Details make the difference: A critique of New Zealand's proposed abortion law

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Table of Contents

Introduction

Abortion is an unavoidable fact, with 18% of all pregnancies in New Zealand being terminated and 25% of women having had an abortion in their lifetime.[1] Currently, in order to get an abortion, New Zealand women are required to meet a very narrow test to give their operating doctor a defence to a crime with a maximum sentence of 14 years. The current legislation, which continues to treat abortion as a criminal activity, was enacted during the 1970s:[2]

> It was a time when the law supported a man's right to sex with his wife regardless of whether she wanted it or not, a time when men were also legally sanctioned to administer moderate physical correction to their wives.

Abortion law reform is well overdue and the new Abortion Legislation Bill (the Bill) has brought debate over this morally fraught issue back into the limelight. The Bill proposes to decriminalise abortion, legalising it up until 20 weeks gestation, after which it takes a medical approach by leaving the decision of whether an abortion is "appropriate" with the medical practitioner. Vitally, the Bill aims to improve women's access to abortion services; protecting their right to reproductive freedom and ensuring the decision is treated as a health matter.

Drawing on a range of arguments, this dissertation claims the Government should adopt a permissive regime with complete legalisation at all gestations and with mechanisms in place to ensure sufficient access to abortion services for all New Zealand women. This places a focus on the ability for women to make life-changing decisions for themselves, while being supported adequately by a medical practitioner. Therefore, while the Bill is effective in its decriminalisation of abortion, this dissertation will argue the Bill should not include a gestational limit.

This analysis is developed over four chapters. Chapter I will describe the current legal framework and explain how it is applied in practice, demonstrating how the law is ineffective and disconnected from the realities of abortion practice. It will then chronicle the process leading to the formulation of the proposed Bill. Chapter II will argue for decriminalisation, using both rights-based and moral justifications. Chapter III will consider the distinctions between legalised and medicalised approaches and will consider gestational limits more

[1] *Report of the Abortion Supervisory Committee* (Annual Report, 2018).
[2] (8 August 2019) 739 NZPD (Abortion Legislation Bill – Jan Logie).

specifically. Finally, Chapter IV will consider the ancillary elements of the Bill, such as ensuring proper access to services, including specific consideration of safe zones, conscientious objection and the ability of Māori women to access services.

This dissertation does not purport to address every issue relevant to the Bill, rather it considers the major issues relating to how the new legal framework should be formulated.

I. The current law and the tides of change

Understanding the necessity for law reform with respect to abortion in New Zealand requires an appreciation for the current legislative framework and its application in practice. There is a significant disconnect between the two[3] which, along with the fact the current law is problematically restrictive, has been one of the main drivers for change.

Abortion law re-emerged into the political arena with the 2017 change of government. Minister for Justice Andrew Little requested the Law Commission consider possible options for reform.[4] This ultimately led to the introduction of a Bill to the House of Representatives on 8 August 2019, proposing to decriminalise abortion.

A. The legislative framework

Currently abortion is regulated by the Contraception, Sterilisation, and Abortion Act 1977 (*CSAA*) and the Crimes Act 1961 (*CA*).

Under s 183 of the CA it is an offence to unlawfully administer a drug, to use an instrument, or to use any other means "with intent to procure the miscarriage of any woman or girl". However, an offence under s 183 will not be committed if two certifying consultants are of the opinion that the abortion comes within one of the grounds listed in the CA. Grounds under 20 weeks include:[5]

- "if continuing the pregnancy would result in serious danger [...] to the life, physical health or mental health of the woman";
- any form of incest;
- mental sub-normality of the woman; and
- if there is a substantial risk that the child, if born, would be "so physically or mentally abnormal as to be seriously handicapped".

Other factors which are not grounds, but which can be accounted for are:[6]

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[3] *Right To Life New Zealand Inc v The Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) at [50]-[52] and [135].
[4] Ken Orr "Abortion a justice issue, not a health issue" *The Gisborne Herald* (online ed, Gisborne, 12 April 2018).
[5] Crimes Act 1961 (CA), s 187A(1).
[6] Section 187A(2).

- extremes of age; and
- sexual violation.

After 20 weeks, grounds include:[7]

- "to save the life of the mother or girl; or
- to prevent serious permanent injury to [her] physical or mental health."

The CSAA establishes the process for authorising abortions within the CA grounds. A woman may request an abortion from her doctor. If her doctor believes a ground may apply they can refer the individual "to another medical practitioner […] who may be willing to perform [the] abortion".[8] The law states the abortion must be carried out at a licensed institution, by an "operating surgeon"[9] and, as discussed, in pursuance of a certificate issued by two "certifying consultants".[10] An institution is licensed by the Abortion Supervisory Committee (ASC).[11] There are "full" and "limited" licences which allow abortions to be performed at any point during pregnancy and within the first 12 weeks only, respectively.[12]

Therefore, in order for a woman to procure an abortion, two certifying consultants must consider that one of the grounds in s 187A apply.[13] One of the consultants must be an obstetrician or a gynaecologist.[14] In considering a request, the consultant must interview the woman if she requests,[15] may consult with another person to assist in the determination if the woman agrees,[16] and may receive information from the doctor or operating surgeon.[17] However, the consultant is not required to interview or examine the woman in making their decision.[18] If the certifying consultant decides a ground applies, they will issue a certificate

[7] Section 187A(3).
[8] Contraception, Sterilisation, and Abortion Act 1977 (CSAA), s 32(2)(a).
[9] The individual who will perform the abortion.
[10] Section 29. As otherwise, to do so is an offence under s 37(1), as well as the CA. There is an exception under s 37(2) for if it is necessary for immediate action to be taken to save the life of the patient or prevent serious permanent injury to one's physical or mental health..
[11] Section 18.
[12] Section 19.
[13] Sections 32(5) and 33(1).
[14] Section 32(2)(b).
[15] Section 32(5).
[16] Section 32(7).
[17] Section 32(6).
[18] Section 32(8).

authorising the abortion,[19] if both decide no grounds apply the abortion is refused,[20] or if they disagree, then the case is referred to a third certifying consultant to determine the matter.[21]

No doctor is required to consent or assist with an abortion if they have a conscientious objection, even if one of the grounds applies and it would be lawful.[22] Furthermore, a doctor can refuse to organise for the woman's case to be considered in accordance with the process in the CSAA, and is only required to inform the woman she could obtain a referral elsewhere.[23]

Once the decision of a certifying consultant is made, it cannot be reviewed by the ASC 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".[24]

B. Practical application

The number of abortions performed in New Zealand is generally decreasing.[25] The most striking statistics are those regarding which grounds abortions in New Zealand are certified under. In 2017, 97.3% of all abortions were granted on the basis of danger to mental health, with 0.7% on the basis of danger to both mental and physical health, 0.8% on the basis of danger to mental health and having a severely handicapped child, and a negligible few on the basis of danger to both mental health and life.[26] This means that, overall, around 98.9% of all abortions carried out in New Zealand employ danger to the mental health of the woman as a justifying ground. This high percentage arguably demonstrates the disconnect between the law and abortion practice: clinicians are enabling access to abortion on the basis of a general liberal application of the mental health ground.

The High Court in *Right To Life New Zealand Inc v The Abortion Supervisory Committee* commented that the high percentage of women receiving abortions on this ground suggests certifying consultants are employing the mental health ground in a much more "liberal fashion

[19] Section 33(1).
[20] Section 33(2).
[21] Sections 33(3) and (4).
[22] Section 46.
[23] *Hallagan v Medical Council of New Zealand* HC Wellington CIV-2010-485-222, 2 December 2010.
[24] *Right To Life New Zealand Inc v The Abortion Supervisory Committee* [2012] NZSC 68, [2012] 3 NZLR at [40].
[25] *Report of the Abortion Supervisory Committee*, above n 1, at 6.
[26] At 21.

than the legislature intended".[27] This has been affirmed by the ASC in stating the "wording has come to have a de facto liberal interpretation" and is not "working as originally intended".[28]

Despite a liberal approach being taken, there are reports of abortions being deemed unjustified by certifying consultants. In 2013-17, certifying consultants found 1309 requests for abortion were not justified under the CA grounds and were therefore rejected.[29] Having said this, women are still open to visit a different certifying consultant, and some of these denials may have been where the woman was genuinely ambivalent as to the decision. These statistics do not account for situations where a general-practitioner fails to refer the woman because of a conscientious objection, which can also impact access. In one case, two women who discovered they were pregnant at 18 weeks were denied a referral to a certifying consultant on the basis their pregnancies were "too advanced", despite not yet not being 20 weeks pregnant when services were sought.[30]

Access to abortion services is also highly relevant and will be examined further in Chapter IV. The ASC have noted the provision of safe and legal abortions is inconsistent throughout the country.[31] As of 20 June 2018 there were only 168 certifying consultants across the country.[32] Furthermore, as of 2010 the average time between first contact with the health system and the date of termination was estimated to be 24.9 days.[33] The ASC have drawn attention to certain areas where access is limited, such as in Counties-Manukau where there are no providers, and in Auckland which only has one main public service.[34] However, they have no power to require the provision of services in a particular area and are limited to recommending a woman should not have to travel more than two hours to receive an abortion.[35] Moreoever, there is no evidence this recommendation has been realised.

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[27] *Right To Life New Zealand*, above n 3, at [135].
[28] At [50]-[52].
[29] "Abortions Denied and Grounds Official Information Act Request" (27 August 2017) at 2 (Obtained under Official Information Act 1982 Request to the Abortion Supervisory Committee).
[30] Susan Strongman "No Choice: when legal abortion is denied" *The New Zealand Herald* (online ed, Auckland, 19 September 2017) and Sarah Harris "Denied abortion: Woman discovers pregnancy at 4 months, 2 weeks" *The New Zealand Herald* (online ed, Auckland, 15 October 2017).
[31] *Right To Life New Zealand*, above n 3, at [51].
[32] *Report of the Abortion Supervisory Committee*, above n 1, at 29.
[33] Silva Martha, Rob McNeill and Toni Ashton "Ladies in waiting: the timeliness of first trimester services in New Zealand" (2010) 7(1) Reproductive Health 19 at 5.
[34] *Report of the Abortion Supervisory Committee* (Annual Report, 2017) at 5.
[35] At 12.

There are two types of abortions performed in New Zealand; a medical abortion which involves taking drugs (mifepristone and misoprostol) to induce a miscarriage, and a surgical abortion, which either involves vacuum aspiration or dilation and evacuation. Typically in the first 9 weeks of pregnancy a medical abortion is preferred, although surgical abortions are offered. Between 9 to 14 weeks of pregnancy a larger dose of mifepristone is required.[36] If a surgical abortion is opted for the vacuum aspiration method is used. By the second trimester the only option is a surgical abortion, involving dilation and evacuation and by late stages of pregnancy this process first requires feticide.[37] These processes take time, for example even for a medical abortion the law requires the drugs to be given on licensed premises over two days,[38] which complicates access.[39]

C. A call for change

The current position, which imposes significant barriers to access, has been readily criticised. Ever since the current legislation was enacted there have been calls for liberalisation. With surprisingly high reports of women being denied abortions,[40] this is a live issue.

1. An outdated approach

As discussed, and as noted by the ASC, the law "no longer aligns with modern healthcare practices".[41] Certifying consultants generally elect to take liberal interpretations and while their decisions cannot be questioned by the ASC,[42] such a generous expansion of the legal test places them at risk of prosecution.[43] Doctors can be victims when abortions are not performed appropriately or safely and when abortion law does not align with practice.

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[36] At 38.
[37] Royal College of Obstetricians and Gynaecologists Working Group *Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales* (RCOG Press, May 2010) at 31; Royal College of Obstetricians and Gynaecologists *The Care of Women Requesting Induced Abortion: Evidence-based clinical guideline number 7* (RCOG Press, November 2011) at 57.
[38] *Report of the Abortion Supervisory Committee*, above n 34, at 38.
[39] *Report of the Abortion Supervisory Committee*, above n 1, at 5. The ASC have suggested that the second dose should be able to be taken at home, but the uptake of this suggestion remains an ongoing concern.
[40] "Abortions Denied and Grounds Official Information Act Request," above n 29, at 2.
[41] *Report of the Abortion Supervisory Committee*, above n 1, at 4.
[42] *Right To Life New Zealand*, above n 24, at [40].
[43] CA, s 182.

