THE PASSING OF THE ABORTION LEGISLATION BILL

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This article takes a critical view of the Abortion Legislation Act 2020, supporting its liberalisation as a step in the right direction but questioning whether the Act goes far enough. The article briefly outlines the preceding law and the process allowing for reform. It then outlines the new regime, justifying the Act's liberalisation by drawing on rights-based and moral arguments. Finally, the article analyses potential issues with the Act, arguing that not enough has been done to ensure that pregnant people have proper access to abortion services by including a gestational limit, failing to introduce safe zones, and not properly addressing access issues for rural dwellers and Māori. Overall we in Aotearoa New Zealand should not consider the debate surrounding abortion and its liberalisation completely resolved.

I INTRODUCTION

The 24th of March 2020 marked a historic day for New Zealanders,[1] as the Abortion Legislation Bill passed through Parliament and was given royal assent, ending a fight for the liberalisation of abortion regulation. With 18 per cent of all pregnancies in Aotearoa being terminated and 25 per cent of people who can get pregnant having had an abortion in their lifetime, abortion is an unavoidable necessity.[2] Prior to 24 March 2020, in order to get an abortion, New Zealanders were required to meet very narrow criteria. If the individual could not meet said criteria, doctors would refuse to provide treatment as they would otherwise be committing a crime with a maximum sentence of 14 years' imprisonment. This was because the approach to abortions prior to the Abortion Legislation Bill treated the procurement of an abortion as a criminal

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1 I generally use "pregnant people" in this article because abortion can be of concern to women, trans men or non-binary individuals. There are however references to "women" in original quotations.

2 *Report of the Abortion Supervisory Committee* (Annual Report, 2018).

activity.[3] That approach was enshrined in legislation which was enacted during the 1970s:[4]

> 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.

Now, following this long overdue change, there is free access to an abortion up to 20 weeks' gestation. This change represents a monumental shift in the way that we respect reproductive freedom and choice in Aotearoa. While the passing of the Bill is a welcome relief, an important question still remains: has it gone far enough and is the battle truly over? The reform is intended to improve access to abortion services, although it is yet to be shown if this will be the case. This article argues that discussions around abortion liberalisation are not over and that there are still issues with the reformed law. Not enough has been done to ensure that people have proper access to abortion services, and the gestational limit of 20 weeks may pose an unnecessary limitation.

II THE PRECEDING LAW

Prior to the 2020 reform, abortions were regulated by the Crimes Act 1961 (CA) and the Contraception, Sterilisation, and Abortion Act 1977 (CSAA). Under s 183 of the CA, it was 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 exception to this offence was if two certifying consultants were of the opinion that the abortion came within one of the grounds listed in the CA. If the person's pregnancy was under 20 weeks, these grounds included:[5]

i) "if continuing the pregnancy would result in serious danger [...] to the life, physical health or mental health of the woman";

ii) any form of incest;

iii) mental sub-normality of the pregnant person; and

3 Crimes Act 1961, s 183 [CA].
4 (8 August 2019) 740 NZPD (Abortion Legislation Bill – First Reading, Jan Logie).
5 CA, s 187A(1).

iv) if there were a substantial risk that the child, if born, would be "so physically or mentally abnormal as to be seriously handicapped".

Other factors which were not grounds, but which could be accounted for were the extremes of age and sexual violation.[6] Then after 20 weeks, the grounds on which a pregnancy could be aborted were only if the abortion was required to:[7]

i) save the life of the mother or girl; or

ii) prevent serious permanent injury to their physical or mental health.

The process that was required to authorise the abortion, either before 20 weeks or afterwards, was then laid out in the CSAA. A person could request an abortion from their doctor and if the doctor believed a ground may apply, they could propose to perform the abortion themselves if authorised under the Act,[8] or refer the person "to another medical practitioner […] who may be willing to perform [the] abortion".[9] The abortion then had to be carried out at a licensed institution,[10] by an "operating surgeon" pursuant to a certificate issued by two "certifying consultants" who authorised the procedure.[11]

Once the decision of a certifying consultant was made to authorise or not authorise a procedure, it could not be reviewed by the Abortion Supervisory Committee (ASC), a supervisory committee established by the CSAA. This was because "to do this would be to engage in a process of attempting to review the clinical judgement of the consultant in an individual case".[12] No doctor was required to consent or assist with an abortion if they had a conscientious objection, even if one of the grounds for an abortion existed.[13] Such an objection also permitted a doctor to

6 Section 187A(2).
7 Section 187A(3).
8 Contraception, Sterilisation, and Abortion Act 1977, s 32(2)(b) [CSAA].
9 Section 32(2)(a).
10 There are "full" and "limited" licenses, the first of which allow abortions to be performed at any point during pregnancy, and the latter within the first 12 weeks only.
11 CSAA, s 29. Failure to follow this procedure is otherwise an offence under s 37(1) as well as the CA. There is an exception under s 37(2) if immediate action is necessary to save the life of the patient or prevent serious permanent injury to one's physical or mental health.
12 *Right To Life New Zealand Inc v The Abortion Supervisory Committee* [2012] NZSC 68, [2012] 3 NZLR 762 at [40] [*Right to Life New Zealand*].
13 CSAA, s 46.

refuse to organise for a case to be considered by certifying consultants, which was otherwise required by the CSAA.[14]

When considering how this law was applied in practice, the most striking statistics are those that detail which of the grounds were used to authorise abortions. In 2017, 97.3 per cent of all abortions were granted on the basis of danger to mental health, with 0.7 per cent on the basis of danger to both mental and physical health, 0.8 per cent on the basis of danger to mental health and having a child with a severe disability, and a negligible few on the basis of danger to both mental health and life.[15] This means that, overall, around 98.9 per cent of all abortions carried out in New Zealand employed danger to the mental health of the person seeking an abortion as a justifying ground. This high percentage demonstrates the disconnect that existed between the law and abortion practice: clinicians were enabling access to abortion on the basis of a general — and allegedly liberal — application of the mental health ground.

While it is arguably logical for certifying consultants to conclude that forcing a person to have an unwanted pregnancy would be likely to seriously endanger their mental health, to the extent such an approach may have been employed, it did not go without scrutiny. In the High Court decision *Right To Life New Zealand Inc v The Abortion Supervisory Committee*, Miller J commented that the high percentage of people receiving abortions based on mental health grounds suggested certifying consultants were employing the ground in a much more "liberal fashion than the legislature intended".[16] Despite the Court of Appeal noting that this comment was outside the scope of the issues before the Court, as it is not for a court to examine the legality of individual instances or "address in any effective way the systemic issues that are properly the concern of the Committee",[17] it is important to note that such scrutiny has been applied. Furthermore, in 2005 the ASC noted that the "wording [of the Act came] to have a de facto liberal interpretation" and was not "working as originally intended".[18]

14 *Hallagan v Medical Council of New Zealand* HC Wellington CIV-2010-485-222, 2 December 2010 at [20].
15 *Report of the Abortion Supervisory Committee*, above n 2, at 21.
16 *Right To Life New Zealand*, above n 12, at [135].
17 *Right To Life New Zealand Inc v The Abortion Supervisory Committee* [2011] NZCA 246 at [213].
18 At [50]–[52].

Despite an allegedly liberal approach being taken to the CA and CSAA, pregnant people continued to face limited access to abortions. In 2013 to 2017, certifying consultants found 1309 requests for abortion were not justified under the CA grounds and were therefore rejected.[19] This statistic does not account for situations where a general practitioner failed to refer a person because of a conscientious objection or otherwise unlawfully refused, both of which impact access. In 2017, 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 being 20 weeks pregnant when services were sought.[20]

Furthermore, the ASC noted the provision of safe and legal abortions was inconsistent throughout the country, with some areas not having any service providers.[21] While the ASC recommended that people should not have to travel more than two hours to receive an abortion,[22] there is no evidence this recommendation was realised. As of 20 June 2018, there were only 168 certifying consultants across the country[23] and in 2010, the average time between first contact with the health system and the date of termination was estimated to be 24.9 days.[24]

III TIDES OF CHANGE

The legal framework established through the CA and CSAA has been readily criticised, and the fight for liberalisation was a long and tough one. There were a range of different factors which instigated reform. The first being that the law was outdated, and it no longer aligned with modern healthcare practices.[25] The liberal interpretation was at times uncertain,[26] which is contrary to the rule of law as valid and effective law should, where possible, be predictable,

19 "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).

