231] Marie Stopes International "Marie Stopes International statement on Guttmacher/WHO study on global abortion trends" (press release, 12 May 2016).
[232] Marie Stopes International, above n 231.
[233] Gilda Sedgh and others "Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008" (2012) 379 *Lancet* 625 at 625. The study found that in developed regions with laws that allow for abortion on request or on socioeconomic grounds, or countries that allow for abortion to preserve the physical or mental health of the woman, 24 women in every 1,000 have one. In countries with restrictive abortion laws, where abortion is illegal or legal only to save the life of the mother, 29 women in every 1,000 have one.
[234]CEDAW, above n 135, at 9.
[235] Comments of Terry Bellamak in O'Connor, above n 76, at [12].
[236] Comments of Ann Weatherall in O'Connor, above n 76, at [4].
[237] Department of Reproductive Health and Research *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008* (World Health Organisation, 2011).

The current legislation was enacted to prevent the unnecessary death and suffering of women who were unwilling or unable to carry a pregnancy. In 1861 abortion was a "technically demanding, dangerous surgical procedure" and medically, it was sensible to restrict it "to only the most compelling of cases."[238] Even in the late sixties and seventies when our legislation was enacted, abortion was significantly safer, but "still carried significant risks."[239] Today any argument that restrictive and criminal prohibitions on abortion are justified for concern of the woman's health are unsupported by medical evidence. Carrying a pregnancy to term holds much more risk to the health of the woman than an abortion.[240] There is no scientific evidence to back up claims that abortion cause infertility or breast cancer.[241] Women are not necessarily harmed by safe, legal abortion. Women are, however, "significantly and demonstrably harmed" by restrictive criminal laws which oblige them to "seek out illegal terminations."[242]

New Zealand women must lie to their medical practitioners in order for a doctor to have the defence that they held a belief the abortion was justified. Not only is requiring women to deceive their medical practitioners unsafe, but to have to claim a "serious mental health problem" in order to obtain an abortion is "demeaning."[243]

(b) Doctors

Under the current regime, doctors have to fear prosecution for performing abortions. New South Wales has arguably similar laws to New Zealand in that doctors must hold a certain belief in order for an abortion to be legal. In 2005, Ms Sood, formerly Dr Sood, was convicted of unlawfully administering to a patient a drug to induce a miscarriage.[244] The doctor had "failed to make the requisite inquiries in order to satisfy herself of the necessity to terminate the pregnancy."[245] Simply because the law in New Zealand has not been enforced in this manner is no reason to accept the law as it is. The sheer number of women who receive terminations on the grounds of "serious danger to mental health" is not realistic and suggests that "certifying consultants collectively are … employing the mental health ground in much more liberal fashion than the legislature intended."[246] Many doctors each year *must* therefore, be performing terminations they do not genuinely believe satisfy the requirements to be a legal

[238] Sheldon, above n 43, at 348.
[239] Potts, Diggory and Peel "Some Operative and Postoperative Hazards of Legal Termination of Pregnancy" (1971) 5782 *BMJ* 270 describes a morbidity rate of 16.8 per cent and one death among 1317 patients admitted for NHS abortions from 1967–70 as cited in Sheldon, above n 43, at 348.
[240] Royal College of Obstetricians & Gynaecologists "The Care of Women Requesting Induced Abortion" (Evidence-based Clinical Guideline No 7, 2011) as cited in Sheldon, above n 43, at 348.
[241] Academy of Medical Royal Colleges "Induced Abortion and Mental Health: A Systematic Review" (December 2011) as cited in Sheldon, above n 43, at 348.
[242] Sheldon, above n 43, at 348.
[243] See footnote 134. *Right to Life New Zealand Inc v Abortion Supervisory Committee*, above n 124, at [53] per Miller J.
[244] *R v Sood* [2006] NSWSC 1141 (31 October 2006).
[245] At [25].
[246] *Right to Life New Zealand Inc v Abortion Supervisory Committee*, above n 124, at [135] per Miller J.

termination under the governing legislation: the very thing that saw Ms Sood in New South Wales convicted.[247]

The Courts have held that individual decisions are not open to "inquiry or investigation" where that would "tend to question a decision actually made in a particular case."[248] This is little reassurance for doctors performing such terminations as any "slight political shift" could see such decisions being open for review, and a lack of belief that the termination is legal could see them being prosecuted under the criminal law.[249] Doctors in Australia suggest that uncertainty in the legal status of abortion, as in New Zealand, lends to the view that abortion is "an unsavoury part of women's health."[250] When abortion is seen as such, "no effective training of health practitioners is going to occur,"[251] and "may drive many doctors away from providing abortion services."[252]

(c) The foetus

One cannot discuss the procedure of abortion without mention of the foetus. Any law reform at all is unlikely to be palatable to those who believe that a foetus is a full, legal person from the moment of conception and that ending that pregnancy is tantamount to murder. However, this is not, nor has ever been the legal position of New Zealand. There is no unalienable right to life of the foetus in New Zealand, confirmed by the Court of Appeal:[253]

> We are satisfied that there is no basis … to derive generally an express right to life in the unborn child. The legislation, as understood from its text and according to its purpose, does not lead us to the interpretation [that a right to life for the foetus exists]. Furthermore, we can find no basis in the CSA Act for an express right to life.

There are those who will always argue that the duty of a mother is to sacrifice her own health, wellbeing, and autonomy to carry a pregnancy to term.[254] This is not the state of the law. No person is under a "duty to take steps to prevent harm occurring to another," however "morally repugnant."[255] The English courts will not entertain an order for treatment of a pregnant woman, even where refusal to undergo medical intervention may harm the foetus, unless the

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[247] *R v Sood*, above n 244.
[248] *Right to Life New Zealand Inc v The Abortion Supervisory Committee*, above n 121, at [40].
[249] O'Connor, above n 76, at [4].
[250] 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 *JLM* 560 at 574.
[251] Douglas, above n 250, at 574.
[252] Douglas, above n 250, at 561.
[253] *Right to Life New Zealand Inc v Abortion Supervisory Committee*, above n 125, at [54], [55] per Stevens J.
[254] Pro Life New Zealand "Just Think: Hard Questions" <http://prolife.org.New Zealand/hardquestions>.
[255] *R v Lunt* [2004] 1 NZLR 498 at [21] per Blanchard J.

capacity of the patient to consent to or refuse the medical treatment is in issue.[256] In New Zealand, the right of competent adults to make their own healthcare decisions is protected in statute.[257] In law, a foetus is not a human being until it has "proceeded in a living state from the body of its mother,"[258] and is not protected by statute until at least the second trimester.[259] These codified and accepted provisions in New Zealand law suggest that there is nothing *inherently* criminal about the ending of a pregnancy.