However, the main victim of such a framework is women. A liberal interpretation is not taken consistently,[44] which is contrary to the rule of law as valid and effective law should, where possible, be predictable, non-arbitrary and clear.[45] Furthermore, as the ASC have pointed out, even the language in the current law is outdated. The statute refers to doctors as "he", uses terms such as "woman's own doctor", which ignores specialised services such as Family Planning, and refers to "severely subnormal" women which is derogatory and inappropriate in contemporary times.[46]

2. International influence

Another driver for reform is international influence. New Zealand's abortion law is amongst the eight most restrictive legal frameworks in the developed world.[47] The Guttmacher Institute[48] characterised international approaches to abortion law into six categories, one being the least restrictive and six the most.[49] New Zealand falls into category four.[50]

There is also an international trend to liberalise approaches to abortion law. [51] Since 2000, Switzerland, Australia and Ireland, amongst 25 other countries, have moved to broaden their criteria for what constitutes a legal abortion.[52] A report by the United Nations Department of Economic and Social Affairs noted that in 2013 more than one third of member states permitted abortions for economic or social reasons, an increase from 1996, while another 30% allowed abortions upon request, an increase from 24% in 1996.[53]

New Zealand is also subject to direct international pressure to liberalise its laws. In 2012 the United Nations Committee on the Convention on the Elimination of All Forms of Discrimination Against Women suggested New Zealand's approach makes "women dependent on the benevolent interpretation of a rule which nullifies their autonomy", and noted

[44] *Right To Life New Zealand*, above n 3, at [51].
[45] The Rt. Hon. Lord Thomas Bingham, House of Lords "The Rule of Law" (Sixth Sir David Williams Lecture, Centre for Public Law, 16 November 2006).
[46] *Report of the Abortion Supervisory Committee* (Annual Report, 2016) at 4.
[47] Susheela Singh and others *Abortion Worldwide 2017: Uneven Progress and Unequal Access* (Guttmacher Institute, 2017) at 15-16.
[48] A research organisation which, among other things, investigates sexual and reproductive health and rights.
[49] At 14.
[50] At 21.
[51] Ignoring state specific restrictions being implemented in the United States of America.
[52] At 18.
[53] United Nations Department of Economic and Social Affairs, Population Division A*bortion Policies and Reproductive Health around the World* ST/ESA/SER.A/343 (2014) at 6.

criminalisation leads to women seeking "illegal abortions, which are often unsafe".[54] In 2019 a Universal Periodic Review by the United Nations Human Rights Council considered New Zealand's human rights record and compared this to international human rights treaties and standards. During the review, a number of member states recommended that New Zealand remove abortion from the CA and address abortion as a health issue.[55]

3. Political movements

Following such reports and international suggestions, during the last election campaign then-leader of the Labour party, Jacinda Ardern, declared her intention to decriminalise abortion should Labour be elected.[56] After the Labour coalition government was established Andrew Little, Minister of Justice, requested that the Law Commission consider options for reform.[57] This led to a significant increase in debate surrounding the issue and, more importantly, to the Law Commission report: *Alternative Approaches to Abortion Law*.

4. Public opinion

A final element supporting abortion reform is public opinion. At the time of the 2017 election, poll results showed a majority of New Zealanders supported the right to access abortion on request.[58] This was also shown in a 2017 survey conducted by the New Zealand Election Study where 63.3% of New Zealanders disagreed with the statement "abortion is always wrong", an increase from 55.4% in 2008.[59] Then in 2019 a study published in the New Zealand Medical Journal involving 20,000 participants showed a majority of those surveyed either strongly agree, or agree, that abortion should be legal, regardless of the reason.[60] They concluded that legislative reform would be well received by the public.[61]

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[54] Convention on the Elimination of All Forms of Discrimination against Women LII CEDAW/C/NZL/CO/7 (2012) at 9.
[55] *Human Rights Council Working Group on the Universal Periodic Review* 32nd Session UN Doc A/HRC/WG.6/32/NZL/3 (21 January 2019) at 8.
[56] Eleanor Ainge Roy "New Zealand election: Jacinda Ardern pledges to decriminalise abortion" *The Guardian* (online ed, Dunedin, 5 September 2017).
[57] Orr, above n 4.
[58] Abortion Law Reform Association of New Zealand "Labour Party Supports Decriminalisation of Abortion" *Scoop* (online ed, Wellington, 5 September 2017).
[59] New Zealand Election Study "New Zealand Election Study" (19 August 2019) <http://www.nzes.org/exec/show/index>.
[60] Yanshu Huang, Danny Osborne and Chris G Sibley "Sociodemographic factors associated with attitudes towards abortion in New Zealand" (2019) 1497 NZMJ 9 at 13.
[61] At 18.

D. Law Commission recommendations

The Law Commission proposed three possible methods of reform, all removing abortion from the CA and instead treating abortion as a health issue. These proposals were:[62]

A No statutory test must be satisfied and the decision is made as any other health decision would be.

B The test would be in health legislation and would be that "the health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman's physical and mental health and wellbeing".

C For pregnancies of less than 22 weeks it would be the same as option A and for pregnancies longer than 22 weeks option B would apply.

The Commission recommended against option B, as it is most restrictive and by leaving the decision in the hands of health practitioner rather than the individual whose physical body is concerned, it actively discriminates against women.[63]

The Commission also made several other recommendations aimed at improving access such as; removing the requirement for abortions to be performed by a doctor,[64] allowing women to self-refer,[65] removing the requirement for abortions to occur in a licensed institution[66] and requiring health practitioners with conscientious objections to refer a woman to another health practitioner.[67]

Overall, the Commission's recommendations were aimed at promoting women's autonomy,[68] improving access to services,[69] prioritising women's health and wellbeing,[70] and aligning the New Zealand approach with comparable jurisdictions.

[62] Law Commission *Alternative Approaches to Abortion Law* (NZLC MB4, 2018) at 76.
[63] At 85.
[64] At 113 and 131.
[65] At 126.
[66] At 128.
[67] At 162.
[68] At 77.
[69] At 78.
[70] At 81.

E. The Abortion Legislation Bill

The Abortion Legislation Bill was introduced into Parliament in August 2019. Following consideration of the Law Commission's recommendations, the Bill adopts option C, but with a 20-week gestational limit rather than the Commission's recommended 22 weeks.[71] The main changes proposed in the Bill are:

- removing any statutory test for a woman who is not more than 20 weeks pregnant;[72]
- for a woman who is more than 20 weeks pregnant, requiring the heath practitioner to reasonably believe the abortion is "appropriate with regard to the pregnant woman's physical health, mental health, and well-being";[73]
- to remove any requirement that a certifying consultant or operating surgeon be involved, and instead allow any qualified health practitioner to provide the service;[74]
- health practitioners must advise women of the availability of counselling services, although such services will not be mandatory;[75]
- women may self-refer to an abortion service provider rather than requiring referral from her healthcare provider;[76]
- create a case-by-case regulation-making power for the Minister of Health to establish "safe areas" around abortion facilities;[77]
- disbanding the ASC. Oversight of the regime will be the responsibility of the Ministry of Health and the professional bodies to which health professionals belong;[78]
- require conscientious objectors to inform the pregnant women about their objection at the earliest opportunity and require them to inform the woman she can obtain services elsewhere;[79] and
- retain the criminal offence for persons other than health practitioners who attempt to procure an abortion for a pregnant woman or supply the means, and the criminal offence

[71] Boris Jancic, Derek Cheng and Jason Walls "Abortion law passes first vote in Parliament 94-23" *The New Zealand Herald* (online ed, 8 August 2019).
[72] Abortion Legislation Bill 2019 (164-1) (Abortion Legislation Bill), s 7 (proposed s 10, CSAA).
[73] Section 7 (proposed s 11, CSAA).
[74] Section 7 (proposed ss 10 and 11, CSAA).
[75] Section 7 (proposed s 13, CSAA). The Minister of Health is required to ensure the availability of counselling services for abortion when entering into Crown funding agreements, as per s 7 (proposed s 12, CSAA).
[76] Section 7 (proposed s 14, CSAA).
[77] Section 7 (proposed s 17, CSAA). In such safe areas it would be prohibited to intimidate, interfere with or obstruct a person with the intention of preventing that person or being reckless as to whether they are prevented from accessing abortion services, seeking advice on such services or providing such services, as per s 7 (proposed s 15, CSAA).
[78] Section 14 and New Schedule to be inserted into the CSAA.
[79] Section 7 (proposed s 19, CSAA).

of killing an unborn child for any person who causes harm to a pregnant woman and in doing so causes the death of a fetus. [80]

All but the last of the nine changes listed above would require amendments to the CSAA to align the legal framework with the regulation of other health services. This removes rules which; restrict where abortions may be performed,[81] require counselling services[82] and outline procedures for when there is a lack of capacity to consent.[83] The CA would be amended to decriminalise abortion repealing all offences relating to abortions performed by medical practitioners.[84] Finally, the Health Practitioners Competence Assurance Act 2003 would be amended to align with the CSAA on conscientious objection.

The Bill is being treated as a conscience issue with members voting based on personal beliefs. It passed easily through its first reading in the House, with 94 in favour and 23 against.[85] Debate suggested the main issues with the Bill that would require further consideration were the gestational limit at 20 weeks and the proposed safe areas.[86] The Bill has been referred to a Select Committee to hear submissions and report back on the issue.[87]

[80] Section 12 (proposed s 183, CA).
[81] CSAA, previously s 18.
[82] Previously s 31.
[83] Previously s 34.
[84] Health practitioners who do not follow the relevant protocol can instead be sanctioned under the discipline regime under the Health Practitioners Competence Assurance Act 2003.
[85] Jancic, Cheng and Walls, above n 71.
[86] (8 August 2019) 739 NZPD (Abortion Legislation Bill – Chris Penk, Ian McKelvie, David Seymour, Anne Tolley, David Parker and Priyanca Radhakrishnan). Dealt with in Chapters III and IVC.
[87] (8 August 2019) 739 NZPD (Abortion Legislation Bill – Andrew Little).

II. Arguments for change

Currently the Bill leaves the decision of whether to get an abortion entirely up to the pregnant woman, at least up until 20 weeks. Where liberal approaches can be justified, they are most commonly and often most convincingly argued for from a right-based perspective. However, there are strong moral arguments in support also. While there is no consensus on which approach best justifies liberalisation, this chapter will argue that overall there are strong justifications supporting the decriminalisation of abortion.

A. A rights-based approach

The most common discourse in the abortion debate is a rights-based approach.

1. Enforceable rights of the woman and the unborn child

Such an approach has been used by overseas jurisdictions with entrenched rights instruments to liberalise abortion law. The United States Supreme Court in *Roe v. Wade* determined that, at least in the early stages of pregnancy, there is a right to access abortion on the basis of a constitutional "right to privacy" premised on Constitutional guarantees to liberty. Such a right to privacy protects the woman's decision on whether or not to terminate a pregnancy.[88] The same was determined in Canada in *R v Morgentaler* where it was held the right to privacy related to the ability to make important decisions about one's own life and to have bodily autonomy.[89]

In comparison, New Zealand lacks an entrenched rights document. Courts are limited to issuing a declaration that the current legislation is inconsistent with the New Zealand Bill of Rights Act 1990 (NZBORA).[90] It is also judicially established that there is no specific right to abortion under the NZBORA because, unlike the other jurisdictions discussed, the NZBORA has no guarantee to liberty and security of person.[91] However, despite a lack of judicial redress, to uphold such rights is something Parliament should consider and these rights are still valued. For example, the Privacy Commissioner submitted to the Law Commission, stating the existing

[88] *Roe v. Wade*, 410 U.S. 113 (1973) at 113 and 153.
[89] *R v Morgentaler* [1998] 1 SCR 30 (SCC) at.
[90] *AG v Taylor* [2018] NZSC 104.
[91] *Right to Life New Zealand*, above n 3, at [98]. This issue was not addressed on appeal, but the Supreme Court did commend the High Court's comments, *Right To Life New Zealand*, above n 24, at [64].

law was "inadequate to protect women seeking to exercise a choice relating to their own reproductive rights".[92]

The courts have also held the fetus has no enforceable rights. Although the CSAA states in its long title that full regard should be had to the "rights of the unborn child", it is judicially established the fetus has no enforceable legal rights[93] as it is not a legal person[94] and New Zealand generally adheres to the born alive rule.[95] This is consistent with the approaches taken in Canada[96] and the USA.[97] English and Canadian courts have even gone so far as to claim the fetus has no rights which prevail over the woman's because the fetus and its mother cannot be considered separate legal people.[98] Furthermore, Crown Law have considered the Bill and concluded decriminalising abortion does not engage the right not be deprived of life under s 8 of the NZBORA as the fetus has no enforceable rights.[99]

Having said this, it is challenging to argue the fetus has no interests whatsoever. This sentiment is currently expressed in legislation. In *Wall v Livingston* Woodhouse P. noted the CSAA still prescribes specific precautionary requirements to balance the "deep philosophical, moral and social attitudes" which existed when the legislation was drafted.[100] Fetal life is not entirely inconsequential and therefore, when making a rights based assessment, moral arguments impact the discussion and fetal interests must be balance to some extent.