20 Susan Strongman "No Choice: When a legal abortion is denied" *The New Zealand Herald* (online ed, 19 September 2017) and Sarah Harris "Denied abortion: Woman discovers pregnancy at 4 months, 2 weeks" *The New Zealand Herald* (online ed, 15 October 2017).

21 In Counties Manukau there are no providers and Tāmaki Makaurau Auckland only has one main public service: *Report of the Abortion Supervisory Committee* (Annual Report, 2017) at 5.

22 At 12.

23 *Report of the Abortion Supervisory Committee*, above n 2, at 29.

24 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.

25 *Report of the Abortion Supervisory Committee*, above n 2, at 4.

26 *Right To Life New Zealand*, above n 12, at [51].

non-arbitrary and clear.[27] Furthermore, as the ASC has pointed out, even the language in the law was outdated. The statute referred to doctors as "he", used terms such as "woman's own doctor", ignored specialised services such as Family Planning, and referred to "severely subnormal" women which is derogatory and inappropriate.[28]

Another driver for reform was international influence. Aotearoa's abortion law was amongst the eight most restrictive abortion regulation frameworks in the developed world.[29] Many other countries were taking steps to liberalise abortion law. Since 2000, Switzerland, Australia and Ireland, amongst 25 other countries, have moved to broaden their criteria for what constitutes a legal abortion.[30] 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, while another 30 per cent allowed abortions upon request, an increase from 24 per cent in 1996.[31] Furthermore, in 2012, the United Nations Committee on the Convention on the Elimination of All Forms of Discrimination Against Women suggested New Zealand's approach made "women dependent on the benevolent interpretation of a rule which nullifies their autonomy" and noted criminalisation leads to pregnant people seeking "illegal abortions, which are often unsafe".[32] 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.[33]

A final element supporting abortion reform was public opinion. At the time of the 2017 election, poll results showed a majority of New Zealanders

27 The Rt Hon Lord Thomas Bingham "The Rule of Law" (Sixth Sir David Williams Lecture, Centre for Public Law, 16 November 2006).

28 *Report of the Abortion Supervisory Committee* (Annual Report, 2016) at 4.

29 The Guttmacher Institute, a research organisation that investigates sexual and reproductive health, characterised international approaches to abortion law into six categories, one being the least restrictive and six the most. New Zealand fell into category four: Susheela Singh and others *Abortion Worldwide 2017: Uneven Progress and Unequal Access* (Guttmacher Institute, New York, 2018) at 14–21.

30 At 18.

31 United Nations Department of Economic and Social Affairs Population Division *Abortion Policies and Reproductive Health around the World* ST/ESA/SER.A/343 (2014) at 6.

32 Committee on the Elimination of Discrimination against Women *Concluding observations of the Committee on the Elimination of Discrimination against Women* CEDAW/C/NZL/CO/7 (27 July 2012) at 9.

33 *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.

supported the right to access abortion on request.[34] This was also shown in a 2017 survey conducted by the New Zealand Election Study where 63.3 per cent of New Zealanders disagreed with the statement "abortion is always wrong", an increase from 55.4 per cent in 2008.[35] Then in 2019 a study published in the New Zealand Medical Journal involving 20,000 participants showed a majority of those surveyed either strongly agreed, or agreed, that abortion should be legal, regardless of the reason.[36] They concluded that legislative reform would be well received by the public.[37]

IV THE ABORTION LEGISLATION BILL

Following such reports and international recommendations, during the 2017 election campaign leader of the Labour party, Jacinda Ardern, declared her intention to decriminalise abortion should Labour be elected.[38] After the Labour coalition government was established, Andrew Little, Minister of Justice, requested that the Law Commission consider options for reform.[39] This led to a significant increase in debate surrounding the issue and, more importantly, to the eventual introduction of the Abortion Legislation Bill to Parliament in August 2019.

The Bill proposed removal of any statutory test for a person who is under 20 weeks pregnant.[40] Then, for a person over 20 weeks pregnant (referred to as the gestational limit), the Bill required the health practitioner to reasonably believe the abortion is "appropriate with regard to the pregnant woman's physical health, mental health, and well-being".[41] It also proposed other important changes such as: allowing any qualified health practitioner to provide the service;[42] requiring health practitioners to advise people of the availability of counselling services without making such services mandatory;[43]

34 Abortion Law Reform Association of New Zealand "Labour Party Supports Decriminalisation of Abortion" *Scoop* (online ed, 4 September 2017).

35 *New Zealand Election Study* (19 August 2019) <www.nzes.org>.

36 Yanshu Huang, Danny Osborne and Chris G Sibley "Sociodemographic factors associated with attitudes towards abortion in New Zealand" (2019) 1497 NZMJ 9 at 13.

37 At 18.

38 Eleanor Ainge Roy "New Zealand election: Jacinda Ardern pledges to decriminalise abortion" *The Guardian* (online ed, 5 September 2017).

39 Ken Orr "Abortion a justice issue, not a health issue" *The Gisborne Herald* (online ed, 11 April 2018).

40 Abortion Legislation Bill 2019 (164–3), cl 7 (s 10, CSAA) [Abortion Legislation Bill].

41 Clause 7 (s 11, CSAA).

42 Clause 7 (ss 2, 10 and 11, CSAA).

43 Clause 7 (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 (s 20A, CSAA).

allowing people to self-refer to an abortion service provider rather than requiring referral from their primary healthcare provider;[44] no longer requiring services to be provided at a licensed institution;[45] and disbanding the ASC. [46]

There were also two controversial proposals which garnered much debate. These were first, that the Bill created a case-by-case regulation-making power for the Minister of Health to establish "safe areas" around abortion facilities[47] and second, that the Bill would require conscientious objectors to inform pregnant people about their objection at the earliest opportunity so that they could obtain services elsewhere.[48]

Despite these changes the Bill still retained important protective measures such as the criminal offence for persons other than health practitioners who attempt to procure an abortion for a pregnant person or supply the means, and the criminal offence of killing an unborn child for anyone who causes harm to a pregnant person and in doing so causes the death of a fetus.[49]

V THE NEW REGIME

The Bill was treated as a conscience issue in the House with members voting based on personal beliefs. On 18 March 2020, the Bill passed through the House of Representatives and abortion was decriminalised in Aotearoa through the Abortion Legislation Act 2020.

The Act was passed with several amendments. First, the safe zone provisions were removed. Secondly, the conscientious objection provision was amended to ensure providers inform a pregnant person how to access the contact details of another person who is their "closest provider" rather than the contact details of any service provider. Finally, an obligation was placed on the Minister of Health to ensure that access to emergency contraception is available throughout Aotearoa within 48 hours of it being requested by any person. All changes made to the Bill have been implemented through amendments to the

44 Clause 7 (s 14, CSAA).
45 Achieved by replacing ss 10 and 11 of the CSAA and repealing ss 24 and 25.
46 Abortion Legislation Bill, cl 17 (Sch 1, Pt 1, s 2 CSAA).
47 Abortion Legislation Bill 2019 (164–1), cl 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 cl 7 (proposed s 15, CSAA).
48 Abortion Legislation Bill 2019 (164–1), cl 7 (proposed s 19, CSAA).
49 Abortion Legislation Bill, cl 12 (s 183, CA).

CSAA, CA and the Health Practitioners Competence Assurance Act 2003. Overall, many saw these changes in the law as a welcome reform.

VI WHY THIS CHANGE IS A STEP IN THE RIGHT DIRECTION

Liberal approaches to abortion law are most commonly and often most convincingly argued for from a rights-based perspective. However, there are also strong moral arguments in support. In this section I consider all of these when assessing why the reform is a step in the right direction.

A A rights-based approach

Often, the most common discourse in the abortion debate focuses on the enforceable rights of the pregnant person and the unborn child. Such an approach has been used by overseas jurisdictions with entrenched rights instruments that 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 "right to privacy" arising from the constitution. Such a right to privacy protects a person's decision to terminate a pregnancy.[50] The same was determined in Canada in *R v Morgentaler* where it was held that the right to privacy, arising from the right to security of person provided for in the Canadian Charter of Rights and Freedoms, related to the ability to make important decisions about one's own life and to have bodily autonomy.[51]

In comparison, New Zealand lacks an entrenched rights framework. Courts are limited to issuing a declaration that legislation is inconsistent with the New Zealand Bill of Rights Act 1990 (NZBORA).[52] The courts have also held that there is no specific right to abortion under the NZBORA because, unlike the other jurisdictions discussed above, the NZBORA has no guarantee to liberty and security of person.[53] Despite this, abortion can be considered part of a suite of moral, if not legal, reproductive rights. For example, the Privacy Commissioner submitted to the Law Commission, when they were considering the options available for reform, that the existing law was

50 *Roe v Wade* 410 US 113 (1973) at 113 and 153.
51 *R v Morgentaler* [1998] 1 SCR 30 (SCC).
52 *Attorney-General v Taylor* [2018] NZSC 104.
53 *Right to Life New Zealand*, above n 12, at [98]. This issue was not addressed on appeal, but the Supreme Court at [64] did commend the High Court's comments.