In any case, the proposed reform is unlikely to change the incidence of abortion.[260] The current law, as interpreted, does very little to prevent the destruction of foetal life. The proposed law reform is likely to improve the number of abortions which take place early in pregnancy.[261] Those particularly concerned with preventing abortions may consider that the nearly $4 million spent on certifying consultants' fees in 2015 could be "better spent on preventing unplanned pregnancies."[262]

(d) The general public

There is significant public support for access to legal abortion. In January 2017, the Abortion Law Reform Association of New Zealand conducted a poll on abortion issues, and found a majority of New Zealanders polled supported abortion being legal on all grounds they asked about. Consistently, there is strong support for abortion where the pregnant woman is likely to die or be permanently harmed, the foetus has no chance of survival or the pregnancy is a result of rape. Perhaps the most telling, however, is that at least half of those polled support abortion being legal purely because the pregnant woman cannot afford another child, the pregnancy was a result of birth control failure, or the woman simply does not want to be a mother.[263]

This echoes a worldwide trend of public support for abortion being legal. Even Northern Ireland, a jurisdiction with a history marred with deaths of women who were refused abortion by doctors fearful of prosecution has committed to holding a referendum on the issue in

[256] *St Georges Healthcare NHS Trust v S* [1998] 3 All ER 673.
[257] New Zealand Bill of Rights Act 1990, s 11; The Code of Health and Disability Consumers Rights 1996, Right 7(7).
[258] Crimes Act 1961, s 159. This is a codification of the historical "born alive" rule.
[259] Crimes Act 1961, s 182 arguably provides an avenue for prosecution of someone who causes the death of a foetus from the second trimester on. *R v Woolnough*, above n 5, at 516 held that no prosecution under this section could apply to a foetus in the first trimester.
[260] See footnote 134. *Right to Life New Zealand Inc v Abortion Supervisory Committee*, above n 124, at [53] per Miller J.
[261] Sheldon, above n 43, at 358.
[262] Former President of the Abortion Law Reform Association of New Zealand Margaret Sparrow "Abortion is not a crime: 16 reasons to change the law" *The Spinoff* (online ed, Auckland, 7 September 2017).
[263] Abortion Law Reform Association New Zealand *Abortion Issues Poll* (Curia Market Research, Wellington, January 2017).

2018.[264] Our closest neighbour, Australia, has ready access to abortion for most women, developed through case law or law reform.[265] Even New South Wales, where abortion is still governed by legislation from 1900 allows women to access abortion for any *economic, social or medical ground or reason* as long as a doctor could reasonably believe it may cause a danger to the woman's physical or mental health at any point during or after pregnancy.[266] 82% of general medical practitioners in Australia believe women should have access to abortion services,[267] and research consistently suggests around 80% of the general public believe that women should have the right to terminate a pregnancy.[268] In recent years, even the Catholic Church has tempered its complete ban on abortion where it comes to life saving surgery of the mother.[269]

*2 Abortion as a health matter*

(a) History and development of abortion as a health issue

Abortion has "existed for a long time and is not an isolated modern phenomenon," yet has been recognised as therapeutic for some time.[270] The first statutory acknowledgement that abortion was a therapeutic procedure was in the Infant Life (Preservation) Act in 1929. The Act included a proviso that no one should be found guilty under the offence of causing a child capable of being born alive to die should the act which caused the death of the child be done in good faith for the purpose of *preserving the life of the mother*.[271] In New Zealand the majority of the grounds for obtaining an abortion are medical issues. Two of the five grounds in section 187A rest exclusively on the physical or mental health of the mother, while another the health of the foetus, and the remainder dealing with sexual offences committed on the woman.[272] After

[264] Savita Halappanavar died in 2012 after complications from a septic miscarriage, after being denied an abortion. Another young woman as recently as 2014 was forced to give birth via caesarean section after attempting a hunger strike and claiming suicidal tendencies; Henry MacDonald "Ireland to hold abortion referendum weeks before pope's visit" *The Guardian* (online ed, London, 26 September 2017).
[265] See (Abolition of Offence of Abortion) Act 2002 (ACT) and Abortion Law Reform Act 2008 (Vic).
[266] *R v Wald*, above n 140, at 29.
[267] Marie Stopes International "General Practitioners: Attitudes to Abortion" (Marie Stopes International, Quantum Market Research, 2005) at 5.
[268] Victorian Law Reform Commission *Law of Abortion: Final Report* (Victorian Law Reform Commission, Melbourne, 2008) at 58. See also Katharine Betts "Attitudes to Abortion: Australia and Queensland in the Twenty-First Century" (2009) 17 *People and Place* 25 at 36 and Christine Read "The Abortion Debate in Australia" (2006) 35 *Australian Family Physician* 699.
[269] The Catholic Church now permits life-saving procedures to be done where it is something other than the foetus threatening the life of the mother. For example, the removal of a cancerous uterus or a fallopian tube supporting an ectopic pregnancy, which would result in the death of the foetus. Directly ending the life of the foetus, however, is still not permitted. Matthew Newsome "Abortion and Double Effect" (2 September 2006) Catholic Magazine <https://www.catholic.com/magazine/print-edition/abortion-and-double-effect>.
[270] Lynda Crowley-Cyr "A century of remodeling: the law of abortion in review" (2000) 7 *JLM* 252 as cited in Talina Drabsch "Abortion and the law in New South Wales" (Briefing paper No. 9/05, NSW Parliamentary Library Research Service, August 2005) at 1.
[271] Infant Life (Preservation) Act 1929 (UK), s 1(1).
[272] Crimes Act 1961, s 187A(1).

twenty weeks gestation, the only allowable grounds for obtaining an abortion is if the procedure would be life-saving, or prevent serious and permanent injury to the mothers physical or mental health.[273]

The fact that abortion is a health issue is therefore well codified: the statutory language itself makes reference to the *health* and the *life* of the mother with regularity. The courts, historically, have treated abortion as a health matter to be decided between a woman and her doctor. As early as 1939, judges were allowing an interpretation of 'the life of the mother' to be extended to include her physical and mental health.[274]

For over a hundred years there has been a gradual shift in legislation towards allowing abortions for medical reasons.[275] Even Northern Ireland, a jurisdiction which has "one of the most restrictive abortion laws in the world" now allows for abortion where the pregnancy endangers the woman's life.[276] What started as simply allowing abortions to save the life of the mother has been developed into allowing women to access abortion where continuing the pregnancy would lead to serious injury to her mental health.[277] We as a society have moved to a position where "we have already implicitly chosen to value women's autonomy and health over the attempt to protect foetal life through the criminal law."[278] This is shown through the weak, if not non-existent enforcement of the law, the fact that even opponents of abortion reform now frame their arguments in terms of the mother's health rather than the sanctity of foetal life,[279] and public opinion which strongly favours a woman's right to choose.[280]

(b) Judicial recognition of abortion as a health issue

The courts have time and time again refused to review abortion decisions made by doctors.[281] The Abortion Supervisory Committee has no "control or authority or oversight in respect of

[273] Section 187A(1)(3).
[274] *R v Bourne*, above n 33.
[275] Infant Life (Preservation) Act 1929 (UK), s 1(1).
[276] Rie Yoshida "Ireland's restrictive abortion law: a threat to women's health and rights?" (2011) 6 *Clinical Ethics* 172 at 172; Protection of Life During Pregnancy Act 2013 (Northern Ireland). The Act allows for abortion where two medical practitioners hold there is a real and substantial risk of loss of the woman's life from a physical illness which can only be averted by abortion, where one medical practitioner believes it necessary in an emergency, or where three medical practitioners believe there is a real and substantial risk of loss of the woman's life by way of suicide.
[277] Crimes Act 1961, s 187A.
[278] Sheldon, above n 43, at 353.
[279] For example, the discussion in Parliament regarding the proposed Abortion (Sex Selection) Bill (2014–15) (UK). Fiona Bruce, the Bills sponsor pointed out three scenarios to give support to her Bill, each focusing on harm to the pregnant woman. One where a husband assaulted his wife upon finding out she was carrying a female foetus, one where a family pressure a woman into an abortion upon finding she was carrying a female foetus, and a woman who decided to abort a female foetus given traumatizing experience as a child. None of her examples focused on this inherent right to life of the foetus, rather the health (mental or physical) of the mother.
[280] ALRANZ, above n 263.
[281] *Wall v Livingston*, above n 121 and *Right To Life New Zealand Inc v The Abortion Supervisory Committee*, above n 121.

the individual decisions of consultants."[282] The Court of Appeal stated this was to ensure the "process of authorisation" remains "squarely upon the medical profession" to make decision based on "a medical assessment pure and simple."[283] The Court of Appeal worried about "the adverse medical implications which could arise from the passage of time should such a determination be easily open to review."[284] The Court clarified its position in no uncertain terms: [285]

> The legislation provides for the formulation of a *medical judgment by medical practitioners* as to whether the performance of an abortion is authorised by s 187A of the Crimes Act which, with two exceptions, is entirely concerned with medical considerations.