2. International Obligations

International obligations also suggest permissive reform is more rights consistent. The Beijing Declaration and Platform for Action, to which NZ is a signatory, noted that women's ability to control their own fertility is an important basis for the enjoyment of other rights and includes the "right to make decisions concerning reproduction free of discrimination, coercion and

[92] Law Commission, above n 62, at 54.
[93] *Wall v Livingston* [1982] 1 NZLR 734 (CA) at 737, *Harrild v Director of Proceedings* [2003] 3 NZLR 289 (CA) and *Right to Life New Zealand*, above n 24, at [1].
[94] *Harrild v Director of Proceedings*, above n 93.
[95] *Right to Life New Zealand*, above n 3, at [81], citing *Harrild v Director of Proceedings,* above n 93.
[96] Canadian Charter of Rights and Freedoms, s 7, pt 1 of the Constitution Act 1982, being sch B to the Canada Act 1982 (UK). Discussed in *Tremblay v Daigle* [1989] 2 SCR 530 (SCC).
[97] Concerning the United States Constitution, amend XIV, § 1. Discussed in *Roe v Wade*, above n 88, at 158.
[98] This is in the context of the right to decline treatment, *St George's Healthcare NHS Trust v S* [1999] Fam 26 (EWCA) and *Winnipeg Child & Family Services (Northwest Area) v G* [1997] 3 SCR 925 (SCC).
[99] Matt McKillop *Abortion Legislation Bill – consistency with New Zealand Bill of Rights Act 1990* (Crown Law, ATT395/294, 1 August 2019) at 14.
[100] At 737.

violence".[101] Furthermore, the United Nations Special Rapporteur on the Right to Health notes criminal laws such as New Zealand's, which penalise and restrict abortions, are "paradigmatic examples of impermissible barriers to the realisation of women's right to health and must be eliminated".[102]

Moreover, the position in New Zealand that the fetus has no enforceable rights is consistent with the United Nations Human Rights Committee's recent General Comment No. 36 on article 6 of the International Covenant on Civil and Political Rights (the right to life) which does not refer to a fetal right to life and instead focuses on protecting women from unsafe abortions.[103]

3. Other conceptions of women's rights

Alternative rights can also be advanced in the New Zealand context to justify a pro-choice stance. For example, recently six women and the Abortion Law Reform Association of New Zealand (ALRANZ) complained to the Human Rights Commission alleging abortion laws are inconsistent with s 19 of the NZBORA, freedom from discrimination. The Human Rights Act 1993 includes sex and pregnancy as grounds for discrimination.[104] ALRANZ alleged the law is discriminatory as pregnant women seeking healthcare receive demonstrably worse treatment than others seeking healthcare as no other individual must seek approval from certifying consultants; can be denied healthcare because their reasons are not those listed in the CA; is forced to lie to doctors about their mental health status; is subject to arbitrary and unpredictable withholding of healthcare; or is subject to possible refusal of services because of the provider's conscience with no warning or recourse.[105]

4. A balance of rights and interests

Despite the need for the interests of the fetus to be considered, these are merely interests and not rights. Leaving the choice of whether to terminate a pregnancy with women better upholds reproductive rights and rights to bodily autonomy, even if such rights do not explicitly exist in

[101] United Nation's Fourth World Conference on Women *The Beijing Declaration and Platform for Action* A/CONF.177/20 (1995) at [94]-[95].
[102] Special Rapporteur of the Human Rights Council *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health* A/66/254 (2011) at [21].
[103] United Nations Human Rights Committee *General comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life* CCPR/C/GC/36 (2018) at [8].
[104] Human Rights Act 1993 (HRA), s 21(a).
[105] Abortion Law Reform Association of New Zealand "ALRANZ's Complaint to the Human Rights Commission" (26 August 2019) ALRANZ Abortion Rights Aotearoa <http://alranz.org/human-rights-complaint/>.

the NZBORA. The Bill, with a permissive approach, would better maintain this right to choose and uphold international obligations.

5. Critiques of such an approach

While a rights-based approach effectively justifies liberalisation, there are significant critiques of the approach. The counterargument is that rights talk should be rejected in favour of other forms of discourse.

Rights theory is criticised generally as there can be bias in both enforcement and the individualistic rights which tend to be protected.[106] Moreover, rights-based discussions are excessively adversarial where protagonists take absolute positions.[107] As can be seen by the cases already cited, this prevents nuanced debate as to what good policy should look like and results in litigation where there is one winner.

Ronald Beiner discusses this specifically in the context of abortion. He suggests abortion debate cannot focus on the competing rights of women and the unborn child, as the decision of who should succeed is left to be determined by the interaction of opposing lawyers and the courts who are not equipped to do so.[108] To credit one right is to automatically impugn the other and if a right can be discredited then it may not be a right at all, giving such discourse an "absolutist and sometimes even fanatical character".[109] A rights-based argument is unavoidably based on moral conceptions of good and Beiner argues using the label of "rights" merely gives a valid and definite gloss to moral arguments.[110] The alternative is to approach discourse from a moral and political angle to allow transparent debate which accounts for the welfare of all. Catriona McKenzie also articulates a similar point of view. She suggests such debate misrepresents the nature of abortion decisions, ignoring the connection between the woman and fetus and the reasons why the right to choose is vital for female bodily autonomy.[111]

[106] Morton Horwitz "Rights" (1988) 23 Harv Civ R/Civ Lib L Rev 393 at 399-400.
[107] Tom Campbell *The Left and Rights: A Conceptual Analysis of the Idea of Socialist Rights* (Routledge & Kegan Paul, Boston, 1983).
[108] Ronald Beiner *What's the matter with Liberalism* (University of California Press, Berkeley, 1992) at 84 and 96.
[109] At 84 and 86.
[110] At 82-83.
[111] Catriona Mackenzie "Abortion and embodiment" (1992) 70(2) Australasian journal of philosophy 136 at 137.

Therefore, New Zealand's process, where the courts are not determining the law through an exclusively rights-based approach, but rather where reform is a matter of policy for Parliament to debate and legislate on, is likely a process such critics would approve of. It allows for clinical input and public contribution to be accounted for.

B. Philosophical and moral perspectives

For more nuanced discussion, moral and deontological arguments should be considered. While these are not entirely disconnected from rights-based discussions, they combat some of the issues with pure rights-based approaches. There are several formulations of this argument which focus on; the fetus, the connection between the woman and the fetus, just the woman herself or the importance of choice.

1. Focus on the fetus

The main argument of the pro-life movement centers on three central propositions; that it is wrong to kill innocent humans, that the fetus is an innocent human being, and therefore it is unjust and the law should prohibit the killing of a fetus.[112] This non-consequentialist view faces criticism as while the fetus is a biological human being, it might not be a moral human being nor have personhood.

An early formulation of this response came from philosopher Mary Anne Warren. She argues that in order to be a person, one must have consciousness, reasoning, be able to undergo self-motivated activity, communicate and have self-awareness. Although all are not required, if only one exists that being cannot be considered a person.[113] The fetus has at most one of these requirements, consciousness. Moreover, this is only gained once the fetus becomes sentient, the time of which is subject to debate.[114] Warren also clarifies that while infants only have consciousness, this theory does not condone infanticide. She outlines that infanticide is not generally permissible as after birth there is no conflict between the infant's and woman's rights

[112] Mary Anne Warren "On the Moral and Legal Status of Abortion"(1973) 57(1) Monist 43 at 44.
[113] At 55.
[114] Royal College of Obstetricians and Gynaecologists Working Group *Fetal Awareness Review of Research and Recommendations for Practice* (RCOG Press, March 2010); Stuart WG Derbyshire "Can fetuses feel pain?" (2006) 332(7546) Bmj 909; and Susan Lee and others "Fetal pain: a systematic multidisciplinary review of the evidence." (2005) 294 Jama 947.

because the fetus is no longer physically reliant on the woman and people would be willing to adopt the child.[115]

A common pro-life response to this is the natural capacities view. This states there is no need to have the capacities Warren identifies, instead one just requires a natural capacity to develop these qualities in order to be considered a person, consequently an embryo is a person from conception.[116] Alternative anti-abortion articulations argue abortion is wrong because it deprives the fetus of a valuable future.[117] However, this is convincingly countered by arguing this grants unwarranted special status to human life,[118] and the fetus would need to have consciousness on a psychological theory of personal identity in order to have an interest in its future.[119] Furthermore, Ronald Dworkin notes such pro-life arguments, which place significant weight on fetal life, cannot be entirely justified as most pro-lifers make concessions such as when the mother's life is at risk, and in the cases of rape and incest, which undermine their claim. [120]

The moral approach to the fetus ingrained in the common law through the born alive rule, is that newborn infants are distinguished from fetuses as fetuses are presumed dead until born.[121] This would suggest "personhood" only crystalises at birth. This is largely justified by the fact "legal complexities and difficult moral judgments would arise if the courts were to […] treat the foetus as a legal person"[122] and it does not preclude legal protection of the fetus through statute.[123]

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[115] Mary Anne Warren "Postscript on Infanticide" (1982) in Joel Feinberg (ed) *The Problem of Abortion* (Wadsworth, Belmont, 1984).
[116] Germain Grisez *Abortion: the Myths, the Realities, and the Arguments* (Corpus Books, New York, 1970); Stephen Schwarz *The Moral Question of Abortion* (Loyola University Press, Chicago, 1990); and Patrick Lee and Robert George "The Wrong of Abortion" in Andrew Cohen and Christopher Wellman (ed) *Contemporary Debates in Applied Ethics* (Blackwell, Oxford, 2005) 13.
[117] Don Marquis "Why Abortion Is Immoral" 86 Journal of Philosophy (1989) 183.
[118] Jeff McMahan *The Ethics of Killing* (Oxford University Press, New York, 2002) at 257-256 and Peter Singer *Practical Ethics* (2nd ed, Cambridge University, Cambridge, 1993) at 149-150.
[119] Jeff McMahan, above n 118, at 271.
[120] Ronald Dworkin *Life's Dominion* (Harper Collins, London, 1993) at 32.
[121] *R v Sims* (1601) Goldsborough 176; 75 ER 1075, as retained in New Zealand in *Harrild v Director of Proceedings*, above n 93, and CA, s 159.
[122] *Harrild v Director of Proceedings*, above n 93, at [117] per McGrath J.
[123] At [118]. Furthermore, the exception to the born alive rule as found in CA, s 182.

2. Connection between the woman and the fetus

However, moral arguments justifying abortion become much stronger once the focus moves from merely considering the fetus. This alternative moral approach contends that even if the embryo can be considered to have interests, an abortion can still be morally justified. The focus of such arguments is on the embodied meaning of pregnancy, justified because the fetus is unavoidably linked to the woman.[124]

One moral philosopher to do this is Judith Jarvis Thompson. She argues the right to life and the moral importance of life is not to never be killed, but rather not to be killed unjustly.[125] Thompson makes this point through the use of a thought experiment comparing pregnancy to waking up plugged into a violinist who will die if you unplug yourself from them at a point sooner than 9 months. She argues the individual should be able to unplug themselves as the right to life does not entail the right to use another's body. This makes the point that the fetus, while it may have a right to life, does not have a right to the pregnant woman's body against her will.[126] While there are morally relevant disanalogies between the violinist scenario and typical cases of abortion, such as the fact that most pregnant women are causally responsible for their circumstance unlike in the Thompson example,[127] the theory was important in changing the way the morality of abortion was considered, shifting focus from the fetus onto what claims it may have over the woman's body.

Catharine MacKinnon built on the conception from Thompson, but produced an alternative articulation of the connection between the mother and fetus, suggesting they are more unavoidably connected. She argues the experience of many women is that the fetus is more than a body part, but still much less than a human: [128]

> It "is" the pregnant woman in the sense that it is in her and of her and is hers more than anyone's. It "is not" her in the sense that she is not all that is there.

[124] Kristin Savell "Is the born alive rule outdated and indefensible" 28 Sydney L Rev 625 at 625.
[125] Judith Jarvis Thompson "A Defense of Abortion" (1971) 1(1) Philosophy and Public Affairs 47 at 57.
[126] At 56-57.
[127] Bonnie Steinbock *Life Before Birth: The Moral and Legal Status of Embryos and Fetuses* (Oxford University Press, Oxford, 1992) compared to David Boonin *A Defense of Abortion* (Cambridge University Press, Cambridge, 2002).
[128] Catharine MacKinnon "Reflections on Sex Equality Under Law" (1991) 100 Yale LJ 1281 at 1316.

She is convincing in outlining that this intricate and intimate connection means the interests of the fetus can never be considered without considering the interests of the woman.

Steven Ross also disagrees with Thompson's analogy, arguing the issue with it is that the violinist is a complete stranger to us, whereas the fetus, if left to develop, will not be.[129] The continuing burden of raising the child is not accounted for in Thompson's analogy, and should be. This sentiment is mirrored by Catriona McKenzie who argues that while, the mother assumes responsibility for the fetus by falling pregnant, this is not the same as accepting parental responsibility.[130] Overall, these arguments suggest a woman should be able to choose whether to terminate her pregnancy as she is most affected and, despite being pregnant, does not accept parental responsibility.