"inadequate to protect women seeking to exercise a choice relating to their own reproductive rights".[54]

Despite the CSAA stating in its long title that full regard should be had to the "rights of the unborn child", it is judicially established a fetus has no enforceable legal rights as it is not a legal person[55] and New Zealand generally adheres to the "born alive" rule.[56] This is consistent with the approaches taken in Canada[57] and the United States.[58] English and Canadian courts have even gone so far as to claim the fetus has no rights which prevail over the pregnant person's because the fetus and its mother cannot be considered separate legal people.[59] Furthermore, Crown Law considered the Bill and concluded decriminalising abortion does not engage the right not to be deprived of life under s 8 of the NZBORA as a fetus has no enforceable rights.[60]

Having said this, it is challenging to argue a fetus has no interests whatsoever. This sentiment is currently alluded to in legislation. In *Wall v Livingston*, Woodhouse P noted the CSAA prescribed specific precautionary requirements to balance the "deep philosophical, moral and social attitudes" which existed when the original legislation was drafted.[61] Furthermore, in *Right to Life New Zealand Inc v Rothwell,* Wild J concluded that it was not untenable for the plaintiff to argue that the unborn child had some rights enforceable at law. Primarily, a fetus has the right to be born unless the mother's pregnancy is terminated in accordance with the provisions of the CSAA.[62] Fetal life is not entirely inconsequential and therefore, when making a rights-based assessment,

54 Law Commission *Alternative Approaches to Abortion Law* (NZLC MB4, 2018) at 54.

55 *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 12, at [1].

56 *Right to Life New Zealand*, above n 12, at [81]. The born alive rule is a well-established common law principle which provides that a fetus is not a legal person. In other words, a fetus has no status to bring a claim and thus has no enforceable rights before birth.

57 Canadian Charter of Rights and Freedoms, art 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).

58 Concerning the United States Constitution, amend XIV, § 1. Discussed in *Roe v Wade*, above n 50, at 158.

59 This is in the context of the right to decline treatment, see *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).

60 Matt McKillop *Abortion Legislation Bill — consistency with New Zealand Bill of Rights Act 1990* (Crown Law, ATT395/294, 1 August 2019) at 14.

61 *Wall v Livingston,* above n 55, at 737.

62 *Right to Life New Zealand Inc v Rothwell* HC Wellington CIV 2005-485-999, 11 October 2005 at [46].

moral arguments impact the discussion and fetal interests must be considered to some extent.[63]

International obligations also suggest permissive reform is more rights consistent. The Beijing Declaration and Platform for Action, to which New Zealand 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 violence".[64] Furthermore, the United Nations Special Rapporteur on the Right to Health notes criminal laws which penalise and restrict abortions are "paradigmatic examples of impermissible barriers to the realisation of women's right to health and must be eliminated".[65]

Alternative rights can also be advanced in the New Zealand context to justify a pro-choice stance. For example, last year six women and the Abortion Law Reform Association of New Zealand (ALRANZ) complained to the Human Rights Commission alleging abortion law was inconsistent with s 19 of the NZBORA, freedom from discrimination. The Human Rights Act 1993 includes sex and pregnancy as grounds for discrimination.[66] ALRANZ alleged the law was discriminatory as pregnant people seeking healthcare received demonstrably worse treatment than others seeking healthcare: no other individual was required to seek approval from certifying consultants; could be denied healthcare because their reasons were not those listed in the CA; was forced to lie to doctors about their mental health status; was subject to arbitrary and unpredictable withholding of healthcare; or was subject to possible refusal of services because of the provider's conscience with no warning or recourse.[67]

Leaving the choice of whether to terminate a pregnancy with the pregnant person better upholds personhood, reproductive justice and bodily autonomy, even if such rights do not explicitly exist in the NZBORA. The new regime's

63 The issue of fetal rights is worth discussing for moral reasons but is beyond the scope of this article. This article is predicated on the assumption that the fetus has interests which should be taken into account to some extent, but not enforceable rights at law.

64 United Nation's Fourth World Conference on Women *The Beijing Declaration and Platform for Action* A/CONF.177/20 (1995) at [94]–[95].

65 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].

66 Human Rights Act 1993, s 21(a).

67 Abortion Law Reform Association of New Zealand "ALRANZ's Complaint to the Human Rights Commission" (26 August 2019) ALRANZ Abortion Rights Aotearoa <www.alranz.org>.

permissive approach better maintains this right to choose and upholds international obligations.

B Critiques of a rights-based approach

While a rights-based approach effectively justifies liberalisation, there are valid critiques of such an approach. Many suggest that rights talk should be rejected in favour of other forms of discourse. Rights theory is criticised as there can be bias in the individualistic rights which tend to be protected.[68] Moreover, rights-based discussions can be excessively adversarial when protagonists take binary and absolute positions.[69] 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 which demands only one winner. Beiner discusses this specifically in the context of abortion. He suggests abortion debate cannot focus on the competing rights of the pregnant person and fetus 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.[70] 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".[71] A rights-based argument is unavoidably based on moral conceptions of good, and Beiner argues that using the label of rights merely gives a valid and definite gloss to moral arguments.[72] The alternative is to approach discourse from a moral and political angle to allow transparent debate which accounts for the welfare of all. Mackenzie articulates a similar point of view. She suggests rights-based debate misrepresents the nature of abortion decisions, ignoring the connection between the pregnant person and fetus and the reasons why the right to choose is vital for bodily autonomy.[73] In agreement with these critics, my view is that New Zealand's process is a preferable approach: where the courts do not determine the law through an exclusively rights-based approach, but rather where reform is a matter of policy

68 Morton Horwitz "Rights" (1988) 23 Harv Civ R/Civ Lib L Rev 393 at 399–400.

69 Tom Campbell *The Left and Rights: A Conceptual Analysis of the Idea of Socialist Rights* (Routledge & Kegan Paul, Boston, 1983).

70 Ronald Beiner *What's the matter with Liberalism* (University of California Press, Berkeley, 1992) at 84 and 96.

71 At 84 and 86.

72 At 82–83.

73 Catriona Mackenzie "Abortion and embodiment" (1992) 70(2) Australasian Journal of Philosophy 136 at 137.

for Parliament to debate. It allows for clinical input and public contribution where the moral nuances impacting the rights involved can be considered.

C 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 purely rights-based approaches. There are several formulations of these arguments which focus on: the fetus; the pregnant person; the connection between the pregnant person and the fetus; or the importance of choice. I address these in turn.

The main argument of the pro-life movement centres on three core propositions: that it is wrong to kill innocent humans, that the fetus is an innocent human being, and therefore abortions are unjust, and the law should prohibit the killing of a fetus.[74]

This view is criticised by those who do not accept that a fetus has personhood. An early formulation of this criticism came from philosopher Mary Anne Warren. She argued 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.[75] A 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.[76] Warren also clarifies that while infants also 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 pregnant person's rights because the fetus is no longer physically reliant on the pregnant person and people would be willing to adopt the child.[77]

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

74 Mary Anne Warren "On the Moral and Legal Status of Abortion" (1973) 57(1) Monist 43 at 44.

75 At 55.

76 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.

77 Mary Anne Warren "Postscript on Infanticide" (1982) in Joel Feinberg (ed) *The Problem of Abortion* (Wadsworth, Belmont, 1984). I do not necessarily agree with this position regarding adoption. This is discussed further in Part VII(C).

just requires a natural capacity to develop these qualities in order to be considered a person. Consequently, an embryo is a person from conception.[78] This is similar to the argument that abortion is wrong because it deprives the fetus of a valuable future.[79] However, this too liberally grants human status.[80] Without consciousness of personal identity, a fetus does not have an interest in its future.[81] In my view, conscious personal identity is not developed at least until viability. This is the position adopted in the regulatory framework with the 20-week gestational limit.[82] Moreover, such pro-life arguments are also undermined when pro-lifers agree that abortion is appropriate when the mother's life is at risk and in cases of rape and incest. [83]

The moral approach to the fetus ingrained in the common law through the born alive rule is that new-born infants are distinguished from fetuses as fetuses are presumed dead until born.[84] "Personhood" only crystalises at birth. This is largely justified by the fact that "legal complexities and difficult moral judgments would arise if the courts were to […] treat the foetus as a legal person"[85] and the fetus can, in any case, be protected through statute.[86] However, it is helpful in identifying the distinction that exists between a fetus and new-born infant.