(c) Incidence of abortion

There is "no reason to believe" that putting the regulation of abortion in its rightful place of the medical law "would have a significant impact on the incidence of abortions."[286] The general trend of the western world is that abortion rates are lowering, even in countries that have decriminalised abortion.[287] This trend of decreasing abortion rates is echoed in New Zealand.[288] The rate of abortion is unlikely to change in New Zealand. Victoria experienced no "flood in the total number of abortions" after decriminalising abortion as was predicted by some, and there is no reason to think any different would occur here.[289] In 2000, former chair of the Abortion Supervisory Committee Dr Christine Forster went on record to state that New Zealand in fact "essentially [had] abortion on demand or request," and "in the main centres, in Auckland, Wellington and Christchurch, if a woman wants an abortion … she'll get one."[290]

If most women in New Zealand who wish to obtain an abortion are receiving them, there is no reason to think that any more women will receive abortions if the process is removed from the criminal law.

*B Simplifying Access to Abortion*

*1 Issues with the process under the current regime*

[282] *Wall v Livingston*, above n 121, at 738–739.
[283] At 738 - 739.
[284] At 739.
[285] At 741 (emphasis added).
[286] Sheldon, above n 43, at 358.
[287] Sheldon, above n 43.
[288] Abortion Supervisory Committee, above n 78.
[289] Hudson, above n 214.
[290] See footnote 134.

There are several problems with the current process for accessing abortion that result in inequity and increased risk of harm for women seeking a termination. Abortion is not equally available to all women in New Zealand. In 2000 the Abortion Supervisory Committee stated that the laws "are not being applied consistently throughout the country."[291] In 2015 there were only 159 certifying consultants in New Zealand,[292] making it "much harder to get those certifying appointments" for women who live in rural areas.[293] These inconsistencies "make [the law] inequitable for poorer women, for women in rural areas, to access the services they need."[294] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists strongly recommend that "equitable access to services should be overseen and supported by health departments in each jurisdiction in the same way it is for other health services."[295]

The Abortion Supervisory Committee is required by law to "determine the minimum number of certifying consultants required to ensure … that every woman seeking an abortion has her case considered expeditiously" and then make that number of appointments.[296] They are also required to ensure there is a "sufficient number of appointees practicing in each area of New Zealand" so that a woman "can have her case considered without involving her in considerable travelling or other inconvenience."[297] The legislation, therefore, has recognised the issue with inequitable access to abortion. It does not appear to have translated into reality. Some of the problems with unequal access were highlighted in a report in 1992, stating that women in rural areas faced not only excessive travel times, but higher costs.[298] Research carried out by the Department of Health found "access to free acceptable abortion services is inequitably distributed throughout the country," and "women in some provincial towns or rural areas face considerable costs when accessing services."[299] Even today Abortion Services in New Zealand states that "in a few areas of the country you will need to travel to get your abortion care."[300] While local District Health Boards will help with referrals and travel costs, this does not help those women who are unable to take the requisite time off work or away from their families.

Currently, the cumbersome referral process results in lengthy delays for women seeking abortions. A 2010 study by Martha Silva, Rob McNeill and Toni Ashton found that while terminations overwhelmingly occur within the first trimester, New Zealand women

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[291] *Report of the Abortion Supervisory Committee 2000* AHJR E28 as cited in *Right to Life New Zealand Inc v Abortion Supervisory Committee*, above n 124, at [51] per Miller J.
[292] Abortion Supervisory Committee, above n 78, at 31.
[293] O'Connor, above n 76, at [14].
[294] At [14].
[295] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists *Termination of Pregnancy* (2016) at 4.
[296] Contraception, Sterilisation and Abortion Act, s 30(2).
[297] Contraception, Sterilisation and Abortion Act, s 30(4)(b).
[298] Federation of Women's Health Councils Aotearoa New Zealand *Abortion Services and the Health Changes* (December 1992) at 10.
[299] At 24.
[300] Abortion Services in New Zealand "Abortion Procedures" <http://abortion.org.nz/abortion-procedures>.

consistently access terminations *later* in the first trimester than other developed countries.[301] The longer the delay in accessing terminations, the higher the risk of complications.[302] In 2015 around 94% of abortions occurred within the first trimester, with 69.1% of those being of 10 weeks or less gestation.[303] In contrast, England and Wales perform 81% of terminations at 10 weeks or less gestation.[304] In America, 80.3% of abortions were performed at or under 10 weeks.[305] In Western Australia, one of the two states in Australia that record statistics, 90% of terminations were performed before 11 weeks' gestation.[306]

This study found New Zealand women waited an average of 24.9 days from the first contact with the health system and the date of the termination.[307] An average of 10 days passed between the first contact and the date the appointment with the terminating clinic was booked, and another 10 days between that booking and the appointment. Over half of the women in the study reported that the delay was too long.[308] Any new law must emphasise protecting the health and safety of women. These delays mean women are not receiving the best care possible.

*2 Proposed regulation of abortion*

(a) Before 20 weeks

It is recommended that New Zealand adopt an operative provision similar to that of the Abortion Law Reform Act of Victoria: a medical practitioner is able to perform an abortion on a woman who is not more than 20 weeks pregnant. This would allow medical professionals to perform abortion on demand until 20 weeks.

Given the advancements in medical technology since even 2008, it is not recommended New Zealand adopt the later gestation time limit of 24 weeks for abortion on demand. There has

[301] Martha Silva, Rob McNeill and Toni Ashton "Ladies in waiting: the timeliness of first trimester services in New Zealand" (2010) 7 *Reproductive Health* 1 at 2.
[302] At 1.
[303] Abortion Supervisory Committee, above n 78.
[304] Department of Health (UK) *Abortion Statistics, England and Wales: 2015* (November 2016).
[305] Tara Jatlaoui and others "Abortion Surveillance – United States 2013" (2016) 65 *MMWR Surveill Summ* 1.
[306] Department of Health *Induced Abortions in Western Australia 2010-2012* (Government of Western Australia, July 2013).
[307] While it is not entirely clear the reason for the delay in access for New Zealand women, Silva points to the referral process that must be followed to obtain a termination in New Zealand. Women must first go to a referring doctor, usually a General Practitioner or a Family Planning doctor, who will refer to a termination clinic. These referring doctors will order diagnostic tests such as blood tests, vaginal swabs, and ultrasound scans. Women may also be referred to pre-decision counselling. Most referring doctors will schedule an appointment with the terminating clinic, though some allow women to call and request an appointment themselves. A written referral from a primary care physician is a prerequisite to continue. Once at the clinic, the woman must be seen by two certifying consultants.
[308] At 5 - 6.

been a trend over the past 20 years for increased survival at 24 and 25 weeks of gestation.[309] In the past five years, babies born at 24 weeks gestation have a 44% percent chance of surviving until discharge from hospital.[310] Only a small fraction of abortions occur after 20 weeks each year, and for only the most serious of circumstances. [311]

(b) After 20 weeks

After 20 weeks' it is suggested that New Zealand retain the standard we use today with some minor changes: an abortion may be performed after 20 weeks if the medical practitioner believes it is necessary to save the life of the woman or girl or to prevent serious permanent injury to her physical or mental health. As an added requirement, like in Victoria, that practitioner must have consulted another practitioner who holds the same belief.[312] In the Abortion Law Reform Act in Victoria, there is no mention of this having to be a formal, written authorisation from the other doctor,[313] and should not be so in New Zealand.

