CONFIDENTIAL

SUBMISSION TO

ROYAL COMMISSION ON HUMAN RELATIONS

ON

QUALITY OF ABORTION SERVICES.

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Recognizing that women now have legal access to abortion facilities, rather than be forced to submit to the dangers of backyard illegal abortions, the issue now is the quality of the abortion facilities available. The present situation is an advancement over the past, but neither the precarious nature of the existing laws regarding abortion, nor the existing available facilities are adequate to meet womens' present and future needs.

Having an abortion is a time when women are forced to confront many conflicting emotions and harsh physical realities. They must face sex-role conditioning, the law, a predominantly male medical profession, and recognize their sexual autonomy. It is a time when women experience emotional and physical vulnerability. In this context the procedure can radically affect their self image, and the environment should be one that clearly supports women in coping with these complex emotional areas, in ways the women themselves indicate are required. It should be possible to turn what for some women is a potentially negative experience into a positive growth experience.

We h ve worked at P.S.I. and feel that P.S.I. is representative of the existing abortion facilities in Australia, (Preterm, Fertility Control Centre, and private doctors' facilities.) P.S.I. is particularly important, however, because it is part of an American multinational fertility control organization, operating in thirteen countries and

pursuing a vigorous expansionist policy. In Australia PSI has clinics at Arncliff and Potts Point and will shortly be moving to Canberra and Melbourne. PSI has also registered in Brisbane to perform those abortions legally allowable.

Whilst PSI programs undoubtedly provide service and information on a large scale with obvious benefits for women, we must be constantly mindful of the possibilities of exploitation of women in the area of fertility control. The extent of PSI operations mean they have a "free hand" to do what they see as necessary and one can question how much the real needs of women are being considered.

In effect the situation has been reached where the fertility needs of women are determined by men (unlike the early years of the birth control movement) they control medical research programs, fertility control units and abortion facilities, frequently with high profit incentives. (e.g. company records disclose G. Davis was paid $ 28,900 for his services for the period May/June 1975.) Men define the needs and women are the recipients.

These observations have been amply demonstrated to us in our experience at PSI. Male dominated and profit motivated (despite assertions to the contrary) -the best that can be said of the organization is that it provides abortions.

We outline below the effect of these structures on women attending the clinics.

1) Physical conditions, especially at Potts Point, are inadequate - cramped, physically uncomfortable and drab. Women are frequently forced to stand or sit on floors due to lack of space.

2) Due to lack of appointment system and inadequate staffing with doctors, women are block booked and forced to wait many hours according to who is chosen to be first or last on the list. Accordingly women are shunted around in large numbers, at the whim of the doctors, giving a " process-line " atmosphere to the procedure.

3) Frequently women are not given a pelvic examination before the operation. This leads to complications: e.g. anaesthetising women too far advanced for the procedure to take place, ignorance of pre-existing medical conditions; fibroids, double-uterus, non-pregnancy. This reflects the " get them on the table at all costs " mentality.

4) Medical facilities are inadequate. Sterilization procedures are unsatisfactory. Instruments are boiled often for three to five minutes only, instead of the required twenty minutes or using an (expensive) Autoclave. Operators use neither a "no touch" technique, nor full sterile procedure. Doctors usually leave premises before the last patients have fully recovered, on occasions leaving women with problems with counsellors or at best with a nurse.

5) The previously low incidence of complications at P.S.I. can only be due to the expertise of G.Davis personally; the

expansion of the organization and his increased concentration on administration work at P.S.I. rather than the medical procedure, has resulted in the use of less proficient doctors with an accompanying increase in complications. These doctors are unable to cope with the same pressures, conditions and techniques which Geoff Davis and P.S.I. impose.

6) Women have no choice between local or general anaesthetic. Local anaesthetic is now only used where the woman has recently eaten or in some other medical contraindications.

7) Dr Davis has recently been performing 18-20 week terminations in one stage, ie dilatation, curettage and aspiration in the one procedure. We have seen many women's cervixes torn and though usually sutured with a single ligature, this procedure is likely to cause cervical incompetence resulting in later mid-trimester miscarriage. One likely reason for undertaking this high risk procedure is a current rift between Geoff Davis and the owner of Rosslyn Hospital, Davis now appears reluctant to use the hospital facilities as he once did for the two-stage procedure. The brunt of politicking between doctors is borne by women.