A pro-life view which considers the embodied experience of pregnancy, is that the development of the fetus is a natural one and to disrupt such a natural process, which helps contribute to such a fundamental aspect of human life, would be immoral.[131] However, as Stephen Coleman outlines, this natural process approach grants unwarranted moral significance to the development of the fetus. He claims many medical procedures are interruptions of some kind of natural disease process and sometimes it is appropriate to interrupt such processes even if they are morally significant. [132] Overall, this conservative criticism ignores the important role women play in pregnancy.

3. Focus on female interests

An alternative moral approach which justifies abortion is about the protection of female interests premised on a feminist approach. For example, MacKinnon argues that if women were truly equal to men, then the current political status of the fetus would be different. She claims that because women are sexually subordinate the fetus is not seen as the woman's own creation, but rather something imposed on her that she has a duty to care for. If seen differently it would be for the woman to decide whether to terminate, as it would be something she created

[129] Steven Ross "Abortion and the Death of the Foetus" (1982) 11 Philosophy and Public Affairs 232 at 235-238.
[130] Mackenzie, above n 111, at 142.
[131] Dave Wendler "Understanding the "Conservative" View on Abortion" (1999) 13 Bioethics 32 at 38-39.
[132] Stephen Coleman *The Ethics of Artificial Uteruses: Implications for Reproduction and Abortion* (Ashgate, England, 2004) at 98.

herself.[133] A paternalistic and restrictive approach maintains this subordination and ensures male control over women's reproductive lives. While this may ignore the function of the father to some extent and is ambivalent to the complex character of women's attitudes towards their fetus,[134] it adds a useful dimension to the debate.

The pro-life position can be framed in a feminist light by arguing restricting abortion concerns female protection. This argument contends that abortion involves significant trauma and regret, whereas motherhood involves joy and fulfilment, therefore abortion is something women must be protected from. But the psychological risks of abortion are commonly overstated[135] and studies do not support the claim abortion has a devastating impact on mental health.[136] It is even suggested permitting abortions allows for better mental health outcomes than denial.[137] Furthermore, arguably this misconstrues what it means to be pregnant by suggesting the choice to terminate a pregnancy is disturbing and painful, whereas the choice not to terminate is straightforward and faultless. Christine Foster and Vendna Jivan argue that in reality, pregnancy can be invasive, onerous, challenging and painful, and is associated with enduring responsibilities.[138]

4. The importance of choice

Overall, legalised abortion regimes rest on the notion women should be able to choose for themselves whether or not to terminate their pregnancy. This is what the final moral approach to justifying abortion rests on.

Feminist Professor Robin West discusses how women view their responsibilities regarding pregnancy. She argues women will make their decision on whether or not to terminate based on what they see as responsible.[139] Because of this, West argues that while allowing women to

[133] MacKinnon, above n 128, at 1326.
[134] Dworkin, above n 120, at 56.
[135] Emily Jackson *Regulating Reproduction: Law, Technology and Autonomy* (Hart, Portland Oregon, 2001) at 75.
[136] M Antonia Biggs and others "Women's Mental Health and Well-being 5 years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study" (2017) 74(2) JAMA Psychiatry 169 and David M Fergusson, L John Horwood and Joseph M Boden "Abortion and mental health disorders: evidence from a 30-year longitudinal study" (2008) 193(6) Br J Psychiatry 444.
[137] Biggs and others, above n 136.
[138] Christine Foster and Vedna Jivan "Abortion Law in New South Wales: Shifting from Criminalisation to the Recognition of Reproductive Rights of Women and Girls" (2017) 24 Journal of Law and Medicine 850 at 856.
[139] Robin West "Taking Freedom Seriously" (1990) 104 Harv L Rev 43 at 84-85.

choose rejects the view the fetus is a person, it still accounts for fetal interests as these interests will be considered when a woman makes a responsible decision. This is backed up by a study from Carol Gilligan where she demonstrated that many women characteristically consider moral issues differently from men, focussing less on abstract moral principles and more on their responsibility to care for others, and prevent hurt and pain.[140] Such a focus on responsibility can justify both the decision to terminate a pregnancy and the decision not to. Indeed one woman may choose to terminate because to have a child which she could not properly care for would be irresponsible, whereas another may find abortion to be irresponsible despite this.[141] This shows the decision is not a unique problem separated from other considerations, but rather a paramount example of decisions people must make in their lives, all of which display convictions about the value of life and meaning of death. MacKinnon reiterates this point by explaining "reproduction in the lives of women is a far larger and more diverse experience than the focus on abortion has permitted". [142]

Moreover, Ann Furedi makes a convincing argument in a similar vein. She outlines that in today's society where fertile men and women are having sex without wanting a child, abortions are inevitable.[143] Since moral disagreement is also inevitable, the most moral regime would be to prioritise the choice of the woman as she is the only individual equipped with the proper understanding of her circumstances to reach a personally appropriate decision.[144] Furedi also notes providing individuals with the right to choose is an important moral concept generally:[145]

> Our ability to make moral judgements, decisions and choices is a precondition of human development in a free society. To deny that women have the capacity to make reproductive choices denies their moral agency; it denies their humanity.

This is a powerful argument defending the need for women to be able to make reproductive decisions for themselves. It is not about being pro-abortion, but pro-choice.

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[140] Carol Gilligan *In a Different Voice: psychological theory and women's development* (Harvard University Press, Massachusetts, 1993) at 105.
[141] See generally at 73-103.
[142] MacKinnon, above n 128, at 1318.
[143] Ann Furedi *The Moral Case for Abortion* (Palgrave Macmillan, London, 2016) at 9-10.
[144] At 77.
[145] At 77.

Overall, the decision to terminate a pregnancy will be a difficult choice for many women and a choice which is morally justified no matter the conclusion. For example, one woman may be making the decision in order to attend school or work, or another because she is in a bad relationship. Some may consider this to be selfish and morally wrong, whereas other women may consider any other decision to be a serious moral mistake. Both are personal positions which the individual can justify to some extent, and universal moral agreement on this divisive and emotional topic is unlikely. Therefore, as shown, West,[146] McKinnon,[147] and McKenzie[148] all argue women are best protected by being empowered to make decisions for themselves, giving effect to their personal moral position.

C. A liberal approach can be justified

In New Zealand, neither the woman nor the fetus are considered to have legally enforceable rights. Despite this, a rights-based argument clearly supports a liberal approach as leaving the decision in the hands of women better upholds rights to health, reproductive independence, autonomy and freedom from discrimination. International human rights standards undoubtedly reinforce this. While there are valid criticism of a rights-based approach, reform in New Zealand does not rely on solely rights-based arguments. Instead there is scope for nuanced debate with moral arguments being considered.

The strongest of these arguments take into account the relationship between the mother and fetus. It is convincingly justified that women should make decisions regarding their own body as fetal interests must be considered in the context of the woman's. Furthermore, as women tend to make responsibility-based decisions, fetal interests will be taken into account. Overall, women will, and should be able to, justify their decision from a personal moral perspective. Allowing them to freely decide for themselves best protects women's rights by ceasing to treat women as incapable of making decisions about their own reproductive lives.

[146] West, above n 139, at 84.
[147] MacKinnon, above n 128, at 1317 and 1326-27.
[148] Mackenzie, above n 111, at 142.

III. Decriminalisation, Medicalisation and Legalisation

A liberal approach to abortion best protects women's interests. However, whether decriminalisation should come in the form of medicalisation, where the decision-making power is held by the health practitioners, or complete legalisation is up for debate. This dissertation argues the approach the Bill should take is to legalise abortion, which would mean no gestational limit.

A. The Bill's approach

The Bill removes abortion from the CA. This legalises abortion before 20 weeks as there are no requirements to establish lawfulness. After 20 weeks a medical practitioner can only terminate a pregnancy if the "practitioner reasonably believes the abortion is appropriate in the circumstances".[149] In order to determine what is "appropriate" the "practitioner must have regard to the pregnant woman's physical health, mental health and well-being".[150] The consequences for a medical practitioner who does not consider this criteria are unclear. Overall, it removes the woman's ability to choose, and shifts the decision making authority to the medical practitioner, effectively medicalising abortions after 20 weeks.

Medicalisation may not be a radical change as case law suggests the current law already treats abortion as a health issue. In *Wall v Livingston* the Court of Appeal held decision making under the CSAA rests with the medical professional and should be based on a "medical assessment pure and simple"[151] given the language of the statute and the fact the exceptions listed in the CA are "concerned with medical considerations".[152]

Having said this, a move to decriminalise abortion is required and justified, and the Bill takes an important step in legalising abortion up until the 20-week mark. The issue faced by the Bill is instead whether medicalisation after 20 weeks via a gestational limit is appropriate.

[149] Abortion Legislation Bill, s 7 (proposed s 11(1), CSAA).
[150] Section 7 (proposed s 11(2), CSAA).
[151] At 739.
[152] At 741.

B. Is a medical model generally appropriate?

While a medical model attempts to improve on New Zealand's current criminalised model, there are several issues with the approach.

Medicalisation is a paternalistic regime where women are determined incapable of making the "correct" choice, requiring the intervention of the medical practitioner.[153] While it is inevitable medical considerations will be relevant, it does not mean they must control the outcome. A medical model entrenches the perspective that women are unable to make decisions, as the approach appears permissive but ultimately defers decision-making authority onto the medical profession.[154]

Also, in leaving the decision-making power with the medical practitioner it poses the question; are doctors really the best people to be making determinations as to what is "appropriate"? The decision is subject to the attitudes and values of the individual medical practitioner.

Sally Sheldon outlines that the approach of medical practitioners can legitimately vary under a medicalised regime. Practitioners can employ either: [155]

(a) decisional decision-making where their decision essentially defers to the decision of the woman;
(b) paternalistic decision-making where the medical practitioner applies their own views of what is appropriate for the woman; or
(c) normalised decision-making where the practitioner accesses all the details of the woman's life, considers these factors, and produces an authorised account of her reality whilst still applying their own opinion.

While some doctors may attempt to minimise their control in determining what is appropriate, by applying decisional decision-making, this is not guaranteed. Even the Royal Commission, when recommending the parameters for New Zealand's current legal framework in 1977, noted there was a risk practitioners would give effect to their personal views in making decisions.[156] This is problematic as it legitmises a third party decision, on a matter which is inextricably

[153] Foster and Jivan, above n 138, at 856.
[154] Sally Sheldon *Beyond Control: Medical Power and Abortion Law* (Pluto Press, London, 1997) at 157.
[155] At 149.
[156] Royal Commission of Inquiry "Contraception, Sterilisation, and Abortion in New Zealand" [1977] AJHR E26 at 293–294.

linked to complex moral debate, as being medical. Furthermore, medicalisation can create the false appearance that healthcare is somehow immune from political power and discourse, when in reality it is intertwined with political considerations.[157] Practitioners are not impervious to the debate surrounding abortion, and they will unavoidably become involved when discretion is granted.

A medical model makes the unfounded assumption doctors are capable of making a better choice than the woman herself.[158] The decision on whether to undergo an abortion is unavoidably associated with a range of social issues, and treating it as a medical decision marginalises these important social and non-medical considerations.[159] It is these considerations that are most significant in practice when considering whether to terminate a pregnancy, as shown by the fact the most common justification for an abortion is mental health reasons.[160] Medical practitioners are not directly trained in making decisions on social or psychological factors. To expect a practitioner to adequately understand what is appropriate in the individual woman's circumstances is unrealistic. This is a sentiment which medical practitioners themselves have concurred with.[161] It will also continue to force a woman to present her circumstances in the worst possible light in an attempt to convince the practitioner the decision to terminate is appropriate. While discussion with a practitioner regarding the reasons for seeking an abortion assists women and provides them with an opportunity to disclose concerns regarding violence or coercion, this discussion can still occurr and it does not justify leaving the final decision to the practitioner.

Furthermore, having a test for when an abortion will be allowed leaves the door open to statutory challenge from groups opposing abortion. For years anti-abortion groups have tried to challenge the law through the courts.[162] While in *Right To Life* the majority determined that once a certified consultant makes a decision it cannot be reconsidered or questioned by the

[157] Rachael Johnstone "Between a Woman and Her Doctor? The Medicalization of Abortion Politics in Canada" in *Abortion: History, Politics and Reproductive Justice after Morgentaler* (UBC Press, Vancouver, 2017) 217 at 222.
[158] Sheldon, above n 154, at 65.
[159] At 153.
[160] In 2017 98.9% of all abortions carried out in NZ employed danger to the mental health of the woman as a ground justifying the procedure. *Report of the Abortion Supervisory Committee*, above n 1.
[161] Law Commission, above n 62, at 86.
[162] For example, the litigation brought in *Wall v Livingston*, above n 93, and *Right To Life New Zealand*, above n 24.

ASC, [163] this was not a unanimous decision and, significantly, the minority somewhat convincingly considered that the ASC could review decisions made by certifying consultants for compliance with law.[164] The case also focussed on the decision making powers of the ASC and not whether the court could assess provider's compliance with the legislative test. This remains something practitioners could be subject to under a medicalised approach. To avoid litigation entirely is difficult, as it is challenging to create a statutory test that is wide enough to let people through who need care, without being so uncertain as to require interpretation.