Additionally, a termination after 20 weeks should be allowable for severe foetal abnormality. Up to 20 weeks under the current law, a termination can be justified if the foetus has severe abnormalities.[314] This is not the case after 20 weeks, despite the fact that "many foetal abnormalities, such as complex cardiac abnormalities, lethal chromosomal abnormalities and developmental brain anomalies are not detected until 20 weeks or later."[315] This gives the option for medical practitioners to terminate a pregnancy that is incompatible with life or likely to be severely handicapped, without having to phrase it in terms of the mother's mental or physical health.

(c) Other regulations

It is also suggested that new regulations allow registered pharmacists and registered nurses to supply or administer the drug or drugs to cause an abortion in a woman who is not more than 20 weeks pregnant. If more than 20 weeks pregnant, a registered pharmacist or nurse may do the same on written direction from a medical practitioner who has authorised an abortion after 20 weeks, and the nurse or pharmacist is employed at a hospital. Allowing registered nurses

[309] Sarah Seaton and others "Babies born at the threshold of viability: changes in survival and workload over 20 years" (2012) 98 *BMJ* 15 at 15.
[310] At 18.
[311] In 2015, 57 abortions out of 13,155 were performed after 20 weeks gestation.
[312] Crimes Act 1961, s 187A(3).
[313] Abortion Law Reform Act 2008 (Vic), s 5. The Act mentions that registered pharmacists and nurses may only provide drugs after 24 weeks on the written direction of a medical professional who has consulted, but not that the consulting doctor must have written approval from the consulted doctor.
[314] Crimes Act 1961, s 187A(1)(aa).
[315] Terry Bellmark "Abortion does not belong in the crimes act" *Stuff* (online ed, Auckland, 29 March 2017) as cited in Hart Reynolds "Cross-Examination: New Zealand's Ancient Abortion Laws" Equal Justice Project < http://equaljusticeproject.co.nz/2017/05/ancient-abortion-law/#_ftn8>.

and pharmacists to dispense the drugs will combat the inaccessibility some women struggle with when attempting to procure an abortion, who cannot afford to take the requisite amount of time off work, or have to travel long distances.[316] Medical abortions much more common internationally,[317] and are safe, effective, and less traumatic for the women.[318] Increasing the number of medical abortions over surgical is a desirable outcome.

Currently, the Abortion Supervisory Committee is charged with appointing suitably qualified persons to provide counselling services for persons considering an abortion or approving any agency for the provision of such.[319] The Committee should stay tasked with ensuring there are enough qualified counsellors. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists recommend that "pre- and post-termination counselling by appropriately qualified personnel should be routinely available."[320] They also suggest "women should be provided with accurate information including that termination of pregnancy is a safe procedure for which major complications and mortality are rare."[321] However, the Victorian Law Commission strongly recommended that "any new abortion law should not contain mandated information provisions," and "should not contain a requirement for mandatory counselling or mandatory referral to counselling."[322] This should be followed in New Zealand. While doctors should give the information necessary for the woman to make a full informed decision, and counselling should be made available if the woman wishes, these have no place being enforced in any new statutory regime.

It is recommended that the requirement that abortions be performed only on licenced premises be removed, given the difficulty of licensing each pharmacy or general practise that could be dispensing the drugs necessary for abortion under the new regime. It is suggested that any reform takes the Victorian approach, and give no restrictions on where an abortion procedures may be performed.[323] Abortion must be administered in an appropriate way that safeguards the health and safety of the women depending on the maturity of the foetus, but existing health

[316] O'Connor, above n 76, at [14].
[317] In 2015, only 1,766 of our 13,155 abortions were medical. This is significantly lower than many other jurisdictions. In the same year, 62% of abortions in England were medical. The Abortion Supervisory Committee expressed concern over how few of our abortions are medical, stating in 2009 that "less than six percent of abortions are induced by medical methods," while "in other countries where Mifegyne is readily available between 20 and 30 percent of women choose a medical rather than a surgical option." The Committee "identified that many clinics lack[ed] the physical facilities and staff experience to be able to offer this option to women." They vowed to work with clinics to "try to develop up-to-date services and options for all women presenting for abortion services." In the six years since, the number of medical only abortions has nearly doubled, but it can be inferred that easier and quicker access to medical only abortion could be effected by a provision allowing a registered nurse or pharmacist to provide the drugs, as in Victoria.
[318] Thoai Ngo and others "Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: a systematic review" (2011) 89 *Bulletin of the World Health Organization* 360 at 360.
[319] Contraception, Sterilisation and Abortion Act, s 31.
[320] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, above n 295, at 4.
[321] Ibid.
[322] Victorian Law Reform Commission, above n 268, at 8.
[323] Victorian Law Reform Commission, above n 268, at 8.

regulation is sufficient for doctors and medical professionals to make the best choice about where is appropriate for any procedure to be performed. As long as an abortion is carried out by a registered medical practitioner, registered pharmacist, or registered nurse, it must be assumed that medical professional is making appropriate decisions with the patients' health at the forefront. The reason for these provisions in the first place was the rampant unsafe abortion being carried out in years past, risking women's lives and health.[324] This is much less a concern where abortion is easily and equally accessible, and where medical providers are trusted to make the best medical decisions.

While it is necessary to retain a conscientious objection clause, any such clause should follow that of the Victorian Abortion Law Reform Act 2008, and require such a doctor to inform the patient the doctor is conscientiously objecting.[325] The practitioner must then refer the woman to another registered health practitioner who the practitioner knows does not have a conscientious objection to abortion.[326] This brings the abortion regulation more into line with the Health Practitioners Competence Assurance Act, which already requires a health practitioner who is objecting to a service on the grounds of conscience to inform the person who requests the service that he or she can obtain the service from another health practitioner or from a family planning clinic.[327] The International Planned Parenthood Federation states that doctors should have the "right to profession conscientious objection" but should also have a "legal duty to refer women to another professional who will assist them."[328] The lack of this is a "barrier to fair access to health services."[329]

Any reform should explicitly state that in an emergency situation a registered medical practitioner is under a duty to perform an abortion where it is necessary to save the life of the woman.[330]

If the changes recommended above are implemented, abortion would be available on demand until 20 weeks' gestation in New Zealand, something some believe we already have.[331] This change in law will simply recognise that, and stop making potential criminals of medical professionals who perform abortions.

*3 Changes necessary in the Contraception, Sterilisation and Abortion Act*

[324] Department of Reproductive Health and Research, above n 237.
[325] Abortion Law Reform Act 2008 (Vic), s 8(1)(a).
[326] Section 8(1)(b).
[327] Health Practitioners Competence Assurance Act 2003, s 174.
[328] International Planned Parenthood Federation "Legal abortion: a comparative analysis of health regulations" (2009) at 166.
[329] At 166.
[330] Section 8(3).
[331] See footnote 134.

Many amendments are required in the CSA Act to achieve the changes suggested above. Section 29 states that no abortion shall be performed "unless and until it is authorised by 2 certifying consultants."[332] It is this section that ought to be replaced with the main provision that any medical practitioner may perform an abortion on a woman who is not more than 20 weeks pregnant. It should also be amended to allow for the dispensing of abortion drugs by registered pharmacists and nurses. Section 32 sets out the procedure that must be followed when a woman seeks an abortion,[333] while section 33 states that after considering a case, if two certifying consultants are of the opinion that any of the grounds in section 187A apply, they shall issue a certificate authorising the performance of an abortion.[334] These sections become irrelevant with the proposed changes as no certifying consultants are needed, and it is no longer necessary to justify an abortion with a ground found in the Crimes Act. They must, therefore, be removed.

Section 35 states that where certifying consultants have made a decision in any case they shall advise her of her right to seek counselling. As discussed above, while counselling should be made available to the woman, and the Abortion Supervisory Committee should indeed ensure there are enough qualified counsellors, it should not be regulated through statute. Section 18 restricts the performance of abortions to licensed premises only.[335] As it is recommended that the restriction requiring licensed premises be removed, this section, along with sections 19 through 25, all dealing with the logistics of licensing, become redundant and should be removed from the Act.[336] Section 37 of the CSA creates offences for every person who performs an abortion elsewhere than in a licensed institution or performs an abortion otherwise than in pursuance of a certificate issued by two certifying consultants.[337] There is no requirement for an abortion to be performed in a licensed institution and no need for consultants or certificates under the proposed changes, and so this section must be repealed.