Moral arguments justifying abortion become much stronger once the focus moves from merely considering the fetus. The moral approach contends that even if the embryo can be considered to have interests, an abortion can still be morally justified when considering the mother's interests. The mother's interests cannot be ignored as a fetus is unavoidably linked to its mother. Thompson argues, for example, that the right to life and the moral importance of life is not to never be killed, but rather, not to be killed unjustly.[87] Thompson makes this point through the use of a thought experiment comparing pregnancy

78 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.

79 Don Marquis "Why Abortion Is Immoral" 86(4) Journal of Philosophy (1989) 183.

80 Jeff McMahan *The Ethics of Killing* (Oxford University Press, New York, 2002) at 257–256; Peter Singer *Practical Ethics* (2nd ed, Cambridge University, Cambridge, 1993) at 149–150.

81 McMahan, above n 80, at 271.

82 My position with regards to this gestational limit is discussed in more detail in Part VII.

83 Ronald Dworkin *Life's Dominion* (Harper Collins, London, 1993) at 32.

84 *Harrild v Director of Proceedings*, above n 55; and CA, s 159.

85 At [117] per McGrath J.

86 At [118]. The exception to the born alive rule is found in the CA, s 182.

87 Judith Jarvis Thompson "A Defense of Abortion" (1971) 1(1) Philosophy and Public Affairs 47 at 57.

to waking up plugged into a violinist with failing kidneys who will die if you unplug yourself from them at a point sooner than nine months. She argues that when you wake up next to a violinist who you are connected to and who you are keeping alive, it is morally permissible to unplug yourself from the violinist even if it will kill them and even if after nine months of being connected, they would live. This is because the right to life does not entail the right to use another person's body. Therefore, in disconnecting from the violinist you do not violate their right to life, you merely deprive them of the use of your body, something they had no right to. This makes the point that the fetus, while it may have a right to life, does not have a right to the pregnant person's body against their will.[88] While there are morally relevant disanalogies between the violinist scenario and typical cases of abortion, such as the fact that most pregnant people are causally responsible for their circumstance unlike in the violinist example, Thompson's theory was important in changing the way the morality of abortion was considered. It shifted the focus from considering the rights of the fetus, to the connection between the fetus and the pregnant person.

MacKinnon built on this, but produced an alternative articulation of the connection between the mother and fetus, suggesting they are more unavoidably connected. She argued the experience of many pregnant people is that the fetus is more than a body part, but still much less than a human: [89]

> 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.

MacKinnon 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 pregnant person.

In a similar vein, and reformulating Thompson's analogy, Ross argues that the issue with the violinist analogy is that the violinist is a complete stranger whereas the fetus, if left to develop, will not be.[90] The continuing burden of raising the child is therefore not accounted for in Thompson's analogy, and should be. Mackenzie mirrors this sentiment in arguing that assuming

88 At 56–57.

89 Catharine MacKinnon "Reflections on Sex Equality Under Law" (1991) 100 Yale LJ 1281 at 1316.

90 Steven Ross "Abortion and the Death of the Foetus" (1982) 11 Philosophy and Public Affairs 232 at 235–238.

responsibility for falling pregnant is not the same as accepting parental responsibility.[91] Overall, these arguments suggest a pregnant person should be able to choose whether to terminate their pregnancy as they are most affected, and pregnancy does not equate to accepting parental responsibility.

A pro-life view which considers the embodied experience of pregnancy is that the development of the fetus is a natural process and to disrupt it would be immoral.[92] However, this conservative criticism ignores the important role the pregnant person plays in pregnancy. As Coleman outlines, the 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.[93]

The final moral approach justifying abortion focuses on pregnant people's interests and is 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. Rather, it is something imposed on a pregnant person that they have a duty to care for. If seen differently, it would be for the pregnant person to decide whether to terminate, as the pregnancy is something they have created.[94] A paternalistic and restrictive approach, however, 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 about the complex character of pregnant people's attitudes towards their fetus,[95] it adds a useful dimension to the debate.

The pro-life position can also be framed by the argument that restricting abortions protects women. However, this argument contends that abortions involve significant trauma and regret, whereas motherhood involves joy and fulfilment. This does not accord with reality and the psychological risks of abortion are commonly overstated.[96] Studies do not support the claim that

91 Mackenzie, above n 73, at 142.
92 Dave Wendler "Understanding the 'Conservative' View on Abortion" (1999) 13 Bioethics 32 at 38–39.
93 Stephen Coleman *The Ethics of Artificial Uteruses: Implications for Reproduction and Abortion* (Ashgate, England, 2004) at 98.
94 MacKinnon, above n 89, at 1326.
95 Dworkin, above n 83, at 56.
96 Emily Jackson *Regulating Reproduction: Law, Technology and Autonomy* (Hart, Portland Oregon, 2001) at 75.

abortions have a devastating impact on mental health. It is even suggested that permitting abortions allows for better mental health outcomes than denial.[97] 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. Foster and Jivan argue that in reality, pregnancy can be invasive, onerous, challenging and painful, and is associated with enduring responsibilities.[98]

Overall, a feminist approach to justifying abortion rests on the importance of choice. West discusses how pregnant people view their responsibilities regarding this choice. She argues pregnant people will make their decision based on what they see as responsible.[99] So while allowing pregnant people to choose rejects the view that the fetus is a person, it still accounts for fetal interests as these interests will be considered when a pregnant person makes a responsible decision. West's perspective is supported by research showing that many pregnant people characteristically consider moral issues differently from men, focussing less on abstract moral principles and more on their responsibility to care for others, and to prevent hurt and pain.[100] Such a focus on responsibility can justify both the decision to terminate a pregnancy and the decision not to. One pregnant person may choose to terminate because to have a child which they could not properly care for would be irresponsible, whereas another may find abortion to be irresponsible despite this.[101] This shows the decision is not a unique problem separated from other considerations, but rather a paramount example of a decision inextricably linked to personal views on 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".[102]

The above provides a summary of the key moral arguments relating to abortion. The common thread to all arguments justifying a person's entitlement

97 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.

98 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.

99 Robin West "Taking Freedom Seriously" (1990) 104 Harv L Rev 43 at 84–85.

100 Carol Gilligan *In a Different Voice: psychological theory and women's development* (Harvard University Press, Massachusetts, 1993) at 105.

101 At 73–103.

102 MacKinnon, above n 89, at 1318.

to receive an abortion is that an individual's choice cannot be ignored. It is my opinion that the most convincing argument is made by Furedi. She outlines that in today's society, where fertile people are having sex without wanting a child, abortions are inevitable.[103] Since moral disagreement is also inevitable, the most moral regime would be to prioritise the choice of the pregnant person as they are the only individual equipped with the proper understanding of their circumstances to reach a personally appropriate decision. Many of the arguments discussed are predicated on the fact that our ability to make decisions for ourselves is a precondition of being human. Furedi argues, and I agree, that to deny a pregnant person reproductive choice denies their moral agency and therefore their humanity.[104] To ignore the wishes of pregnant people and to make decisions for them by limiting their reproductive choices ignores the fact that pregnant people are human beings capable of making complex decisions, that hugely impact their own lives, for themselves. The newly developed line of argument is not about being pro-abortion, but pro-choice.

D A liberal approach can be justified

Overall, the decision to terminate a pregnancy will be a considered choice for many pregnant people and a choice which is morally justified no matter their conclusion. For example, one person may be making the decision in order to attend school or work, or another because they are in a bad relationship. Some may consider this to be selfish and morally wrong, whereas other pregnant people may consider any other decision to be a serious moral mistake. Both are personal positions which are individually justified, and universal moral agreement on this topic is unlikely. Therefore, pregnant people's personhood is best recognised through their empowerment to make decisions for themselves, giving effect to their personal moral positions. This position also better upholds rights to health, reproductive independence, autonomy and freedom from discrimination. Rights which ought to be respected in Aotearoa, as they are internationally. New Zealand's reform is effective as it does not rely solely on rights-based arguments and has allowed for nuanced debate that has included moral considerations.

103 Ann Furedi *The Moral Case for Abortion* (Palgrave Macmillan, London, 2016) at 9–10.
104 At 77.

VII DOES THE REFORM GO FAR ENOUGH?

Despite the welcome reform, the question still remains: does decriminalisation of abortion in Aotearoa go far enough?