Despite these concerns, the medicalised approach employed in the Bill, which introduces the gestational limit, means these issues must be weighed against the importance of having some kind of control for late-term abortions.

C. Specific consideration of gestational limits

The more important question is whether the Bill is effective in implementing a gestational limit.

1. Late-term abortions

In 2017, only 0.54% of abortions occurred after 20 weeks of gestation.[165] This could be because the current law only allows for an abortion at this point when it is to save the woman's life or to prevent her from suffering serious permanent physical or mental injury.[166] However, 6.1% of abortions occur later than 13 weeks into pregnancy so, even without exceptionally stringent requirements, fewer abortions occur at late stages under current law.[167]

The procedure of abortion itself changes at later stages of pregnancy, becoming more invasive. As discussed in Chapter IB, for an abortion after 16 weeks the dilation and evacuation method is required involving induced labour.[168] Furthermore, after 22 weeks, unless there are exceptional circumstances, feticide should be part of the process involving injection of a drug directly into the fetus' cardiac ventricle to stop the heart.[169] This is coupled with more severe

[163] *Right To Life New Zealand*, above n 24, at [40].
[164] At [56].
[165] *Report of the Abortion Supervisory Committee*, above n 1, at 19.
[166] CA, s 187A(3).
[167] *Report of the Abortion Supervisory Committee*, above n 1, at 19.
[168] *Standard of Care for Women Requesting Abortion in Aotearoa New Zealand: Report of a Standards Committee to the Abortion Supervisory Committee Standards of Care* (Abortion Supervisory Committee, 2018) at 41 [*Standards of Care*].
[169] Standard 9.9.6.

side effects including pain,[170] and there are higher rates of complications such as incomplete abortion and hemorrhages.[171]

2. Why a gestational limit?

Gestational limits are associated with a range of justifications, including the fact the procedure becomes more arduous.

(a) Moral justifications for a gestational limit

Many of those who argue for abortion do not argue for unrestricted access, contending it is only morally justified up to a certain point. For example, Warren notes late-stage abortions require more in the way of moral justification,[172] giving several reasons for this. The first being that when a child is viable, meaning the fetus is capable of surviving outside of the woman's uterus with artificial medical aid,[173] it is no longer clear the woman has a moral right to opt for an abortion.[174] This is justified as not only could the fetus survive at the point of viability, but if it did it could be adopted by individuals willing and able to care for it.[175] The second reason is that the fetus is sentient at later stages. Warren argues sentient beings should benefit from continued life as they have higher moral status and are more characteristic of persons because they can feel pain, and have thought and other conscious mental states.[176] The point at which sentience accrues is debatable, with some research suggesting it is before 24 weeks, and other research suggesting this is impossible. Despite this, it is accepted consciousness and the ability to feel pain is obtained late in the second trimester and that this should be the general test for sentience.[177] Therefore, it is Warren's view the only justification for a late-term abortion is to save the woman's life or because of disastrous fetal abnormalities, [178] both medical reasons, suggesting it should be for the doctor to consider it medically necessary.

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[170] T Kelly and others "Comparing medical versus surgical termination of pregnancy at 13–20 weeks of gestation a randomised controlled trial" (2010) 117(12) BJOG: An International Journal of Obstetrics & Gynaecology 1512.
[171] Daniel Grossman, Kelly Blanchard and Paul Blumenthal "Complications after Second Trimester Surgical and Medical Abortion" (2008) 16 Reproductive Health Matters 173.
[172] Mary Anne Warren "The Moral Difference Between Infanticide and Abortion: A Response to Robert Card" (2000) 14 Bioethics 352 at 352.
[173] *Roe v Wade*, above n 88, at 732.
[174] At 353.
[175] Warren, above n 172, at 57.
[176] At 353-354.
[177] Bonnie Steinbock "Fetal Sentience and Women's Rights" (2011) 41(6) Hastings Center Report at 1.
[178] Warren, above n 172, 358-359.

This is a sentiment mirrored by Bonnie Steinbock. It is her view that consciousness should be a pre-requisite for the possession of interests.[179] L W Sumner concurs that the late fetus has moral value, when the early fetus does not, as it develops sentience.[180] Such arguments contend that the interest in preserving the life of the fetus increases as the fetus develops, based on capacity for sentience or viability which is gained at around 24 weeks.

This is the most convincing of the justifications and leads to most of the anxiety around the ethical problem of late-term abortions.

This attitude is also reflected in case law from New Zealand and other jurisdictions. In *R v Woolnough* Richmond P. stated that the "further a pregnancy progresses, the more stringent the requirements should be which will justify its termination".[181] Similarly, *Roe v. Wade* held the right to privacy diminishes as the pregnancy progresses, only allowing third trimester abortions to save the woman's life.[182] At this point the interests of the fetus can no longer be as clearly overcome by the rights of the woman.

(b) Practitioner perspectives

In making their recommendations the Law Commission consulted with practitioners, some of whom supported gestational limits. They noted that practitioners are more willing to perform terminations at earlier stages and there are limited numbers of clinicians who are qualified and experienced to perform late-term abortions. Their concern was that these limited numbers may decline if there was no limitation on access because there would be no basis to decline the abortion if the clinician was uncomfortable performing it.[183]

(c) Issue of infanticide

A final justification for gestational limits is the problem of infanticide. As discussed by Warren, infants and fetuses are distinguished despite both only having consciousness, as after birth the

[179] See generally Steinbock, above n 127.
[180] L W Sumner "A Third Way" in Susan Dwyer and Joel Feinberg *The Problem of Abortion* (Wadsworth, Belmont, 1984) 72.
[181] *R v Woolnough* [1977] 2 NZLR 508 (CA) at 516–517.
[182] *Roe v Wade* 410 US 113 (1973) at 732.
[183] Law Commission, above n 62, at 87.

infant is no longer physically reliant on the woman.[184] However, at late stages once the fetus gains viability, the fetus is also not technically reliant on the mother. Therefore, it is argued late-stage terminations cannot be allowed, as otherwise this would condone infanticide.[185]

3. Issues with gestational limits generally

Despite this justification for gestational limits, they are associated with significant issues. Much of these concerns are those which are associated with medical models, as previously discussed in this Chapter at B. However, there are further issues.

(a) A moral response to gestational limits

To have no gestational limit suggests fetal interests are only attained at birth, as prior to this the state does not intervene to protect the fetus. One of the main justifications for this is that viability or sentience should not be the moral benchmark of fetal personhood. This approach takes sentience and viability to be more social than physiological, in that it is not about the ability to live a life separate from the woman, but the need to actually be living that life.[186] Such an argument contends that the fetus is merely developing potential and not actual personhood, justifying that fetal life is subordinate to human will. As Peter Singer outlines, a potential X does not have the same value as X, or all the rights of X.[187] When potential has not yet been realised, a developmental change in this potential, like becoming sentient, may not make a significant difference to moral status as this change is still not the realisation of that potential. Another analogy employed by Singer is that while Prince Charles is a potential King of England, he is not yet King and these do not have the same value.[188] Even if someone who was more distantly in line from the throne was to move closer this would be a negligible change to potential and not a morally relevant realisation of that potential.[189] Therefore, arguably a developing human does not acquire significant intrinsic moral status, despite continual development, until birth. This also convincingly responds to the issue of infanticide.

[184] Discussed at Chapter IIB1.
[185] Robert Card "Infanticide and the Liberal View on Abortion" (2000) 14(4) Bioethics 340.
[186] Michael L Gross "After Feticide: Coping with Late-Term Abortion" (1999) 8 Cambridge Quarterly of Healthcare Ethics 449 at 456-459.
[187] Singer, above n 118, at 153.
[188] At 153.
[189] Coleman, above n 132, at 114.

Furthermore, Warren's point on adoption also faces criticism. Furedi notes that adoption is an alternative to raising a child, not an alternative to abortion as a woman must continue to be pregnant against her wishes.[190] Gerald Paske also counters this point by introducing the concept of the right not to be a biological parent. Paske recognises the value given to biological descendancy, as it is commonly held that wherever possible children should be raised by their genetic parents, and argues individuals should have a right not to be one.[191] Steven Ross also discusses this and notes women do not just want to no longer be pregnant, but to not be a parent in any sense of the word.[192] While this right not to be a biological parent is not unlimited in considering the rights of the other genetic parent and the interests of the fetus,[193] it does explain that adoption is not a straightforward solution to the issues with late-stage abortions.

Such arguments could be rejected on the grounds they enjoin treating the fetus with disrespect, they are not the best construction of the meaning of life and they ignore the fact becoming viable is more significant than other changes in fetal development. However, these claims assume no concern will be given to fetal life, or fetal viability, in the decision-making process. Abortions are available earlier in the pregnancy, and usually if pregnancies reach late-term there originally was a desire for the child to survive. Instead there are generally complex considerations which have developed and are leading to the decision such as abnormality, health risks or drastic changes of circumstance, with concern being had for fetal interests.

(b) Reasons for late-stage abortions

The complex range of reasons for late-term abortions was considered by a study which suggested women who sought abortions after 20 weeks fit into one of five categories, other than to save the life of the woman or because of fetal abnormality.[194] These categories were:[195]

1. they would suddenly be raising the child alone;
2. they were depressed or using illicit substances;
3. they were in a situation of domestic violence;

[190] Furedi, above n 143, at 13.
[191] Gerald Paske "Sperm-napping and the right not to have a child" (1987) 65(1) Australasian journal of philosophy 98 at 101.
[192] Ross, above n 129, at 232-245.
[193] Coleman, above n 132, at 141.
[194] Diana Greene Foster and Katrina Kimport "Who Seeks Abortions at or After 20 Weeks?" (2013) 45(4) Perspectives on sexual and reproductive health 210 at 210.
[195] At 215-216.

4. they had trouble accessing services earlier; or
5. they were young and nulliparous.[196]

While there are limitations to this study[197] it does provide a good indication of the complex range of factors considered. It also shows that such limits tend to disproportionately disadvantage vulnerable people, who are facing limited support, difficult situations, and have poor access. The only individual who is able to properly understand these considerations is the woman herself.

(c) The issue of viability

Viability is also problematic in terms of finding an accurate or logical limit. Determining the exact point of viability is unclear and debated. Moreover, the stage of viability is subject to change as medical practices develop and improve. In 1981 it was a significant medical development to have a fetus survive from 28 weeks,[198] whereas now a fetus is commonly considered viable around 24 weeks. Even then, a fetus born at 24 weeks has only a 35% chance of survival.[199] Viability will become an even more problematic measure in the future as artificial uteruses may soon make it possible to develop a fetus outside of the womb.[200]

(d) Practitioner perspectives

When the Law Commission made its suggestions regarding option C it noted that most health practitioners and professional bodies consulted did not support a gestational limit.[201] Some reasons provided for opposing the option were that a woman's mental or physical health can deteriorate even at late stages in pregnancy, and a limit may mean women feel rushed in decision making, particularly in the case of fetal abnormality.[202] For example, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

[196] A woman who has never given birth.
[197] This study only considered 30 facilities over a 3 year period (at 211). Furthermore, the authors note that the study should be considered in the cultural context of the USA where the study was completed (at 217).
[198] Peter Singer and Deane Wells *The Reproductive Revolution: New Ways of Making Babies* (Oxford University Press, Oxford, 1984) at 131.
[199] Jon Tyson and others "Intensive Care for Extreme Prematurity — Moving Beyond Gestational Age" (2008) 358(16) New England Journal of Medicine 1672.
[200] Carlo Bulletti (an Associate Professor at Yale University) believes a functioning artificial womb could be created within the next decade (Natasha Preskey "In The Future, You Could Be Pregnant Outside Your Body" *Vice* (online ed, 15 Jun 2018)). Furthermore, none of the issues facing the studies seem unsurmountable and a breakthrough could happen at any time (Coleman, above n 132, at 13-14).
[201] Law Commission, above n 62, at 88.
[202] At 89.

guidelines indicate delaying decision-making when a condition affecting the pregnancy is uncertain at earlier stages in the pregnancy can reduce uncertainty and regret.[203] Other reasons practitioners gave was that the decision is a personal one which others should not judge.[204]

4. Gestational limits in practice

(a) International approaches

Abortion law in most other comparable jurisdictions includes a gestational limit.[205] The main jurisdictions without such limits are Australian Capital Territory[206] and Canada.[207]

In Canada, while the legalisation of abortion has meant reporting is voluntary so comprehensive abortion statistics are limited,[208] it is noted that despite abortion being effectively available on demand, the reality is the lack of a gestational limit has not resulted in a drastic increase in late-term abortions.[209] Furthermore, terminations are almost always provided for maternal health reasons or serious fetal abnormalities.[210] Access remains variable for later gestations as shown by the fact multiple provinces have effective gestational limits at twelve weeks (New Brunswick) and twenty-four weeks (Ontario) which are not implemented by law, but by the discretion of medical practitioners, funding and availability of facilities.[211]

In Australian Capital Territory the main provider for late-stage abortions is a private abortion provider. Public provision is minimal, with one of only two hospitals in the territory refusing to perform abortions at any gestation and the other only performing late-stage abortions in cases of emergency or fetal abnormality.[212]

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[203] Royal Australian and New Zealand College of Obstetricians and Gynaecologists *Late Termination of Pregnancy* (RANZCOG, C-Gyn-17A, 2016) at 2.
[204] Law Commission, above n 62, at 89.
[205] Such as the United States of America, the United Kingdom, Ireland, Victoria, Tasmania and Queensland.
[206] (Abolition of Offence of Abortion) Act 2002 (ACT).
[207] *R v Morgentaler*, above n 89.
[208] Jeanelle Sabourin and Margaret Burnett "A Review of Therapeutic Abortions and Related Areas of Concern in Canada" (2012) Journal of Obstetrics and Gynaecology Canada 532 at 537.
[209] Sabourin and Burnett, above n 208; Rachael Johnstone and Emmett Macfarlane "Public Policy, Rights, and Abortion Access in Canada" (2015) 51 International Journal of Canadian Studies 97.
[210] Sabourin and Burnett, above n 208, at 534; and Johnstone and Macfarlane, above n 209, at 107.
[211] Johnstone and Macfarlane, above n 209, at 107.
[212] Barbara Baird "Decriminalization and Women's Access to Abortion in Australia" (2017) 19(1) Health and human rights 197.