Section 44 of the CSA deals with a woman procuring her own miscarriage. The Royal Commission of Inquiry on Contraception, Sterilisation and Abortion in New Zealand contemplated the removal of this offence altogether in 1977 when the Act was drafted.[338] Forty years later, the fact that an offence remains seem a relic of a distant past. There is no offence for a patient of any other medical procedure whose doctor has not followed the correct procedural requirements, and as abortion under this proposed reform will be removed as a crime from the Crimes Act, it makes little sense to have an offence at all for the woman. Once this section is repealed, it takes away the final possibility of a woman being charged with

[332] Contraception, Sterilisation and Abortion Act, s 29.
[333] Contraception, Sterilisation and Abortion Act 1977, s 32(2).
[334] Section 33.
[335] Contraception, Sterilisation and Abortion Act, s 18.
[336] Contraception, Sterilisation and Abortion Act, ss 19 – 25.
[337] Section 37.
[338] New Zealand Royal Commission of Inquiry, above n 73, at 280–281.

procuring an abortion, leaving the only potential offence involving abortion being that of an unqualified person who performs an abortion, or a doctor, nurse or pharmacist who does so after 20 weeks' gestation without the proper consultation.

Section 46 allows for any medical practitioner to exercise a conscientious objection and refuse to perform an abortion.[339] This section must be changed to reflect the new requirements when a practitioner is objecting on the grounds of conscience. The Health Practitioners Competence Assurance Act must also be amended to maintain consistency between the Acts.[340]

*4 Current medical guidelines are sufficient to regulate abortion*

There are those who will be concerned that an abortion regime as suggested above will result in rampant disregard for the regulations. This will not be so. Every medical professional is subject to professional guidelines and even criminal sanction should they commit an offence.[341] There is no reason shifting abortion into the health sphere "would have any negative impact on provision for informed consent: this would remain, as now, subject both to the standards of general medical practice and specific professional guidance."[342] Abortion is no different to other medical procedures in that there is no reason why "the intervention of the criminal law" is necessary "to ensure that proper medical safeguards apply."[343]

Abortion is a medical procedure performed by registered medical professionals and has been acknowledged as such by the law, whether intentionally or otherwise, for some time. It is "the only medical procedure which requires two doctors' signatures," states Professor Lesley Regan, president of the United Kingdom Royal College of Obstetricians and Gynaecologists, who argues abortions "should be treated no differently from other medical procedures."[344]

Health regulations are more than equipped to deal with practitioners who don't comply with rules or codes of practice. A doctor in New Zealand was found guilty of professional misconduct in 2013 by the Health Practitioners Disciplinary Tribunal for dispensing the drug misoprostol in a "manner contrary to legal pregnancy termination procedures specified in the Contraception, Sterilisation and Abortion Act 1977."[345] The doctor in question not only failed to record the dispensing of the drugs properly and update the patients' medical records, but did

[339] Section 46.
[340] Health Practitioners Competence Assurance Act 2003, s 174. See Appendix 1.
[341] For example, the Health Practitioners Competence Assurance Act (2003).
[342] Sheldon, above n 43, at 357.
[343] Royal Commission on Human Relationships *Final Report* (1977) vol 3 at 159 per Evatt J as Chair as cited in Drabsch, above n 270, at 52.
[344] Comments of Professor Lesley Regan in Sophie Borland "Abortions on demand: Top medic says the rule that two doctors must sign for a termination should be scrapped" *Daily Mail* (online ed, London, 16 September 2017).
[345] *In the matter of Dr N* Health Practitioners Disciplinary Tribunal 543/Med12/224P, 11 March 2013.

not undertake the necessary clinical assessments of the patients. The Tribunal found there was a "complete failure to provide the patients with an opportunity to consider expected risks, side effects, benefits and costs of the options."[346] This shows that the current regulatory framework is more than capable of dealing with doctors who act inconsistently with the legislation and the best interests of the patients.

*C Changes Required in the Crimes Act*

*1 Abortion offences*

If abortion is to be decriminalised and regulated through the new provisions in the Contraception, Sterilisation and Abortion Act, the sections that create offences for unlawfully procuring a miscarriage must be repealed. So too must the meaning of "unlawfulness" which creates the abortion grounds. Instead, sections 183 and 186 should be replaced with new provisions that create an offence for an unqualified person who performs an abortion, and ensures that no common law offence of abortion can apply, following the approach taken in Victoria.[347]

Section 183 creates the offence of unlawfully administering or causing to be taken by the woman any drug, using an instrument, or unlawfully using any other means to procure a miscarriage.[348] In place of the equivalent section in the Crimes Act 1958 (Vic),[349] the Abortion Law Reform Act substituted a new offence whereby a person who is not a qualified person must not perform an abortion on another person, under a maximum penalty of 10 years imprisonment.[350] Subsection two ensures that a woman who consents to or assists in the performance of an abortion on herself is not guilty of an offence, and subsection three states that qualified persons are registered medical practitioners and for the purpose of performing an abortion by administering or supplying drugs, a registered pharmacist or nurse.[351] The same should be adopted in New Zealand.

Section 186 is the offence of suppling or procuring any poison, drug or noxious thing, or any instrument or other thing believing that it is to be unlawfully used to procure miscarriage.[352] The equivalent provision in Victoria prohibited supply of an instrument or substance knowing it would be used to unlawfully terminate a pregnancy.[353] The Abortion Law Reform Act repealed this section, inserting instead a new section stating that any rule of common law that

[346] At [26].
[347] Abortion Law Reform Act 2008 (Vic).
[348] Crimes Act 1961, s 183.
[349] Victoria Law Reform Commission, above n 268, at 16.
[350] Abortion Law Reform Act 2008 (Vic), s 11; Crimes Act 1958 (Vic), s 65.
[351] Crimes Act 1958 (Vic), s 65.
[352] Crimes Act 1961, s 186.
[353] Victoria Law Reform Commission, above n 268, at 16.

created an offence in relation to procuring a woman's miscarriage was abolished.[354] This change was two pronged. It removed the only other section that a criminal charge for abortion could be brought under, meaning other than for unqualified persons, performing an abortion (before 24 weeks) could no longer be a criminal offence in Victoria. The new section also removed any possibility that those against abortion could have recourse to the common law. This is the approach we should take in New Zealand.

Section 187 refers to both sections 183 and 186 in clarifying the supplied means need not have been able to actually induce a miscarriage in order for the offence to be complete.[355] If sections 183 and 186 are removed, or amended so that they make no reference to miscarriage or the means used to procure one, this section becomes a nullity and ought to be repealed. Section 187A is the substantial provision of our abortion law, defining 'unlawfully', and therefore when an abortion is legal. There is no reason that the Contraception, Sterilisation and Abortion Act cannot give some guidance to medical professionals as to when an abortion should be performed, particularly after 20 weeks, but with no reference to 'unlawful' abortion in the Crimes Act, there is no reason for the Crimes Act to define what 'unlawful' is. Once removed, there is no longer legislative backing of the current process that must be followed in order for a woman to receive an abortion in New Zealand. When there are no offences in the Crimes Act and no grounds necessary to be satisfied, the process will be entirely regulated by the Contraception, Sterilisation and Abortion Act.