The approach taken by the reform is not complete legalisation, but medicalisation: after the 20-week gestational limit the decision-making power is held by health practitioners. Specifically, after 20 weeks, a medical practitioner can only terminate a pregnancy if the "practitioner reasonably believes that the abortion is clinically appropriate in the circumstances".[105] In order to determine what is "appropriate" the "practitioner must have regard to the pregnant woman's physical health, mental health and overall well-being".[106] Overall, it removes the person's ability to choose and shifts the decision-making authority to the medical practitioner, effectively medicalising abortions after 20 weeks. While a medical model is an improvement on New Zealand's earlier criminal model, there are several outstanding issues, as follows.

A Issues with a medical model

Medicalisation is a paternalistic regime where pregnant people are deemed incapable of making the "correct" choice, requiring the intervention of a medical practitioner.[107] A medical model entrenches the perspective that pregnant people are unable to make decisions by deferring to a medical authority (for abortions after 20 weeks).[108] This is problematic for two reasons. First, a medical model assumes that doctors are capable of making better decisions than the pregnant person about what is "appropriate". While it is inevitable medical considerations will be relevant to a pregnant person's decision, it does not mean they should control the outcome. Whether to undergo an abortion is unavoidably associated with a range of social issues, and treating it as a medical decision marginalises important non-medical considerations.[109] It is these considerations that are most significant in practice when considering whether to terminate a pregnancy, as shown by the fact that the most common justification for an abortion is mental health.[110] Medical practitioners are

105 Abortion Legislation Bill, cl 7 (s 11(1), CSAA).
106 Clause 7 (s 11(2), CSAA).
107 Foster and Jivan, above n 98, at 856.
108 Sally Sheldon *Beyond Control: Medical Power and Abortion Law* (Pluto Press, London, 1997) at 157.
109 At 153.
110 In 2017 98.9 per cent of all abortions carried out in New Zealand employed danger to the mental health of the pregnant person as a ground justifying the procedure. See *Report of the Abortion Supervisory Committee*, above n 2, at 21.

not directly trained in making decisions on social or psychological factors. To expect a practitioner to adequately understand what is appropriate in the individual pregnant person's circumstances is unrealistic. This is a sentiment which medical practitioners themselves have concurred with.[111] It will also continue to force a pregnant person to present their circumstances in the worst possible light in an attempt to convince the practitioner that the decision to terminate is appropriate. While discussion with a practitioner regarding the reasons for seeking an abortion assists pregnant people and provides them with an opportunity to disclose concerns regarding violence or coercion, this discussion can still occur, and it does not justify leaving the final decision to the practitioner.

The second issue associated with a medical model is that the decision will be subject to a practitioner's individual attitudes and values. Sheldon outlines that the approach of medical practitioners can legitimately vary under a medicalised regime. Practitioners can employ:[112]

i) a decisional approach where they essentially defer to the pregnant person;

ii) paternalistic decision-making where they decide what is appropriate for the pregnant person; or

iii) normalised decision-making where they access all the details of the pregnant person's life, consider these factors, and produce an authorised account of the person's reality to which they apply their own opinion.

While some doctors may attempt to minimise their control in determining what is appropriate by applying a decisional approach, this is not guaranteed. Even the Royal Commission, when recommending the parameters for New Zealand's previous legal framework in 1977, noted there was a risk practitioners would give effect to their personal views in making decisions.[113] This is problematic as it legitimises a third-party decision, on a matter which is inextricably linked to complex moral debate, as being medical. Furthermore, medicalisation can create the false appearance that healthcare is somehow

111 Law Commission, above n 54, at 86.

112 Sheldon, above n 108, at 149.

113 Royal Commission of Inquiry "Contraception, Sterilisation, and Abortion in New Zealand" [1977] II AJHR E26 at 293–294.

immune from political power and discourse, when in reality it is intertwined with political considerations.[114] Practitioners are not impervious to the debate surrounding abortion and such issues unavoidably become involved when discretion is granted.

Furthermore, having a test such as "appropriateness" 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. While in *Right To Life* the majority determined that once a certified consultant makes a decision it cannot be reconsidered by the ASC,[115] this was not a unanimous decision. Significantly, the minority took the view that decisions made by certifying consultants could be reviewed for compliance with the law.[116] Under a medicalised approach, decisions will remain open to challenge.

B Concerns with late-term abortions

There is an argument that the medical concerns surrounding late-term abortions justify the use of a medical model at this later stage.

In 2017, only 0.54 per cent of abortions occurred after 20 weeks of gestation. This could be because the law only allowed for an abortion at this point when it was to save a pregnant person's life or to prevent them from suffering serious permanent physical or mental injury. However, 6.1 per cent of abortions occurred later than 13 weeks into pregnancy so, even without exceptionally stringent requirements, generally fewer abortions occur at later stages.[117] The abortion procedure becomes more invasive and involved with more developed pregnancies. For an abortion after 16 weeks, the dilation and evacuation method, which involves inducing labour, is required.[118] After 22 weeks, unless there are exceptional circumstances, a drug must be used to stop the fetus' heart.[119] This is coupled with more severe side effects including

114 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.

115 *Right To Life New Zealand*, above n 12, at [40].

116 At [56].

117 *Report of the Abortion Supervisory Committee*, above n 2, at 19.

118 *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand: Report of a Standards Committee to the Abortion Supervisory Committee* (Abortion Supervisory Committee, 2018) at 41.

119 Standard 9.9.6.

pain[120] and higher rates of complications such as incomplete abortion and hemorrhaging.[121] The fact the procedure becomes riskier and more invasive at later stages is only one of the concerns justifying gestational limits.

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,[122] giving several reasons for this. The first is that when a fetus is capable of surviving outside of the pregnant person's uterus with artificial medical aid,[123] it is no longer clear the pregnant person has a moral right to opt for an abortion.[124] The fetus could therefore be adopted by individuals willing and able to care for it.[125] 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.[126] 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 that consciousness and the ability to feel pain are obtained late in the second trimester and that they should be the general test for sentience. Therefore, it is Warren's view that the only justification for a late-term abortion is to save the pregnant person's life or because of significant fetal abnormalities.

Both are medical reasons, which suggests it should be for the doctor to consider it medically necessary. This is a sentiment mirrored by Steinbock. It is her view that consciousness should be a pre-requisite for the possession of interests.[127] The argument is 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

120 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.

121 Daniel Grossman, Kelly Blanchard and Paul Blumenthal "Complications after Second Trimester Surgical and Medical Abortion" (2008) 16(31) Reproductive Health Matters 173.

122 Mary Anne Warren "The Moral Difference Between Infanticide and Abortion: A Response to Robert Card" (2000) 14(4) Bioethics 352 at 352.

123 *Roe v Wade*, above n 50, at 732.

124 Warren, above n 122, at 353.

125 At 357.

126 At 353–354.

127 Bonnie Steinbock "Fetal Sentience and Women's Rights" (2011) 41(6) Hastings Center Report 49. See also L W Sumner "A Third Way" in Susan Dwyer and Joel Feinberg *The Problem of Abortion* (Wadsworth, Belmont, 1984) 72.

against late-stage abortions and leads to most of the anxiety around the ethical problem of late-term abortions.

A further justification for gestational limits concerns the issue of infanticide. As discussed, Warren distinguishes between infants and fetuses, despite both only having consciousness and no other indicia of personhood, as after birth the infant is no longer physically reliant on the pregnant person. She outlines that infanticide is not generally permissible as after birth there is no conflict between the infant's and pregnant person's rights because the fetus is no longer physically reliant on the pregnant person and others would be willing to adopt the child. However, at late stages, once the fetus gains viability, the fetus is also not necessarily reliant on the mother. Therefore, the argument is that late-stage terminations cannot be allowed on the basis that they effectively condone infanticide.

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".[128] Similarly, *Roe v Wade* held the right to privacy diminishes as the pregnancy progresses, only allowing third trimester abortions to save a pregnant person's life.[129] At that point, the interests of the fetus can no longer be as clearly overcome by the rights of the pregnant person.

In making their recommendations on reform, the Law Commission consulted with medical practitioners, some of whom supported gestational limits. It noted that medical 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. Its 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.[130]

C Issues with gestational limits

Despite these justifications for gestational limits, such limits are associated with significant issues beyond those which merely come from the introduction of a medical model, and so there is merit in considering removing gestational limits.

128 *R v Woolnough* [1977] 2 NZLR 508 (CA) at 516–517.
129 *Roe v Wade*, above n 50, at 732.
130 Law Commission, above n 54, at 87.