Alternatively, the proposed New Zealand Bill reflects the approach taken in Victoria and the Northern Territory in requiring an abortion to be considered appropriate by a medical practitioner, and providing considerations which must be taken into account when determining "appropriateness".[213] In Victoria this is only required after 24 weeks (but 2 medical practitioners must deem it "appropriate") and in Northern Territory it is after 14 weeks. There is limited judicial comment or comment from the medical field on the meaning of "appropriate" as employed by these sections.

One study done in Victoria since the law change indicated a particular concern of abortion experts was the lack of availability of abortions for women over 20 weeks, as access had actually decreased since the reforms. While the law includes no test until 24 weeks, other barriers continue to limit provision, even where the legal criteria is met, such as lack of clinics willing to provide services.[214] The only clinic which will deem non-medical reasons to be sufficient is private and it will not provide services after 24 weeks. The public hospitals in the region only provide services for non-medical reasons before 18 weeks.[215] This is occurring despite the legislation calling for the "woman's current and future physical, psychological and social circumstances" to be considered in determining whether an abortion is "appropriate".[216]

Overall, international approaches show limited differences in practical access to late-term abortions regardless of gestational limits because of professional and institutional policies. Access is determined by which hospitals and clinics are willing to provide services. To remedy this is an access issue which will be discussed in Chapter IV.

(b) How is the test likely to function?

In recommending the test, the Law Commission outlined that the test directs the health practitioner to consider what is "appropriate" to allow the assessment to be made from a medical perspective, rather than a legal one, on an individualised basis.[217] It was envisaged that it would be broader than the tests currently outlined in the CA.[218] Furthermore, it was based on similar provisions from Victoria and Northern Territory.

[213] Abortion Law Reform Act 2008 (Vic), s 5; and Termination of Pregnancy Law Reform Act 2017 (NT), s 7.
[214] LA Keogh and others "Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia" (2017) 43(1) J Fam Plann Reprod Health Care 18 at 22.
[215] Baird, above n 212.
[216] Abortion Law Reform Act 2008 (Vic), s 5.
[217] Law Commission, above n 62, at 84.
[218] At 84.

This test has a number of practical strengths. Firstly, it is broad compared to the current test and allows a woman to justify her request on the basis of social issues rather than purely medical issues in the sense that these relate to her wellbeing. Furthermore, the fact the practitioner must consider the pregnant woman's physical health, mental health and well-being[219] means the objective morality of the individual doctor and what would offend the public should not legitimately be brought into the consideration, so they cannot use it to legitimise a conscientious objection.

However, the test is very broad. It could be that what one practitioner considered to be appropriate would not be considered as such by the next, as one may make an assessment purely on their personal views as to what is medically or socially appropriate, whereas the other may best attempt to give effect to the choice made by the woman. It seems unpredictable which approach will become common practice, and even more importantly, there is no certainty as to what approach the court would take if required to determine the meaning of appropriate. Furthermore, as can be seen in Victoria, the reality is that late-stage abortions are still mostly provided to save the life of the woman.

Overall, the test seems to invite doctors to provide a personal assessment of what they deem to be "appropriate". This assessment is then legitimised as a medical decision when it, importantly, will not be based on solely medical considerations. If the test is going to function there is a need for further clarification to ensure doctors are not overstepping their roles or making decisions they are not qualified to make.

D. The recommended approach of this dissertation

1. Preferred approach

Gestational limits are most convincingly justified by the fact that at later stages of development, once the fetus gains sentience and becomes viable, the interests of the fetus increase. While this means the ethical obligation to protect fetal interests increases, those interests are still merely potential and not yet realised. It is the position of this dissertation that it is an

[219] Abortion Legislation Bill, s 7 (proposed s 11(2), CSAA).

insufficient justification for a gestational limit and the fetus cannot be considered without considering the woman who carries it. Instead the Bill should legalise abortions at any stage.

Women are unlikely to subject themselves to the trauma, pain and risk of a late-stage abortion without reason, and without respect being given to the fetus they are carrying. A medical model ignores this in assuming doctors are capable of making better decisions for a woman than she is capable of making for herself. It also legitimises the decisions made by practitioners who, without good reason, do not give effect to the legitimate wishes of the woman seeking the abortion.

Furthermore, as can be seen by the other jurisdictions considered, the practical impacts of gestational limits are minimal. Most late-term abortions are only provided to save the woman's life or because of fetal abnormality, showing gestational limits fail to achieve their desired goal of protecting fetal interests any differently than without limitation. It is not just that providers are uncomfortable with providing abortions at a late stage, but that women will not seek abortions at these stages without good reason. Moreover, while there is no evidence gestational limits reduce late-term abortions, there is evidence cutoffs harm, particularly disadvantaged and vulnerable, women.[220] Gestational limits restrict women's ability to make decisions for themselves without proper justification.

The only justification for a gestational limit which was not responded to in Chapter IIIC3 is the possibility of reduced access at late stages without a limit, as practitioners may be disincentivised from providing services if they could not deny the abortion if they were uncomfortable. However, as will be discussed in Chapter IV, the Bill tackles access issues with many other provisions. Furthermore, practitioners will have the ability to conscientiously object to late-term abortions, and abortion service providers will be able to determine up until which gestation and in what circumstances they wish to offer abortions. Moreover, practitioners still have some say on the matter. As the Law Commission noted, when recommending a model with no gestational limit, it remains open to health professional bodies to develop guidance on when an abortion may be medically appropriate.[221]

[220] See Chapter IIIC3 and Biggs and others, above n 136.
[221] The type of guidance which would be appropriate is discussed in Chapter IIID2(a). Law Commission, above n 62, at 79-80.

There are also several ways fetal interests can be and are protected without gestational limits. Firstly, practitioners must gain informed consent before offering a service, which is not unique to abortion. This is described by the Medical Council of New Zealand as:[222]

> an interactive process between a doctor and patient where the patient gains an understanding of his or her condition […] including an assessment of the expected risks, side effects, benefits and costs […] and thus is able to make an informed choice and give their informed consent.

This means that even without medical control over the decision, the decision is not made solely by the woman and the practitioner will play a role in ensuring she understands the decision she is making; this includes a discussion of fetal interests. Already, the ASC require providers to discuss short and long-term complications including psychological issues,[223] the anatomy and physiology relevant to the length of gestation, the process of the abortion, and the possible complications.[224] This can continue under any new standards of care. Counselling is also available and tends to have increased uptake at later stages.[225] Furthermore, the ASC require counselling to be available onsite,[226] and to be free and readily accessible.[227] Under the Bill, counselling also must be made available to women by providers. While counselling should be neutral and non-judgmental, it provides women with a place to discuss all factors relevant to the decision they are making, including the moral complexities associated with late-stage abortions. Finally, it is arguable that fetal interests are better considered without restrictions as women are not required to make early or rushed decisions.

Overall, this position is not in favour of on-demand late-stage abortions, but is in favour of acknowledging that women are the best people to make decisions for themselves and should be empowered with the final decision. Practitioners should aid the woman in reaching her decision, not make the decision on her behalf. This approach would have the same practical effect as the gestational limit proposed in the Bill, but with a better realisation of the rights of women and in a more flexible manner.

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[222] Medical Council of New Zealand *Information, choice of treatment and informed consent* (Medical Council of New Zealand, Wellington, 2011) at [2].
[223] *Standards of Care*, above n 168, standard 7.4. See also standard 8.3.4 which states "women should be informed of the range of emotional responses they may experience before, during and after an abortion."
[224] Standard 8.1.1.
[225] Law Commission at 151.
[226] *Standards of Care*, above n 168, at 23.
[227] Standard 8.2.1.

2. If gestational limits are adopted

Frustratingly, while it is the position of this dissertation that there should be no gestational limit, it is also true that taking a medical approach may ensure the Bill passes through Parliament as many members voiced concern for permissive approaches to late-stage abortions.[228] If a gestational limit is required, the test itself and the point at which the limit is implemented should be considered.

(a) The test

If gestational limits are to be implemented the test of "appropriate", as discussed, requires further clarification to ensure the decision made meets a proper purpose and practitioners are not overstepping their roles by making decisions they are not qualified to make. Such guidelines should ensure decisions give effect to the wishes of the woman and that the doctor's role is only to look out for red-flags such as coercion. These could be created by bodies such as the Ministry of Health or, more likely, by professional bodies such as RANZCOG. Current medical practices require practitioners to provide services consistent with that of a reasonably competent doctor who is skilled in that area.[229] Such a standard of care could require giving effect to the decision of the woman. Furthermore, this standard of care, as well as the standards issued by professional bodies, are legally enforceable through the Code of Health and Disability Services Consumers' Rights.[230]

(b) Where should the line be drawn?

The Law Commission recommended the gestational limit should be at 22 weeks, determining this to be the date of viability.[231] However, the Bill sets the limit at 20 weeks. Louisa Wall indicated that the justification for this was that it is consistent with the Births, Deaths, Marriages and Relationships Act 1995.[232] Under this Act a stillbirth is classified as such after

[228] (8 August 2019) 739 NZPD (Abortion Legislation Bill – Chris Penk, Ian McKelvie, Jo Hayes, Jonathan Young, Louisa Wall and Andrew Little).
[229] Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (Code of Health), right 4.
[230] Right 4.
[231] Law Commission, above n 62, at 90.
[232] (8 August 2019) 739 NZPD (Abortion Legislation Bill – Louisa Wall).

the 20th week of pregnancy[233] and a stillbirth must be registered as a birth.[234] This definition is likely sufficiently broad to include an aborted fetus as it was recognised as such by the Victorian Law Reform Commission when reviewing equivalent legislation.[235]

These are arbitrary dates which lack significant justification. Firstly, as discussed, viability is difficult to determine, and any assessment is impermanent and subject to scientific advancements.[236] It has been shown that before 23 weeks fetuses only survive in exceptional circumstances,[237] meaning 22 weeks is an optimistic assessment for viability. Although survival rates improve for babies between 23-25 weeks, most survivors face serious lifelong disabilities.[238] Secondly, to justify the 20-week margin to maintain legal consistency is an insufficient justification as it can be remedied by requiring health service providers to treat abortions after 20 weeks as stillbirths and register them.

Nonetheless, it is conceded that if a gestational limit is to be included, determining the appropriate date is challenging and a line must be drawn somewhere. It is the position of this dissertation that if there was the need for a gestational limit it should not be at 20 weeks as the justification given is insufficient. Instead 24 weeks would be more appropriate as this is the time which is more generally accepted to be the point of viability.

[233] Births, Deaths, Marriages and Relationships Act 1995, s 2.
[234] Section 9. There is also a duty to bury a stillbirth child's body under s 46E of the Burials and Cremations Act 1964 in the same way that any deceased person would be buried.
[235] Victorian Law Reform Commission *Law of Abortion* (Victorian Law Reform Commission, 9780975846605, 2008) at 52.
[236] See Chapter IIIC3.
[237] The American College of Obstetricians and Gynaecologists "FAQ173" (August 2019) The American College of Obstetricians and Gynaecologists <https://www.acog.org/-/media/For-Patients/faq173.pdf?dmc=1&ts=20190908T2357420536> at 1.
[238] At 1.

IV. Ensuring proper access to abortion services

While legalsing abortion will improve general access to abortion, it does not ensure adequate access. The Bill includes several mechanisms to improve access, which require consideration.