*2 Section 182*

Section 182 of the Crimes Act deals with causing the death of a child that had not become a human being in such a manner that he or she would have been guilty of murder if the child had become a human being.[356] Unless the act causing the death of the child was done in good faith for the preservation of the life of the mother, any person who causes such a death is subject to imprisonment for up to 14 years. As discussed earlier, there is some debate as to when this section applies, but it has generally been held to exclude at least the first trimester of pregnancy.[357]

This section is necessary in some form to recognise the foetus far enough along in development to be capable of being born alive. The Abortion Act 1967 in England dealt with the conflict with an amendment to the equivalent provision stating that along with saving the life of the mother, no one shall be guilty of such an offence who is a registered medical professional performing a termination in accordance with the Abortion Act.[358]

[354] Crimes Act 1958 (Vic), s 66.
[355] Crimes Act 1961, s 187.
[356] Crimes Act 1961, s 182.
[357] *R v Woolnough*, above n 5, at 516.
[358] Abortion Act 1967 (UK), s 5.

The equivalent provision in Victoria was section 10 of the Crimes Act 1958 (Vic).[359] The section had similar potential overlap with late term abortions as section 182, but had predominately been used to prosecute assaults on pregnant women, late in pregnancy, that were intended to harm the foetus.[360] Victoria dealt with this conflict with a section in the Abortion Law Reform Act which simply stated that section 10 of the Crimes Act 1958 was repealed.[361] Another provision in the Abortion Law Reform Act amended the definition of 'serious injury' in the Crimes Act 1958 to include the "destruction, other than in the course of a medical procedure, of the foetus of a pregnant woman, whether or not the woman suffers any other harm."[362]

This meant that the offence of child destruction was removed, removing any confusion as to when the offence applied. Adding the destruction of a foetus to the definition of serious injury (other than in the course of a medical procedure) meant assaults on pregnant women were still covered by the Crimes Act and those who caused the death of a foetus still able to be prosecuted, whether intentional or reckless behaviour.[363]

It is suggested any law reform in New Zealand take this same approach. If section 182 is removed from the Crimes Act it eliminates this possibility of being used to prosecute those who perform late term abortions. Adding either a new provision in the Crimes Act specifically dealing with the destruction of a foetus through an assault on the pregnant woman, or amending an existing assault provision in the Crimes Act to include the same will achieve the result of protecting foetus' capable of being born alive, without the confusion of section 182.

*D Effect of this Reform*

These changes in the Contraception, Sterilisation and Abortion Act, along with the Crimes Act will bring New Zealand's abortion law into the modern age. For a country that has long since prided itself on progressive attitudes and equality for all, our abortion legislation has been left sorely lacking. Canada, some jurisdictions in Australia, and a plethora of European countries have long since legalized access to abortion on request for women.[364] This proposed reform is

[359]Crimes Act 1968 (Vic), s 10. Child Destruction (1) Any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act unlawfully causes such child to die before it has an existence independent of its mother shall be guilty of felony, to wit of child destruction, and shall be liable on conviction thereof to be imprisoned for a term of not more than twenty years. (2) For the purposes of this section evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be prima facie proof that she was at that time pregnant of a child capable of being born alive.
[360] Victoria Law Reform Commission, above n 268, at 7.
[361] Abortion Law Reform Act 2008 (Vic), s 9.
[362] Crimes Act 1958 (Vic), s 15.
[363] Victoria Law Reform Commission, above n 268, at 7.
[364] Centre for Reproductive Rights *The World's Abortion Laws* (2017) The World's Abortion Laws <http://worldabortionlaws.com/>.

not a radical change. The incidence and rate of abortion is unlikely to change, given that New Zealand already "essentially [has] abortion on demand or request."[365] These changes in the law will simply make the process more streamlined, more accessible for all women, less disingenuous, and more transparent.

[365] See footnote 134.

## *VI Conclusion*

This dissertation has looked at three different jurisdictions in the commonwealth, as well as our own and how they regulate abortion. All have technically broader access to abortion for women in the legislation or through the common law than New Zealand. All jurisdictions are experiencing a decrease in abortion rates. The approach taken in Victoria and subsequently recommended in this dissertation is simple and effective. It has removed abortion from the criminal law and put the regulation of it in its rightful place of the health sphere.

The primary focus in this debate must be on the health and safety of women. No one wants to see a return to the days where women resort to using wire hangers or ingesting gunpowder as a desperate attempt to induce an abortion.[366] Unfortunately, when access to abortion is restricted, that is the outcome. The only way to stop women from dying from unsafe abortions is to ensure that abortion is legal, safe, and available to all women. Under the current laws, women who want a termination are receiving one. This is unlikely to change. However, under the current system women must endure a disingenuous and drawn out process. Doctors can jeopardise their careers and open themselves up to prosecution for providing terminations. Women must effectively lie to receive medical treatment and doctors are "fitting the grounds to the women."[367]

New Zealand, a country known for social equality and forward-thinking policy must ensure women are equally able to access safe, legal abortion that is regulated under healthcare and not the criminal law. Women have been terminating unwanted or dangerous pregnancies for as long as we can trace.[368] It is a fact of life that unintended pregnancies occur and that women who are desperate to avoid an unplanned birth will "resort to unsafe abortions if safe abortion is not readily available."[369] Inevitably, "some will suffer complications as a result, and some will die."[370] Our legislature must acknowledge this fact and enact legislation that works for women, the medical profession, and reflects the current beliefs of society. Only then can we have, as Victoria did: [371]

> "a profound shift in the relationship between the state and its female citizens. It changes both nothing and everything. Nothing, because the number, rate and incidence of abortion will not change. And everything, because for the first time women will be recognised as the authors of our own lives. With that comes our full citizenship."

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[366] Brookes, above n 9, at 5.
[367] See footnote 134.
[368] The Assyrian Code (12th Century B.C.) provision 53 makes mention of a woman aborting her own child and sets the punishment for her as to be "impaled and not buried."
[369] Sedgh, above n 233, at 631.
[370] Sedgh, above n 233, at 631.
[371] Wainer, above n 197, as cited in Sheldon, above n 43, at 359.

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*Appendix 1 – New Zealand Legislation*

Crimes Act 1961

**182 Killing unborn child**

(1) Every one is liable to imprisonment for a term not exceeding 14 years who causes the death of any child that has not become a human being in such a manner that he or she would have been guilty of murder if the child had become a human being.

(2) No one is guilty of any offence who before or during the birth of any child causes its death by means employed in good faith for the preservation of the life of the mother.

**182A Miscarriage defined**

For the purposes of sections 183 to 187 the term **miscarriage** means—

(a) the destruction or death of an embryo or fetus after implantation; or

(b) the premature expulsion or removal of an embryo or fetus after implantation, otherwise than for the purpose of inducing the birth of a fetus believed to be viable or removing a fetus that has died.

**183 Procuring abortion by any means**

(1) Every one is liable to imprisonment for a term not exceeding 14 years who, with intent to procure the miscarriage of any woman or girl, whether she is pregnant or not,—

(a) unlawfully administers to or causes to be taken by her any poison or any drug or any noxious thing; or

(b) unlawfully uses on her any instrument; or

(c) unlawfully uses on her any means other than any means referred to in paragraph (a) or paragraph (b).

(2) The woman or girl shall not be charged as a party to an offence against this section.

**186 Supplying means of procuring abortion**

Every one is liable to imprisonment for a term not exceeding 7 years who unlawfully supplies or procures any poison or any drug or any noxious thing, or any instrument or other thing, whether of a like nature or not, believing that it is intended to be unlawfully used to procure miscarriage.

**187 Effectiveness of means used immaterial**

The provisions of section 183 to 186 shall apply whether or not the poison, drug, thing, instrument, or means administered, taken, used, supplied, or procured was in fact capable of procuring miscarriage.