The removal of gestational limits suggests fetal interests are only attained at birth, as prior to this the state would not intervene to protect the fetus. This can be justified by arguing that viability or sentience should not be the moral benchmark for 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 pregnant person, but the need to actually be living that life.[131] Such an argument contends that the fetus is merely developing potential and not actual personhood, justifying treating that fetal life as subordinate to human will. As Singer argues, a potential X does not have the same value as X, or all the rights of X.[132] 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. This is demonstrated in an analogy employed by Singer. While Prince Charles is a potential King of England, he is not yet King and these two positions do not have the same value.[133] Even if someone who was more distantly in line from the throne was to move closer to the throne, this would be a negligible change to their potential.[134] While this analogy suffers from limitations it does help to illustrate that arguably a developing human does not acquire significant intrinsic moral status, despite continual development, until birth. In my view this also responds to the issue of infanticide as it seeks to draw a distinction still between infants and late-stage fetuses.[135] That is, despite the latter having the potential to survive outside the womb as infants do, it is still only the potential, and that is a significant difference.

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 pregnant person must continue to be pregnant against their wishes.[136] Paske also counters Warren's 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

131 Michael L Gross "After Feticide: Coping with Late-Term Abortion in Israel, Western Europe, and the United States" (1999) 8(4) Cambridge Quarterly of Healthcare Ethics 449 at 456–459.

132 Singer, above n 80, at 153.

133 At 153.

134 Coleman, above n 93, at 114.

135 But it should be noted that Singer unacceptably advocates for the infanticide of disabled children and assisted suicide for disabled adults.

136 Furedi, above n 103, at 13.

a right not to be one.[137] Ross also discusses this and notes pregnant people do not just want to no longer be pregnant, but to not be a parent in any sense of the word.[138] 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,[139] it does explain that adoption is not a straightforward solution to the issues with late-stage abortions.

Such arguments could be rejected because they treat the fetus with disrespect, are not the best construction of the meaning of life, and ignore the significance of viability. 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 complex considerations which have developed leading to the decision, and one of these considerations will unavoidably be fetal interests. The complex range of reasons for late-term abortions was considered by a study which suggested that people who sought abortions after 20 weeks fit into one of five categories, other than to save the life of the pregnant person or because of fetal abnormality.[140] These categories were:[141]

i) they would suddenly be raising the child alone;

ii) they were depressed or using illicit substances;

iii) they were in a situation of domestic violence;

iv) they had trouble accessing services earlier; or

v) they were young and nulliparous.[142]

While there are limitations to this study[143] it does provide a good indication of the complex range of factors considered. It also shows that gestational limits

137 Gerald H Paske "Sperm-napping and the right not to have a child" (1987) 65(1) Australasian Journal of Philosophy 98 at 91.

138 Ross, above n 90, at 232–245.

139 Coleman, above n 93, at 141.

140 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.

141 At 215–216.

142 A person who has never given birth.

143 This study only considered 30 facilities over a three-year period (at 211). Furthermore, the authors note that the study should be considered in the cultural context of the United States where the study was completed (at 217).

tend to disproportionately disadvantage vulnerable people who are facing limited support, difficult situations and who have poor access to abortion services. The study supports the position that the only individual who is able to properly understand these considerations is the pregnant person.

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,[144] whereas now a fetus is commonly considered viable around 24 weeks. Even then, a fetus born at 24 weeks has only a 35 per cent chance of survival.[145] 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.[146]

When the Law Commission made its suggestions it noted that most health practitioners and professional bodies consulted did not support a gestational limit.[147] Some reasons provided for opposing a gestational limit were that a person's mental or physical health can deteriorate even at late stages in pregnancy and a limit may mean pregnant people feel rushed in decision-making, particularly in the case of fetal abnormality.[148] For example, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) guidelines indicate delaying decision-making when a condition affecting the pregnancy is uncertain at earlier stages in the pregnancy can reduce uncertainty and regret.[149] Other reasons practitioners gave was that the decision is a personal one which others should not judge.[150]

144 Peter Singer and Deane Wells *The Reproductive Revolution: New Ways of Making Babies* (Oxford University Press, Oxford, 1984) at 131.

145 Jon Tyson and others "Intensive Care for Extreme Prematurity — Moving Beyond Gestational Age" (2008) 358(16) New England Journal of Medicine 1672.

146 Carlo Bulletti (an Associate Professor at Yale University) believes a functioning artificial womb could be created within the next decade, referenced in Natasha Preskey "In The Future, You Could Be Pregnant Outside Your Body" *Vice* (online ed, 15 Jun 2018).

147 Law Commission, above n 54, at 88.

148 At 89.

149 Royal Australian and New Zealand College of Obstetricians and Gynaecologists *Late Termination of Pregnancy* (RANZCOG, C-Gyn-17A, 2016) at 2.

150 Law Commission, above n 54, at 89.

D International perspectives

Abortion law in most other comparable jurisdictions includes a gestational limit.[151] The main jurisdictions without such limits are Australian Capital Territory[152] and Canada.[153] In Canada, while the legalisation of abortion has meant reporting is voluntary so comprehensive abortion statistics are limited,[154] it is noted that despite abortion being effectively available on demand, the reality is the lack of a gestational limit has not appeared to result in a drastic increase in late-term abortions.[155] Furthermore, terminations are almost always provided for maternal health reasons or serious fetal abnormalities.[156] Access remains variable for later gestations as shown by the fact multiple provinces have effective gestational limits at 12 weeks (New Brunswick) and 24 weeks (Ontario) which are not implemented by law, but by the discretion of medical practitioners, funding and availability of facilities.[157] 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.[158]

Alternatively, New Zealand's approach reflects that taken in Victoria and the Northern Territory in requiring an abortion to be considered appropriate by a medical practitioner.[159] One study done in Victoria since their law reform indicated that one particular concern of abortion experts was the lack of availability of abortions for people over 20 weeks pregnant, as access had actually decreased since the reform. While the law in Victoria does not require people to meet specific criteria for receiving an abortion until 24 weeks, other barriers continue to limit provision even where the legal criteria are met, such

151 Such as the United States of America, the United Kingdom, Ireland, Victoria, Tasmania and Queensland.

152 Crimes (Abolition of Offence of Abortion) Act 2002 (ACT).

153 *R v Morgentaler*, above n 51.

154 Jeanelle Sabourin and Margaret Burnett "A Review of Therapeutic Abortions and Related Areas of Concern in Canada" (2012) 34(6) Journal of Obstetrics and Gynaecology Canada 532 at 537.

155 Rachael Johnstone and Emmett Macfarlane "Public Policy, Rights, and Abortion Access in Canada" (2015) 51 International Journal of Canadian Studies 97.

156 Sabourin and Burnett, above n 154, at 534.

157 Johnstone and Macfarlane, above n 155, at 107.

158 Barbara Baird "Decriminalization and Women's Access to Abortion in Australia" (2017) 19(1) Health and Human Rights 197.

159 Abortion Law Reform Act 2008 (Vic), s 5; and Termination of Pregnancy Law Reform Act 2017 (NT), s 7.

as a lack of clinics willing to provide services.[160] 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.[161] 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".[162]

Overall, international approaches show limited differences in practical access to late-term abortions regardless of gestational limits, partly due to professional and institutional policies. Access is determined by which hospitals and clinics are willing to provide services. To remedy this is an access issue, however further restriction does nothing to improve the circumstances. The notion that gestational limits are required to prevent unfettered late-term abortions is not a legitimate one.

E The "appropriateness" test

Another possible issue with New Zealand's gestational limit is the "appropriateness" test itself. 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 on an individualised basis, rather than on a legal one.[163] This test has a number of practical strengths. First, it is broad compared to the previous test and allows a pregnant person to justify their request on the basis of social issues regarding their wellbeing rather than purely medical issues. Secondly, the fact the practitioner must consider the pregnant person's physical health, mental health and well-being[164] means the objective morality of the individual doctor and what would offend the public should not legitimately be brought into consideration. Therefore, it cannot be used to legitimise a conscientious objection.

However, because the test is very broad it could be that what one practitioner considers to be appropriate would not be considered as such by the next. One may make an assessment purely on their personal views as to what

160 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.
161 Baird, above n 158.
162 Abortion Law Reform Act 2008 (Vic), s 5.
163 Law Commission, above n 54, at 84.
164 Abortion Legislation Bill, cl 7 (s 11(2), CSAA).

is medically or socially appropriate, whereas the other may best attempt to give effect to the choice made by the pregnant person, seeing this as appropriate. It seems unpredictable which approach will become common practice, and even more importantly, there is no certainty as to what approach the courts would take if required to determine the meaning of "appropriate". Furthermore, the reality is that the test may be ignored altogether, as can be seen in Victoria where late-stage abortions are only provided to save the life of the pregnant person rather than when "appropriate".