A. Access issues

Mere legalisation of abortion fails to ensure women have access to abortion services. For example, in Canada where there are no legal requirements for access, there is substantial variation in services, policies and general access, with some areas having no providers and others only having private providers.[239] Furthermore, in 2016 the United Nations Human Rights Commissioner's report recognised the limited access to abortion in Canada and called the government to remedy the inequities.[240] This has been mirrored in several states in Australia post-liberalisation.[241]

Access to abortions is vital. The average gestational age at which abortions are performed decreases as access to services increase.[242] Furthermore, the earlier an abortion is performed, the safer, less intrusive and less emotionally challenging it is. This is a problem in New Zealand as New Zealand women consistently access terminations later in the first trimester than in other developed countries.[243] While legalislation is a step in the correct direction in terms of improving access, direct policies to improve access and change attitudes are essential.[244]

1. New Zealand current practices

There are significant access issues in New Zealand with the current approach. Abortion services vary across the country and can be very limited, as discussed in Chapter IB.

The need for a woman to be referred to a certifying consultant requires her to have a general-practitioner who does not conscientiously object to abortion. While the Law Commission did

[239] Sabourin and Burnett, above n 208, at 534.
[240] *United Nations Committee on the Elimination of Discrimination against Women: concluding observations on the combined eighth and ninth periodic reports of Canada* CEDAW/C/CAN/CO/8-9 (18 November 2016) at 2.
[241] For example, in Victoria. Keogh and others, above n 214.
[242] Dorothy Shaw and Wendy V. Norman "When there are no abortion laws: A case study of Canada" (2019) Best Practice & Research Clinical Obstetrics & Gynaecology at 2.
[243] Martha, McNeill and Ashton, above n 33, at 1.
[244] Baird, above n 212.

find that a number of abortion service providers have adopted the approach that a "woman's own doctor" can be a doctor at the abortion clinic, it certainly leads to delays in access. Furthermore, there are currently very few individuals in New Zealand willing to and capable of performing abortions. As of June 2018 there were only 168 certifying consultants across the entire country[245] which acts to limit access.

Furthermore, abortions must occur in a specially licensed facility which must have adequate surgical and overnight facilities.[246] This also limits access as it means, despite such facilities being unnecessary for medical abortions, services are generally limited to larger centres.[247] Furthermore, some licences are limited to only performing abortions within the first 12 weeks,[248] or 9 weeks of pregnancy.[249] This means some women must travel large distances in order to receive care.

B. General changes in the Bill

The Bill includes specific policies aimed at improving access including; empowering women to self-refer, [250] introducing safe access zones, [251] allowing any medical practitioner to perform an abortion,[252] repealing the requirement for abortions to occur in an institution licensed by the ASC[253] and altering the requirements for doctors who wish to conscientiously object. [254]

Self-referral was included in the Bill upon recommendation from the Law Commission.[255] While women can already self-refer to some abortion providers,[256] this would ensure self-referral to all and reduce delays caused by conscientious objection. In the Bill the Ministry of Health is also directed to provide a maintained list of abortion service providers and the types of services they provide, in order to give women the practical ability to self-refer.

[245] *Report of the Abortion Supervisory Committee*, above n 1, at 29.
[246] CSAA, s 21. The second requirement is only necessary for a full licence.
[247] Law Commission, above n 62, at 127.
[248] CSAA, s 19. Tauranga and Palmerston North Hospitals have such a limit.
[249] For example, Tauranga Family Planning clinic.
[250] Will be discussed in Chapter IVC. Abortion Legislation Bill, s 7 (proposed s 14, CSAA).
[251] Section 7 (proposed s 17, CSAA).
[252] Section 7 (proposed ss 10 and 11, CSAA).
[253] Abortion Legislation Bill 2019 (164-1) (explanatory note) at 5.
[254] Will be discussed in Chapter IVD. Abortion Legislation Bill, a 7 (proposed s 19, CSAA).
[255] Law Commission, above n 62, at 126.
[256] At 126.

The proposed change which permits any qualified medical practitioner to perform an abortion is justified as there have been improvements to the safety and technology used in performing abortions, and nurses and midwives now perform a wider range of tasks.[257] This is also recommended by the World Health Organisation[258] and is common practice in comparable jurisdictions.[259] This would help solve the limited number of practitioners that currently provide services and therefore increase access.

Under the Bill, abortions can occur in any medical facility, rather than only in licensed institutions. This will allow smaller providers such as medical centres and Family Planning clinics to provide services, at least for medical abortions.[260] It also means women can take mifepristone at home, limiting a medical abortion to one visit rather than two.[261] This is consistent with professional guidelines and international approaches.[262] Furthermore, there is no need for licensing, even of practices which will carry out surgical abortions, as the safety of facilities can be governed by general health law under the Health and Disability Services (Safety) Act 2001.

C. Safe zones

1. The issue and proposed reform

Another issue which limits access is harassment of women outside facilities as they attempt to seek services. Harassing demonstrations can include holding vigils, carrying signs with pictures of fetuses and babies, approaching women with the intention to dissuade them, and shaming women.[263] While the Law Commission could not see any evidence that existing laws dealing with intimidation are inadequate,[264] there have been calls to implement safe zones around facilities for several years[265] and anti-abortion activists themselves claim to engage in

[257] At 130.
[258] World Health Organization *Technical and Policy Guidance* (2nd ed, World Health Organisation, 2012) at 3.3.1.
[259] For example, a number of states in Australia, the United States of America, the United Kingdom, France and Sweden.
[260] Law Commission, above n 62, at 127.
[261] At 127-128. Some clinics administer both misoprostol and mifepristone at the same time.
[262] Royal College of Obstetricians and Gynaecologists, above n 37, at [4.28] and World Health Organization, above n 258, at 44.
[263] Law Commission, above n 62, at 176.
[264] At 178.
[265] Claire Trevett and Sarah Harris "Abortion 'no-protest zone' suggested" New Zealand Herald (online ed, 16 August 2016); and Anna Whyte "Students urge Government for abortion no-protest buffer zone around hospital" *1 News Now* (online ed, 7 November 2019).

"side-walk counselling".[266] Furthermore, such demonstrations have the potential to become more prolific if permissive reform was to occur.

The Bill attempts to protect women from anti-abortion protestors by empowering the Minister of Health, on a case-by-case basis, to establish safe zones of up to 150m around abortion facilities. In safe zones it would be prohibited to intimidate, interfere with or obstruct "a person with the intention of preventing that person, or being reckless as to whether they are prevented, from accessing abortion services, seeking advice [on such] services or providing [such] services". It would also be prohibited to communicate with a person seeking services if it was "intended to cause [that] person emotional stress and would cause emotional stress to an ordinary reasonable person".[267]

2. Rights consistency

This creates a limit to freedom of expression as protected by the NZBORA.[268] Under the Bill, the Minister's decision to implement a safe zone would be what engages the right and not the empowering provision in the Bill. Therefore, the analysis of whether such decisions can be demonstrably justified in a free and democratic society[269] would need to occur on a case-by-case basis. However, for the purposes of considering the consistency of this section of the Bill with the NZBORA, the principle act of criminalising certain communications within safe areas can be examined.

One type of prohibited behavior is communication which is intended to cause emotional stress. This directly engages s 14, as communication of controversial views is central to the purpose of this right.[270] To determine if it can be demonstrably justified the test from *R v Hansen* should be applied which requires the provision to; achieve a sufficient purpose, be proportional in that it is rationally connected to the objective and impair the right as little as possible.[271] In this instance the purpose of this provision is to protect individuals attempting to access legal

[266] Law Commission, above n 62, at 126. A spokesperson from Voice for Life New Zealand has said she was a "sidewalk counsellor" who was part of a group in Hastings who "helped 32 women choose to continue their pregnancies".
[267] Abortion Legislation Bill, s 7 (proposed s 15, CSAA).
[268] New Zealand Bill of Rights Act 1990 (NZBORA), s 14.
[269] As is required by s 5.
[270] McKillop, above n 99, at 7.
[271] As is required by the *R v Oakes* [1986] 1 SCR 103 test adopted in *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 (SC) at [64].

healthcare which is sufficient and necessary. This is because, despite limited evidence current harassing behavior is restricting women's access to services, such demonstrations could become more common after the Bill is passed.[272] Furthermore, this limitation is rationally connected to the aim of improving access to abortion services as it will limit people from causing emotional stress to women seeking services, when her emotional disposition affects her ability to access such services. Finally, it impairs the right as little as possible as it requires the communication to actually have a negative impact of emotional distress. Therefore, unobtrusive protest from a reasonable distance would continue to be permissible. Arguably, this provision is demonstrably justified.

The second type of prohibited expression is intimidation, interference with and obstruction of people seeking services. Similar behaviour is already limited by the criminal law[273] and instead of the *Hansen* test being applied, the Supreme Court in *Brooker v Police* held infringements with the NZBORA should be accounted for by a narrower interpretation of whether public order is disrupted.[274] However, as outlined by Crown Law, in this instance the mens rea is different as it is "less focussed on disruption of public order and more on disruption of access to a public service" which engages the right of freedom of expression less directly.[275] However, even if the right is incidentally engaged, since this behaviour is about intentionally preventing access to a lawful service it is likely to be readily justifiable.

Ministerial discretion on whether to implement a zone or not better protects the s 14 right as the Minister will only implement such zones if satisfied it is proportionate and appropriate in the specific circumstance. However, it is the position of this dissertation that the limitation to rights is still justified and minimally impairing even if it was to be mandatory, and that this should be what is implemented in the Bill. Such zones have been introduced in some Australian states and in Canada. For example, in Tasmania, Victoria, New South Wales and Northern Territory safe zones are considered to be 150m from any facility providing abortions.[276] In

[272] As was the case in Canada following a liberalisation of the law, as discussed in *R v Lewis* (1996) 139 DLR (4th) 480 (BCSC) at [19].
[273] Summary Offences Act 1981, ss 3, 4, 21 and 22,
[274] See *Brooker v Police* [2007] NZSC 30, [2007] 3 NZLR 91; and *Morse v Police* [2011] NZSC 45, [2012] 2 NZLR 1.
[275] McKillop, above n 99, at 7.
[276] Victoria (Public Health and Wellbeing Act 2008 (Vic), ss 185A-185H), Tasmania (Reproductive Health (Access to Terminations) Act 2013 (Tas), s 9), New South Wales (Public Health Act 2010 (NSW), ss 98A–98F) and Northern Territory (Termination of Pregnancy Law Reform Act 2017 (NT), ss 14-16).

these states the High Court of Australia determined a limit to the right to freedom of political communication is justified.[277] More comparably, in Canada, the British Columbian Court of Appeal held that absolute prohibition on protest within a safe zone was a justifiable limitation to the Charter right of freedom of expression.[278] Overall, the Bill should create mandatory zones, not zones implemented on a case-by-case basis.

D. Conscientious objections

The ability of practitioners to conscientiously object to abortions limits women's access.

1. Current approach

Under the current law a practitioner with a conscientious objection is not required to perform an abortion,[279] but has a duty to inform the individual that they can obtain the service from another practitioner.[280] However, the High Court in *Hallagan v Medical Council of New Zealand* held that referring, both to the service provider and to another doctor who does refer to service providers, are not required if one conscientiously objects. The duty only requires a practitioner to inform the woman that she has the option to be treated elsewhere.[281] Despite this, once the practitioner has an "involvement of a medical character" the focus should be on the rights of the patient and one is less able to invoke a conscientious objection.[282]

This has a significant impact on the ability of women to access services, creating barriers and delays.[283] Not only this, but it may increase stigma, costs (by requiring more doctors visits) and confusion, as in some cases women believe this means they do not qualify for an abortion, especially women in vulnerable situations.[284] This is a contributor to the current average 24.9 day wait between a woman's first hospital visit, and when she receives the abortion,[285] as studies show most of this delay comes at the referral stage.[286]

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[277] For example, in Victoria in *Clubb v Edwards; Preston v Avery* [2019] HCA 11.
[278] *R v Spratt* (2008) 235 CCC (3d) 521 (BCCA) at [91].
[279] CSAA, s 46(1).
[280] Health Practitioners Competence Assurance Act 2003, s 174.
[281] *Hallagan*, above n 23.
[282] As it is only then that patients are fully protected by the rights under the Code of Health; see *Hallagan*, above n 23, at [23].
[283] Law Commission, above n 62, at 157.
[284] Foster and Jivan, above n 138, at 860.
[285] Martha, McNeill and Ashton, above n 33, at 5.
[286] Angela Ballantyne, Colin Gavaghan and Jeanne Snelling "Doctors' rights to conscientiously object to refer patients to abortion service providers" (2019) 132 NZMJ 64 at 69.

2. Bill's changes

While the ability of women to self-refer means the impact of conscientious objectors is less significant, it still must be addressed. The Bill does this by requiring practitioners to disclose the fact of their objection at the earliest opportunity and tell the women how she can access the contact information of those who will provide the service.[287] This will be done by informing the woman on how to access a maintained list, compiled by the Minister for Health, of practitioners and providers who will provide the service.[288] This is indirect referral as the objector is not required to directly refer the woman to the service provider.