**187A Meaning of unlawfully**

(1) For the purposes of sections 183 and 186, any act specified in either of those sections is done unlawfully unless, in the case of a pregnancy of not more than 20 weeks' gestation, the person doing the act believes—

(a) that the continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health, of the woman or girl; or

(aa) that there is a substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped; or

(b) that the pregnancy is the result of sexual intercourse between—

(i) a parent and child; or

(ii) a brother and sister, whether of the whole blood or of the half blood; or

(iii) a grandparent and grandchild; or

(c) that the pregnancy is the result of sexual intercourse that constitutes an offence against section 131(1); or

(d) that the woman or girl is severely subnormal within the meaning of section 138(2).

(2) The following matters, while not in themselves grounds for any act specified in section 183 or section 186, may be taken into account in determining for the purposes of subsection (1)(a), whether the continuance of the pregnancy would result in serious danger to her life or to her physical or mental health:

(a) the age of the woman or girl concerned is near the beginning or the end of the usual child-bearing years:

(b) the fact (where such is the case) that there are reasonable grounds for believing that the pregnancy is the result of sexual violation.

(3) For the purposes of sections 183 and 186, any act specified in either of those sections is done unlawfully unless, in the case of a pregnancy of more than 20 weeks' gestation, the person doing the act believes that the miscarriage is necessary to save the life of the woman or girl or to prevent serious permanent injury to her physical or mental health.

(4) Where a medical practitioner, in pursuance of a certificate issued by 2 certifying consultants under section 33 of the Contraception, Sterilisation, and Abortion Act 1977, does any act specified in section 183 or section 186 of this Act, the doing of that act shall not be unlawful for the purposes of the section applicable unless it is proved that, at the time when he or she did that act, he or she did not believe it to be lawful in terms of subsection (1) or subsection (3), as the case may require.

**14 Functions and powers of Supervisory Committee**

(1) The Supervisory Committee shall have the following functions:

(a) to keep under review all the provisions of the abortion law, and the operation and effect of those provisions in practice:

(b) to receive, consider, grant, and refuse applications for licences or for the renewal of licences under this Act, and to revoke any such licence:

(c) to prescribe standards in respect of facilities to be provided in licensed institutions for the performance of abortions:

(d) to take all reasonable and practicable steps to ensure—

(i) that licensed institutions maintain adequate facilities for the performance of abortions; and

(ii) that all staff employed in licensed institutions in connection with the performance of abortions are competent:

(e) to take all reasonable and practicable steps to ensure that sufficient and adequate facilities are available throughout New Zealand for counselling women who may seek advice in relation to abortion:

(f) to recommend maximum fees that may be charged by any person in respect of the performance of an abortion in any licensed institution or class of licensed institutions, and maximum fees that may be charged by any licensed institution or class of licensed institutions for the performance of any services or the provision of any facilities in relation to any abortion:

(g) to obtain, monitor, analyse, collate, and disseminate information relating to the performance of abortions in New Zealand:

(h) to keep under review the procedure, prescribed by sections 32 and 33, whereby it is to be determined in any case whether the performance of an abortion would be justified:

(i) to take all reasonable and practicable steps to ensure that the administration of the abortion law is consistent throughout New Zealand, and to ensure the effective operation of this Act and the procedures thereunder:

(j) from time to time to report to and advise the Minister of Health and any district health board established by or under the New Zealand Public Health and Disability Act 2000 on the establishment of clinics and centres, and the provision of related facilities and services, in respect of contraception and sterilisation:

(k) to report annually to Parliament on the operation of the abortion law.

(2) The Supervisory Committee shall have all such reasonable powers, rights, and authorities as may be necessary to enable it to carry out its functions.

**18 Restrictions on where abortions may be performed**

(1) Subject to the provisions of this Act, no abortion shall be performed elsewhere than in an institution licensed for the purpose in accordance with this Act.

(2) Subject to the provisions of this Act, no abortion shall be performed, after the pregnancy has subsisted for at least 12 weeks, elsewhere than in an institution in respect of which a full licence is for the time being in force under this Act.

**19 Types and effect of licences**

(1) The Supervisory Committee may from time to time, in accordance with this Act, issue in respect of any institution—

(a) a full licence; or

(b) a limited licence.

(2) A full licence shall authorise the holder to permit the performance of abortions in the institution to which the licence relates regardless of the length of time for which the pregnancy has been continuing.

(3) A limited licence shall authorise the holder to permit the performance of abortions in the institution to which the licence relates only during the first 12 weeks of the pregnancy.

**29 Abortions not to be performed unless authorised by 2 certifying consultants**

Subject to the provisions of this Act, no abortion shall be performed unless and until it is authorised by 2 certifying consultants.

**30 Supervisory Committee to set up and maintain list of certifying consultants**

(1) The Supervisory Committee shall set up and maintain a list of medical practitioners (in this Act termed certifying consultants) who may be called upon to consider cases referred to them by any medical practitioner and determine, in accordance with section 33, whether to authorise an abortion.

(2) Before drawing up the list, the Supervisory Committee shall determine the minimum number of certifying consultants required to ensure, so far as possible, that every woman seeking an abortion has her case considered expeditiously, and shall make that number of appointments in accordance with this section. Thereafter, the Committee shall keep that number under review, and shall from time to time make such further appointments, or revoke such number of appointments, as it considers necessary to meet any change in the circumstances.

(3) Having determined the number of appointments to be made, the Supervisory Committee shall consult with the New Zealand Medical Association, and may consult with any other professional or other body, before determining whom to appoint.

(4) In making appointments to the list, the Supervisory Committee shall ensure that the following requirements are met:

(a) at least one-half of the total number of appointees shall be practising obstetricians or gynaecologists, and the list shall be marked in such a way as to indicate which of the appointees are so qualified:

(b) there shall be a sufficient number of appointees practising in each area of New Zealand to ensure that every woman seeking an abortion can have her case considered without involving her in considerable travelling or other inconvenience.

(5) In addition, in making such appointments, the Supervisory Committee shall have regard to the desirability of appointing medical practitioners whose assessment of cases coming before them will not be coloured by views in relation to abortion generally that are incompatible with the tenor of this Act. Without otherwise limiting the discretion of the Supervisory Committee in this regard, the following views shall be considered incompatible in that sense for the purposes of this subsection:

(a) that an abortion should not be performed in any circumstances:

(b) that the question of whether an abortion should or should not be performed in any case is entirely a matter for the woman and a doctor to decide.

(6) Every appointment to the list of certifying consultants shall be for a term of 1 year, but the Supervisory Committee may reappoint any practitioner on the expiry of his term.

(7) The Supervisory Committee may at any time, at its discretion, revoke the appointment of any certifying consultant.

**31 Supervisory Committee to appoint or approve counselling services**

(1) For the purposes of this Act, the Supervisory Committee shall from time to time—

(a) appoint suitably qualified persons to provide counselling services for persons considering having an abortion; or

(b) approve any agency for the provision of such counselling services.

(2) In appointing or approving persons or agencies for the provision of counselling services under this section, the Supervisory Committee shall have regard to the following matters:

(a) every counselling service should be directed by an experienced and professionally trained social worker:

(b) that suitably trained lay counsellors may also be used where there are insufficient professional social workers:

(c) every counsellor should be thoroughly familiar with all relevant social services and agencies, and able to advise patients, or refer them to appropriate agencies for advice, on alternatives to abortion, such as adoption and solo parenthood.

**32 Procedure where woman seeks abortion**

(1) Every medical practitioner (in this section referred to as the woman's own doctor) who is consulted by or in respect of a female who wishes to have an abortion shall, if requested to do so by or on behalf of that female, arrange for the case to be considered and dealt with in accordance with the succeeding provisions of this section and of section 33.