F Options moving forward

While it is understood that in order to pass the Bill through Parliament, a gestational limit was required because of the concerns that late-stage abortions raise, my view is that removing such limits should be revisited in the future. Pregnant people 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 by assuming doctors are capable of making better decisions for a pregnant person than they are capable of making for themselves. It also legitimises the decisions made by practitioners who may, without good reason, fail to give effect to the legitimate wishes of the person seeking the abortion. The practical impacts of gestational limits are insufficient to justify their requirement. It is not just that providers are uncomfortable with providing abortions at a late stage, but that pregnant people 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 cut-offs cause harm, particularly to disadvantaged and vulnerable people.

The only justification for a gestational limit which I have not already responded to is the possibility of reduced access at late stages without a limit, as practitioners may be disincentivised from providing services without any avenue to deny the abortion if they are uncomfortable providing it. However, as discussed below, access issues are more likely than not to improve with more liberal approaches. 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 stage and in what circumstances they wish to offer abortions. 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.[165] There are several ways fetal interests can be and are protected without gestational limits. First, 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:[166]

> … 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 pregnant person. The practitioner will play a role in ensuring they understand the decision they are making. This includes a discussion of fetal interests. Already, the ASC require providers to discuss short- and long-term complications including psychological issues,[167] the anatomy and physiology relevant to the length of gestation, the process of the abortion, and the possible complications.[168] This could continue under new standards of care. Second, counselling, which tends to have an increased uptake at later gestational states, must also be made available.[169] While counselling should be neutral and non-judgemental, it provides pregnant people 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 pregnant people are not required to make early or rushed decisions.

This position is not in favour of on-demand late-stage abortions, but is in favour of acknowledging that pregnant people are the best people to make decisions for themselves and should be empowered to make the final decision. Practitioners should aid the pregnant person in reaching their decision, not make the decision on their behalf. This approach would have the same practical

165 Law Commission, above n 54, at 79–80.

166 Medical Council of New Zealand *Information, choice of treatment and informed consent* (Medical Council of New Zealand, Wellington, 2011) at [2].

167 *Standards of Care*, above n 118, 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".

168 Standard 8.1.1.

169 Law Commission, above n 54, at 151.

effect as having a gestational limit, but with a better realisation of the rights of pregnant people and in a more flexible manner. Whether the change to remove gestational limits will truly be required will remain to be seen depending on the practical impact of the new regime. However, the key point is that the discussion regarding liberalising abortion is not over and gestational limits will need to be revisited.

For now, an important step moving forward will be to clarify the legal test to ensure doctors are not overstepping their roles or making decisions they are not qualified to make. This clarification will have to come from the medical community as it is not included in the law. Such guidelines should ensure decisions give effect to the wishes of the pregnant person and that the doctor's role is only to look out for red flags, such as coercion. These guidelines could be created by bodies such as the Ministry of Health or 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.[170] Such a standard of care could require giving effect to the decision of the pregnant person. 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.[171] Currently the Ministry of Health is operating on interim standards which are based on previous standards from the ASC. It has been said that the Ministry will create its own standards in due course. It will be interesting to see if and how the issue of late-term abortions is dealt with and whether any guidance is given on what should be deemed "appropriate".

VIII WILL ACCESS TO ABORTIONS BE SUFFICIENTLY IMPROVED?

Mere legalisation of abortion fails to ensure pregnant people 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.[172] Furthermore, in 2016 the United Nations Human Rights Commissioner's report recognised the limited access to abortion in Canada

170 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 [Code of Health], right 4.

171 Right 4.

172 Sabourin and Burnett, above n 154, at 534.

and called on the government to remedy the inequities.[173] This has been mirrored in several states in Australia post-liberalisation.[174] Access to abortions is vital. The average gestational age at which abortions are performed decreases as access to services increase. The earlier an abortion is performed, the safer, less intrusive and less emotionally challenging it is. This is a problem in Aotearoa as pregnant people consistently access terminations later in the first trimester than in other developed countries.[175] While legalisation is a step in the right direction in terms of improving access, direct policies to improve access and change attitudes are essential.

Prior to the change in law, New Zealand suffered from varied and limited access with very few doctors being willing to, and capable of, performing abortions. As of June 2018, there were only 168 certifying consultants across the country.[176] Abortions had to occur in specially licensed facilities with adequate surgical and overnight facilities meaning that services were generally limited to larger centres.[177] Furthermore, some licences were limited to only performing abortions within the first 12 weeks, or nine weeks of pregnancy. This means some pregnant people were required to travel large distances in order to receive care.

The new regime includes some specific policies aimed at improving this, including empowering pregnant people to self-refer,[178] allowing any medical practitioner to perform an abortion,[179] repealing the requirement for abortions to occur in an institution licensed by the ASC (the safety of facilities will be governed by general health law under the Health and Disability Services (Safety) Act 2001) and altering the requirements for those who wish to conscientiously object.[180] The Ministry of Health is also directed to produce and maintain a list of abortion service providers and the types of services they provide, in order to give pregnant people the ability to self-refer. Practically these changes should increase the number of professionals who are willing to perform the service and allow smaller providers such as medical centres and

173 *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.
174 Keogh and others, above n 160.
175 Martha, McNeill and Ashton, above n 24, at 1.
176 *Report of the Abortion Supervisory Committee*, above n 2, at 29.
177 Law Commission, above n 54, at 127.
178 Abortion Legislation Bill, cl 7 (s 14, CSAA).
179 Clause 7 (ss 10 and 11, CSAA).
180 Clause 7 (s 19, CSAA).

Family Planning clinics to provide services, at least for medical abortions.[181] It also means pregnant people can take mifepristone at home, limiting a medical abortion to one visit rather than two.[182] This is consistent with professional guidelines and international approaches.[183]

A Conscientious objection

Conscientious objection can have a large impact on pregnant people's access. Prior to the change in law, a practitioner with a conscientious objection was not required to perform an abortion nor to refer to another service provider or another doctor who would refer to service providers. A practitioner was only required to inform the pregnant person that they had the option to be treated elsewhere.[184] This had a significant impact on the ability of pregnant people to access services, creating barriers and delays. Not only this, but it increased stigma, costs (by requiring more doctor visits) and confusion, as in some cases pregnant people believed this meant they did not qualify for an abortion, especially people in vulnerable situations.[185] This contributed to the average 24.9 day wait between a pregnant person's first hospital visit and when they received an abortion, as studies show most of the delay came at the referral stage.[186] Now, under the new law, practitioners are required to disclose the fact of their objection at the earliest opportunity and tell the pregnant person how they can access the contact information of another person who is the closest provider of the service, taking into account the physical distance between providers, the date and time of the request and the operating hours of the provider.[187]

While it is true that the ability of a practitioner to object is important as part of their moral integrity, which forms part of their personal identity,[188]

181 Law Commission, above n 54, at 127. A medical abortion involves taking drugs (mifepristone and misoprostol) to induce a miscarriage. Typically, in the first nine weeks of pregnancy a medical abortion is always preferred. Between nine to 14 weeks of pregnancy a larger dose of mifepristone is required.

182 At 127–128. Some clinics administer both misoprostol and mifepristone at the same time.

183 Royal College of Obstetricians and Gynaecologists *The Care of Women Requesting Induced Abortion: Evidence-based clinical Guideline Number 7* (RCOG Press, November 2011) at [4.28] and World Health Organization *Technical and Policy Guidance* (2nd ed, World Health Organisation, 2012) at 44.

184 *Hallagan*, above n 14.

185 Foster and Jivan, above n 98, at 860.

186 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.

187 Abortion Legislation Bill, cl 7 (s 19, CSAA).

188 Mark R Wicclair "Conscientious objection in medicine" (2000) 14(3) Bioethics 205 as discussed in Ballantyne, Gavaghan and Snelling, above n 186, at 67.

and that there is a right to freedom of conscience,[189] this must be balanced against the importance of providing adequate medical care as part of a medical practitioner's vocational role. The legislative reform in Aotearoa minimally impairs the right to freedom of conscience as it does not require individuals to provide the services themselves, merely to inform, as practitioners should already do.[190] The change does not go as far as the frameworks in Victoria, Northern Territory and New South Wales where it is an offence not to ensure the woman is referred to an alternative health provider.[191] However, it should make a vast improvement as people are able to leave with all the information required to access services.