The common responses justifying conscientious objection are that being able to object is important as it is part of the practitioner's moral integrity which forms part of their personal identity[289] and that there is a right to freedom of conscience.[290] However, this must be balanced against the importance of providing adequate medical care as part of a medical practitioner's vocational role. Furthermore, the limit proposed in the Bill to the right to conscientiously object is a demonstrably justified one. As discussed, to improve access to abortion is a legitimate purpose. Ensuring indirect referral should improve access and avoid delays. Furthermore, it is minimally impairing as it does not require individuals to provide the services themselves, merely to inform, as practitioners should already do.[291]

A weakness of the proposed conscientious objection provision is that it does not require direct referrals to a provider. In Victoria, Northern Territory and New South Wales the practitioner must ensure the woman is referred to an alternative health provider, and it is an offence not to.[292] This improves access as women leave with all the information required to access services.

[287] Abortion Legislation Bill, s 7 (proposed s 19, CSAA).
[288] Section 7 (proposed s 18(c), CSAA).
[289] Mark R Wicclair "Conscientious objection in medicine" (2000) 14(3) Bioethics 205 as discussed in Ballantyne, Gavaghan and Snelling, above n 286, at 67.
[290] NZBORA, s 13.
[291] Code of Health, right 6.
[292] Victoria (Abortion Law Reform Act 2008 (Vic), s 8), New South Wales (Abortion Law Reform (Miscellaneous Acts Amendment) Bill 2016 (NSW), 1.3) and Northern Territory (Termination of Pregnancy Law Reform Act 2017 (NT), s 11-12,).

3. Effects on employment

Another change included in the Bill is those who have a conscientious objection must be accommodated for employment purposes, as long as it does not unreasonably disrupt the employer's ability to provide abortion services.[293] This is done to protect the rights of employees under the Human Rights Act 1993, replicating s 28(3) in requiring the accommodation of ethical beliefs unless it would unreasonably disrupt the employer's activities. However, this also conflicts with the right to freedom from discrimination[294] on the basis of political opinion.[295]

This discrimination is justified for similar reasons as discussed above. It is a legitimate goal to improve access to abortion services. This would achieve this goal as it could, and should, be utilised in remote areas where there are limited practitioners to ensure that there are sufficient practitioners without an objection. Moreover, it is minimally impairing by requiring the employer to accommodate the objection when it is reasonable to do so.[296]

E. Further methods of improving access

Despite these improvements, it will likely be insufficient to adequately ensure proper access to abortions, especially in rural areas. A woman's access is directly related to the "availability of trained, technically competent providers in medically safe facilities that are easily reached".[297] It is these elements which should be improved to improve access overall.

1. Improving physical access

In an attempt to control hospitals which refuse to offer services, the Canadian federal government has taken measures such as withholding funding. However, such measures exerted minimal pressure on compliance.[298] Alternatively, threats of legal action have helped increase access, for example in Prince Edward Island.[299] While using litigation to ensure access is less likely in this country, New Zealand has an even better opportunity to ensure adequate access because reform would be through Parliament and not the courts. Furthermore, it is primarily a

[293] Abortion Legislation Bill, s 7 (proposed s 20, CSAA).
[294] NZBORA, s 19.
[295] HRA, s 21(1)(j).
[296] McKillop, above n 99, at 17.
[297] Law Commission, above n 62, at 10.
[298] Sabourin and Burnett, above n 208, at 534.
[299] Shannon Stettner *The unfinished revolution* (1st ed, Athabasca University Press, Canada, 2016) at 366.

public health system and not a federal system. While the ASC had no power to require services in a particular area or up to a particular gestation, with the Ministry of Health's oversight and Parliamentary intervention if necessary, this may be possible. This could be justified, similarly to how withholding of funding in Canada was justified, because the government recognises abortion services as medically necessary.[300]

Another creative method to improve access is to introduce medical abortion services through telemedicine. This has been implemented effectively in Australia and tested in the United States, with staff citing many benefits to access.[301] Telemedicine has been found to decrease the overall rate of abortion, but increase the number of abortions received before 13 weeks. [302] When compared to face-to-face methods, it was found both were comparable in satisfaction and outcomes, and telemedicine did not reduce the quality of aftercare.[303] The Bill proposes to allow abortions to be carried out not on licensed premises, therefore, telemedicine could become possible and should be introduced in New Zealand.

2. Improving attitudes

The stigma associated with abortion also acts as a significant barrier to access.[304] Legalising abortion should diminish this stigma.[305] Furthermore, better training of medical students in and around abortion services could improve access as evidence suggests experience with services improves the attitudes of practitioners towards abortion, increases the likelihood of them becoming a future abortion provider and makes them more likely to discuss abortion with their patients.[306] Moreover, improved sexual education in secondary school has been shown to reduce general stigma about abortion, improving women's ability to access services and

[300] Johnstone and Macfarlane, above n 209, at 109.
[301] See generally Kate Grindlay, Kathleen Lane and Daniel Grossman "Women's and providers' experiences with medical abortion provided through telemedicine: a qualitative study" (2013) 23 Women's Health Issues 117.
[302] Kate Grindlay, Kathleen Lane and Daniel Grossman "Changes in service delivery patterns after introduction of telemedicine provision of medical abortion in Iowa" (2013) 103 American journal of public health 73 at 73.
[303] Kate Grindlay, Kathleen Lane and Daniel Grossman "Effectiveness and acceptability of medical abortion provided through telemedicine" (2011) 118 Obstetrics & Gynecology 296 at 302.
[304] Johnstone and Macfarlane, above n 209, at 114; and Sabourin and Burnett, above n 208, at 540.
[305] Keogh and other, above n 214, at 19.
[306] Sarp Aksel, Lydia Fein, Em Ketterer, Emily Young and Lois Backus "Unintended Consequences: Abortion Training in the Years After *Roe v Wade*" (2013) 103(3) AJPH 404 at 405.

reducing the incidence of unwanted pregnancy.[307] The Ministry of Health should consider these options.

C. Recognition of Tikanga Māori

A final factor, relating to access to services which must be considered, is ensuring any reform has adequate consideration of Māori women and recognition of tikanga. The ASC has noted New Zealand's health policy and law has developed in a Eurocentric fashion which devalues and marginalises mātauranga Māori.[308] In order to uphold the Treaty of Waitangi principle of good faith, Māori approaches to healthcare must be considered.[309] Furthermore, studies show Māori women are less likely to seek services than Pākeha women.[310] Jade Sophia Le Grice notes this is likely to have arisen from strong cultural perspectives which create an unsupportive environment for women who are facing the decision of whether or not to terminate.[311]

1. Māori perspectives

Māori views on abortion cannot be simply formulated, are varied and are the subject of limited research.[312] Historical accounts of Māori perspectives tell a confusing story. Abortion was not linguistically separate from miscarriage and there are some accounts of abortion practice prior to colonisation.[313] However, reproduction is also a celebrated and protected process, and ensuring the next generation is a priority in Māori culture. [314] Furthermore, Māori perspectives were significantly influenced by colonisation and conversion to Christianity, which is known globally for its condemnation of abortion.[315]

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[307] Mónica Frederico and others "Factors Influencing Abortion Decision-Making Processes among Young Women" (2018) 15(2) International journal of environmental research and public health 329 at 337.
[308] Defined as "theories, practices and protocols for being in the world, ideas about what it is to know something and how knowledge is organised […] about what counts as reality or truth […] these ideas traverse western philosophical concepts of metaphysical, ontological and epistemological ways of knowing"; see Linda Smith and others "Indigenous knowledge, methodology an mayhem: What is the role of methodology in producing indigenous insights? A discussion from Matauranga Maori" (2016) 4(3) Knowledge Cultures 131 cited in Jade Sophia Le Grice and Virginia Braun "Indigenous (Māori) perspectives on abortion in New Zealand" (2017) 27(2) Feminism & Psychology 144 at 148.
[309] *Standards of Care*, above n 168, at 11.
[310] Arthur Grimes, Robert MacCulloch and Fraser McKay "Indigenous Belief in a Just World: New Zealand Māori and Other Ethnicities Compared" (2015) 15(14) Motu Economic and Public Policy Research 1 at 19.
[311] Le Grice and Braun, above n 308, at 145.
[312] Law Commission, above n 62, at 63.
[313] Le Grice and Braun, above n 308, at 146.
[314] At 146.
[315] At 147.

In 2017, Grice completed an empirical study attempting to understand the varying perspectives of Māori on abortion by interviewing 43 Māori participants on their views. She found there were a range of different perspectives, from the importance of new life and whānau protection, to the importance of female choice.[316] Participants also emphasised the relevance of wider whānau investment in reproductive decision making, with many reporting whāngai as a preferred option to abortion as the child can remain a part of the wider whānau.[317] Overall, it was female choice which was the approach the majority of participants agreed on and people who would disagree with abortion would refer to it only as their personal view.[318]

Furthermore, in a 2019 study Māori were found to be more supportive of abortion for any reason than any other group,[319] indicating there is also a call for liberalisation from the Māori community.

2. Protection of Māori women

There is still a need for Māori protection and to facilitate a culturally appropriate and supportive environment to prevent post-abortion distress.[320] Access for Māori can be "fraught with stigma, embarrassment, a lack of information, and limited access to culturally appropriate services".[321] The current system is inequitable and barriers to access disproportionately affect Māori[322] because, as it was submitted to the Law Commission, areas with high Māori populations have limited access to reproductive health services and general-practitioners who will refer to abortion services.[323] Self-referral, coupled with a requirement for conscientious objectors to refer, should improve access for Māori women.

The mechanisms protecting Māori in the current regime include ensuring counsellors have knowledge on the cultural norms and practices related to: care; touch and respect of the human

[316] At 150-153.
[317] At 154-155.
[318] At 152.
[319] Huang, Osborne and Sibley, above n 60, at 18.
[320] Le Grice and Braun, above n 308, at 157-158.
[321] Beverley Lawton and others "E Hine: access to contraception for indigenous Māori teenage mothers" (2016) 8(1) J Prim Health Care 52 at 53.
[322] Te Whāriki Takapou, the Abortion Law Reform Association of New Zealand and Family Planning New Zealand "Alternate Report to the 70th CEDAW Pre-sessional Working Group 2017" at [12].
[323] Law Commission, above n 62, at 122.

body; disposal of human tissue; and the influence of spiritual beliefs on how decisions are made.[324] There is a requirement for service providers to have a place for women to wash after the procedure and to facilitate the return of the "products of conception" to ancestral lands if desired.[325] Providers also must take cultural competency training, have an active plan to recruit Māori staff and be familiar with concepts of tapu.[326] Since the ASC will no longer be the supervisory body, the Ministry of Health must ensure these procedures are maintained. However, this is insufficient to improve access in areas with high Māori populations. While it is beyond the scope of this dissertation, there is nothing in the Bill specifically aimed at improving access for Māori women and this is something which should be addressed by the Select Committee.

[324] Counselling Advisory Committee to the Abortion Supervisory Committee *Standards of Practice for the Provision of Counselling* (April, 1998) at 8.
[325] *Standards of Care*, above n 168, standards 6.3.12-6.3.15.
[326] Standards 6.3.1, 6.3.2, 6.3.9 and 8.2.7.

Conclusion

New Zealand has historically been at the vanguard of women's rights, being the first country to give women the vote and having a strong statutory framework protecting their equal rights. However New Zealand is currently faced with a restrictive, out-of-date and entirely dysfunctional abortion regime which is amongst the most prohibitory in the developed world. Ever since 1977, when the last significant change to abortion legislation was made, there have been demands for liberalisation, and pressure is mounting. The Bill provides a crucial opportunity for legal reform; reform which should properly recognise female reproductive rights, improve gender equality and protect vulnerable women at one of the most significant points in their life.

This dissertation has reviewed the Bill in an attempt to ascertain the most effective legal framework. There are clear and convincing justifications for decriminalisation, both from a rights-based and moral perspective. Women should be granted the ability to make decisions for themselves, upholding their fundamental human rights and protecting their equality before the law. Furthermore, there are also strong justifications for why the Bill should legalise abortion at all gestational limits. Women are, at late stages of pregnancy, at their most vulnerable and need to be empowered, along with support from their medical practitioner, with the final decision. A late-stage abortion is generally not sought without good reason and a medicalised approach runs the risk of neglecting those reasons.

Finally, legalisation of abortion is insufficient, and must be paired with improved and protected access for all New Zealand women, particularly for vulnerable Māori women. The Bill is effective in its introduction of safe zones and self-referral, removal of any provisions requiring procedures to be carried out by a certifying consultant or in a licensed institution, and improvement of the provisions relating to conscientious objection. However, as seen in other jurisdictions, this can be insufficient and so more must be done to ensure ready access to services so women are able to, where possible, terminate their pregnancy earlier and more safely than they otherwise might.

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