(2) If, after considering the case, the woman's own doctor considers that it may be one to which any of paragraphs (a) to (d) of subsection (1), or (as the case may require) subsection (3), of section 187A of the Crimes Act 1961 applies, he shall comply with whichever of the following provisions is applicable, namely:

(a) where he does not propose to perform the abortion himself, he shall refer the case to another medical practitioner (in this section referred to as the operating surgeon) who may be willing to perform an abortion (in the event of it being authorised in accordance with this Act); or

(b) where he proposes to perform the abortion himself (in the event of it being authorised in accordance with this Act), he shall—

(i) if he is himself a certifying consultant, refer the case to one other certifying consultant (who shall be a practising obstetrician or gynaecologist if the woman's own doctor is not) with a request that he, together with the woman's own doctor, determine, in accordance with section 33, whether or not to authorise the performance of an abortion; or

(ii) if he is not himself a certifying consultant, refer the case to 2 certifying consultants (of whom at least 1 shall be a practising obstetrician or gynaecologist) with a request that they determine, in accordance with section 33, whether or not to authorise the performance of an abortion.

(3) Where an operating surgeon to whom a case is referred under subsection (2)(a) is satisfied, after considering the case, that it is one to which any of paragraphs (a) to (d) of subsection (1), or (as the case may require) subsection (3), of section 187A of the Crimes Act 1961 applies, he shall, if he is willing to perform the abortion, either—

(a) if he is himself a certifying consultant, refer the case to 1 other certifying consultant (who shall be a practising obstetrician or gynaecologist if the operating surgeon is not, and who shall not be the woman's own doctor) with a request that he, together with the operating surgeon, determine, in accordance with section 33, whether or not to authorise an abortion; or

(b) if he is not himself a certifying consultant, refer the case to 2 certifying consultants (of whom at least 1 shall be a practising obstetrician or gynaecologist, and of whom 1 may be the woman's own doctor) with a request that they determine, in accordance with section 33, whether or not to authorise the performance of an abortion.

(4) Where any medical practitioner is required to refer any case to any other practitioner under this section, he shall refer it in accordance with the procedure for the time being prescribed by the Supervisory Committee.

(5) As soon as practicable after a case is referred to him, each certifying consultant shall consider the case and shall, if requested to do so by the patient, interview her; and at any such interview she shall be entitled to be accompanied by her own doctor (if he agrees).

(6) The woman's own doctor and the proposed operating surgeon shall be entitled (with the patient's consent) to make such representations and to adduce such medical or other reports concerning the case as he thinks fit to each certifying consultant.

(7) Every certifying consultant may, in considering any case, with the consent of the patient, consult with any other person (whether or not a medical practitioner) as he thinks fit in order to assist him in his consideration of the case, but he shall not disclose the patient's identity without her consent.

(8) Notwithstanding anything in this section, or in section 33, no certifying consultant shall be obliged to determine any case without first interviewing and examining the patient.

**33 Determination of case**

(1) If, after considering the case, the certifying consultants are of the opinion that the case is one to which any of paragraphs (a) to (d) of subsection (1), or (as the case may require) subsection (3), of section 187A of the Crimes Act 1961 applies, they shall forthwith issue in accordance with subsection (5) of this section, a certificate in the prescribed form authorising the performance of an abortion.

(2) If the certifying consultants are of the contrary opinion, they shall refuse to authorise the performance of an abortion.

(3) If one of the certifying consultants is of the opinion that the case is one to which any of the said provisions applies and the other consultant is of the contrary opinion, they shall refer the case to another medical practitioner for his opinion, being a medical practitioner who is on the list of certifying consultants maintained under section 30(1).

(4) If that other medical practitioner is of the opinion that the case is one to which any of the said provisions applies, the certifying consultant who is of the same opinion shall issue, in accordance with subsection (5), a certificate in the prescribed form authorising the performance of an abortion.

(5) Where 2 certifying consultants determine that they should authorise an abortion, they shall forward the said certificate to the holder of the licence in respect of the licensed institution in which the abortion is to be performed.

(5A) Where the operating surgeon is not one of the certifying consultants issuing the certificate, he shall endorse on the certificate a statement that he is willing to perform an abortion on the patient to whom the certificate relates, but a failure to comply with this requirement shall not invalidate the certificate for the purposes of section 37(1)(b) of this Act or section 187A(4) of the Crimes Act 1961.

(6) If, in respect of any case, any certifying consultant has not reached a decision within 14 days after it was referred to him, he shall advise the Supervisory Committee in writing of the matter, and of the reasons for the delay.

**35 Counselling**

When the certifying consultants have made a decision in any case (whether they have decided to authorise or to refuse to authorise the performance of an abortion), they shall (in consultation, where practicable, with the woman's own doctor) advise her of her right to seek counselling from any appropriate person or agency.

**37 Offences**

(1) Every person who—

(a) performs an abortion elsewhere than in a licensed institution; or

(b) performs an abortion otherwise than in pursuance of a certificate issued by 2 certifying consultants under section 33,—

commits an offence and is liable on conviction to imprisonment for a term not exceeding 6 months or a fine not exceeding $1,000.

(2) Nothing in subsection (1) shall apply to the performance of an abortion by a medical practitioner who believes that abortion is immediately necessary to save the life of the patient or to prevent serious permanent injury to her physical or mental health.

(3) It shall be a defence to a charge brought under subsection (1)(b) if the defendant shows that he believed that a certificate had been issued in respect of the patient.

**44 Female procuring her own miscarriage**

(1) Every female commits an offence and is liable on conviction to a fine not exceeding $200 who, with intent to procure miscarriage, whether she is pregnant or not,—

(a) unlawfully administers to herself, or permits to be administered to her, any poison or any drug or any noxious thing; or

(b) unlawfully uses on herself, or permits to be used on her, any instrument; or

(c) unlawfully uses on herself, or permits to be used on her, any other means whatsoever.

(2) For the purposes of subsection (1) the term miscarriage means—

(a) the destruction or death of an embryo or fetus after implantation; or

(b) the premature expulsion or removal of an embryo or fetus after implantation, otherwise than for the purpose of inducing the birth of a fetus believed to be viable or removing a fetus that has died.

(3) For the purpose of determining whether any act referred to in subsection (1) is or is not done unlawfully the provisions of section 187A of the Crimes Act 1961, so far as they are applicable and with the necessary modifications, shall apply.

(4) The provisions of subsection (1) shall apply whether or not the poison, drug, thing, instrument, or means administered or used was in fact capable of procuring miscarriage.

**46 Conscientious objection**

(1) Notwithstanding anything in any other enactment, or any rule of law, or the terms of any oath or of any contract (whether of employment or otherwise), no medical practitioner, nurse, or other person shall be under any obligation—

(a) to perform or assist in the performance of an abortion or any operation undertaken or to be undertaken for the purpose of rendering the patient sterile:

(b) to fit or assist in the fitting, or supply or administer or assist in the supply or administering, of any contraceptive, or to offer or give any advice relating to contraception,—

if he objects to doing so on grounds of conscience.

(2) It shall be unlawful for any employer—

(a) to deny to any employee or prospective employee any employment, accommodation, goods, service, right, title, privilege, or benefit merely because that employee or prospective employee objects on grounds of conscience to do any act referred to in subsection (1); or

(b) to make the provision or grant to any employee or prospective employee of any employment, accommodation, goods, service, right, title, privilege, or benefit conditional upon that other person doing or agreeing to do any thing referred to in that subsection.

(3) Every person who suffers any loss by reason of any act or omission rendered unlawful by subsection (2) shall be entitled to recover damages from the person responsible for the act or omission.

(4) Nothing in this section limits or affects the provisions of section 5.

Health Practitioners Competence Assurance Act 2003

**174 Duty of health practitioners in respect of reproductive health services**

(1) This section applies whenever—

(a) a person requests a health practitioner to provide a service (including, without limitation, advice) with respect to contraception, sterilisation, or other reproductive health services; and

(b) the health practitioner objects on the ground of conscience to providing the service.

(2) When this section applies, the health practitioner must inform the person who requests the service that he or she can obtain the service from another health practitioner or from a family planning clinic.