It is also specified in the Act that 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.[192] This is done to protect the rights of employees under the Human Rights Act 1993, replicating s 28(3) of that Act in requiring the accommodation of ethical beliefs unless it would unreasonably disrupt the employer's activities. This change will hopefully help improve access as it can, and should, be utilised in remote areas where there are limited practitioners, to ensure that there are sufficient practitioners without an objection.

B Safe zones

Another significant issue limiting access is the harassment of people attempting to seek services. Harassing demonstrations outside facilities can include holding vigils, carrying signs with pictures of fetuses and babies, approaching women with the intention to dissuade them, and shaming them. There have been calls to implement safe zones around facilities for several years and anti-abortion activists themselves claim to engage in "side-walk counselling".[193] Such demonstrations have the potential to become more prolific with the more permissive approach to abortions that the law now takes. While the

189 New Zealand Bill of Rights Act 1990 [NZBORA], s 13.

190 Code of Health, above n 170, right 6.

191 Victoria (Abortion Law Reform Act 2008 (Vic), s 8), New South Wales (Abortion Law Reform (Miscellaneous Acts Amendment) Bill 2016 (NSW), s 1.3) and Northern Territory (Termination of Pregnancy Law Reform Act 2017 (NT), ss 11–12).

192 Abortion Legislation Bill, cl 7 (s 20, CSAA).

193 Law Commission, above n 54, at 126 and 176. 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".

original drafting of the Abortion Legislation Bill included a provision on safe zones, this was removed before the final version of the Bill was passed. Then, in July 2020 the Contraception, Sterilisation, and Abortion (Safe Areas) Amendment Bill was introduced to Parliament (Safe Areas Bill). The Safe Areas Bill allows the Ministry of Health to recommend regulations prescribing a safe area around abortion facilities.[194] In these safe areas certain behaviour will be prohibited. Prohibited behaviour would be behaviour that intimidates and obstructs a person from accessing abortion services or is a communication (or visual recording) that would be known to an ordinary reasonable person to cause emotional distress.[195] While it is argued that such provisions would limit the right to freedom of expression as protected by the NZBORA (including by the Attorney-General and the New Zealand Law Society),[196] I believe any potential limitation is justified.

The first type of prohibited expression is intimidation, interference with and obstruction of people seeking services. Comparable behaviour is already limited by the criminal law[197] and instead of the *Hansen* test being applied, the Supreme Court in *Brooker v Police* held infringements of the NZBORA should be accounted for by a narrower interpretation of whether public order is disrupted.[198] As outlined by Crown Law when considering the draft version of the Bill, in this instance the mental element is different from that considered in *Brooker v Police* 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.[199] Even if the right is incidentally engaged, since this behaviour is about intentionally preventing access to a lawful service, the provision prohibiting interference is likely to be readily justifiable.

Secondly, the prohibition of communication which could reasonably cause emotional distress directly engages s 14 of the NZBORA as communication of controversial views is central to the purpose of this right. The Attorney-

194 Contraception, Sterilisation, and Abortion (Safe Areas) Amendment Bill, (310–1), cl 5 (s 13C, CSAA).
195 Contraception, Sterilisation, and Abortion (Safe Areas) Amendment Bill, (310–1), cl 5 (s 13A, CSAA).
196 NZBORA, s 14. See *Report of the Attorney-General under the New Zealand Bill of Rights Act 1990 on the Contraception, Sterilisation, and Abortion (Safe Areas) Amendment Bill* and New Zealand Law Society "Submission on the Contraception, Sterilisation and Abortion (Safe Areas) Amendment Bill".
197 Summary Offences Act 1981, ss 3, 4, 21 and 22.
198 See *Brooker v Police* [2007] NZSC 30, [2007] 3 NZLR 91; and *Morse v Police* [2011] NZSC 45, [2012] 2 NZLR 1.
199 McKillop, above n 60, at 7.

General's report on the Safe Areas Bill[200] takes the view that this limitation cannot be demonstrably justified as any communication which may cause emotional distress is not rationally connected to the objective of ensuring access to abortion services and does not impair freedom of expression as little as possible in order to achieve its objective.[201] The report notes that if prohibited communication required an intention to cause harm this would likely be consistent as it would limit the right impairment in a justified way.[202] I disagree with this assessment. The fact that the behaviour is only prohibited in limited safe zones around abortion facilities rationally connects the limitation to the objective. Further, any communication which may cause emotional distress could prevent people from accessing or providing abortion services, therefore it is necessary to limit all such communications. While fostering freedom of expression may be important, it should not be interpreted as an obligation on anyone else to receive such messages. Ensuring dignified access to healthcare is a vital pursuit.

The Safe Areas Bill leaves the decision to implement safe zones to ministerial discretion. Instead, the Bill should simply prescribe that safe zones should be created around all service providers. 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 150 metres from any facility providing abortions.[203] In these states the High Court of Australia determined a limit to the right to freedom of political communication is justified.[204] In Canada, the British Columbian Court of Appeal held that absolute prohibition on protest within a safe zone was a justifiable limitation to freedom of expression.[205]

Overall, the introduction of safe zones is necessary and the Safe Areas Bill is a welcome revision on the initial decision to remove such provisions from the Abortion Legislation Bill.

200 Above n 196.

201 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].

202 At 23.

203 Victoria (The 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).

204 For example, in Victoria in *Clubb v Edwards; Preston v Avery* [2019] HCA 11.

205 *R v Spratt* (2008) 235 CCC (3d) 521 (BCCA) at [91].

C Other possible methods of improving access

A straightforward method for improving access is to train nurses to provide medical abortions. There is already legal scope for nurses to provide abortions as they are considered to be a qualified health practitioner.[206] The current limitation is that the interim standards refer to "doctors" performing abortions. In the updated standards, the Ministry should consider how nurses can play a role in increasing access to medical abortions.

Another 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. Telemedicine has been found to decrease the overall rate of abortion, but increase the number of abortions received before 13 weeks.[207] 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.[208] Since the Act changes the requirements for where an abortion can occur, in that it is no longer required to occur on licensed premises, telemedicine is possible and its introduction should be considered in Aotearoa.

The stigma associated with abortion also acts as a significant barrier to access. Legalising abortion will go some way towards diminishing stigma, but will be insufficient without the deployment of methods outside of the realm of abortion regulation to reframe perspectives on abortion. 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.[209] Moreover, improved sexual education in secondary schools has been shown to reduce general stigma about abortion, improving people's

206 Under s 2 of the Contraception, Sterilisation, and Abortion Act 1977 a qualified health practitioner is defined to be a health practitioner who is acting in accordance with the Health Practitioners Competence Assurance Act 2003. This includes a nurse.

207 Kate Grindlay, Kathleen Lane and Daniel Grossman "Changes in Service Delivery Patterns After Introduction of Telemedicine Provision of Medical Abortion in Iowa" (2012) 103(1) American Journal of Public Health 73 at 73.

208 Daniel Grossman and others "Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine" (2011) 118(2) Obstetrics & Gynecology 296 at 302.

209 Sarp Aksel and others "Unintended Consequences: Abortion Training in the Years After *Roe v Wade*" (2013) 103(3) AJPH 404 at 405.

ability to access services and reducing the incidence of unwanted pregnancy.[210] The Ministries of Health and Education need to continue to pursue these measures and others.

IX CONCLUSION

Aotearoa has historically been a vanguard of women's rights, being the first country to give women the vote and having a strong statutory framework protecting their equal rights. The decision to reform our previously restrictive, out-of-date and dysfunctional abortion regime has been a vital step in properly effecting reproductive justice and improving gender equality.

However, there is room for further reform. The inadequacies of the reform are evident for late-stage abortions, for which medical professionals retain the right to decide whether an abortion may proceed. There are significant and more complex elements which feed into the decision to seek a late-stage abortion. It is people who are seeking the abortion who are best suited to make that decision. A late-stage abortion is generally not sought without good reason and a medicalised approach runs the risk of neglecting those reasons. Therefore, the decision to include a gestational limit, which shifts the decision-making power from the pregnant person to a medical professional once a pregnancy reaches 20 weeks, should be reconsidered in the future.

Furthermore, legalisation of abortion is insufficient and must be paired with improved and protected access. While the Abortion Legislation Act 2020 is effective in its introduction of self-referral, in the removal of any provisions requiring procedures to be carried out by a certifying consultant or in a licensed institution, and in the improvement of provisions relating to conscientious objection, more can be done. Overall, time will tell how the Act operates in practice, but Aotearoa should not consider the debate surrounding abortion and its liberalisation completely resolved.

210 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.