8) Women are routinely issued with 4 or 5 different drugs on leaving, paying $2 for each. Many doctors consider these drugs unnecessary. Furthermore, women are given less tablets than is written on the prescription (at financial gain to P.S.I.) Sample packets of oral contraceptives are sold for $2. These practices are illegal. Other clinics dispense these drugs free.

9) The consultant doctor and counsellors are not encouraged to recommend oral contraception for the women's individual specifications ("as this is contrary to 'high through-put' " -Geoff Davis.) If she requires O/C she almost invariably receives Nordette 28. Occaisional changes in his favorite pill are most likely dictated by huge boxes of free samples provided by drug companies.

If she requires an IUD she invariably receives the Anderson Leaf. As the Anderson Leaf is an Australian designed product it is not obliged to be passed by the Drug Evaluation Board. It is in experimental stages yet women are not informed of this. The Anderson Leaf has been in use in the Fertility Control Clinic, but has gone out of use due to "high failure rate" -Dr. B. Wainer. The pamphlet issued by P.S.I. on the IUD (enclosed) is an illustration of the lack of choice women have due to inadquate information. The Anderson Leaf is the only IUD depicted on the pamphlet. The information is limited, often medically contentious and generally insulting to women in tone.

10) Third day follow-ups are frequently done by unqualified staff. Although follow-ups should be included in Medibank operation costs, it seems separate billing to Medibank for follow-ups sometimes get paid. Women are actively discouraged from returning to their own doctors for follow-ups though it may be at great inconvenience to them. Though it may be medically preferable for women to return to a clinic dealing exclusively with abortion, it is also protection for P.S.I. -there is no way for other medical practioners to be

aware of P.S.I. practices.

11) The lack of appointment system and periodic over booking is sometimes dangerous. With women referred by Children By Choice flying in from Queensland for abortions and returning the same afternoon, the pressure frequently leads to a situation where women must be dressed and walked to awaiting airport taxi by the counsellors while still recovering from anaesthetic. These women are frequently heard to exclaim 'how did I get here' as the taxi drives off.

12) When medical complications arise, (perforated uterus, insertion of IUDs in small uteri, retained products of conception, anaesthetic complications,) women are usually not fully informed. Counsellors are told "tell them anything you like, but never say they have a perforation". General Manager A. Pantell. It is P.S.I. policy to give women with medical complications minimal or incorrect information about the nature of their problem. Geoff Davis having control of information about complications, we only have his word for his low complication rate.

13) Counsellors are discouraged from responding to women's expressed needs on all levels, ie. emotional support, providing adaquate information on possible complications (incompetent cervixes, perforation, infection etc.), contraception, sexual and other related family and social problems. The counselling areas are cramped and unpleasant, time spent with women is limited and counsellors have been forced to wear white coats to give them an " air of professionalism "

which further alienates the women being counselled. Counsellors and women have repeatedly asked for literature on such subjects as O.C. , vaginal infections, sexually transmitted diseases and information on less popular contraceptive methods, eg. diaphragm, spermacides. Literature that was provided by counsellors to cover this lack has been banned from use at the clinic. Women thus remain unable to make informed decisions about their own bodies, and instead are forced to accept P.S.I. policies which are conveyed through counsellors. Counsellors are pressured to push women to accept general anaesthetic, the current P.S.I. preferred IUD, (and O.C.) and to return to P.S.I. for follow-ups.

14) The role of counsellors appears more to be one of facilitating the smooth running of the system, rather than providing emotional and informational support to women, ie. monitoring women's progress along the conveyor belt. In this context counsellors' energies are strained and initiatives prohibited. Unlike at other clinics, counsellors are not allowed to follow women through all stages of the procedure thereby providing emotional support and continuity.

15) In common with many existing abortion facilities the a mosphere at P.S.I. still retains many aspects of earlier abortion practices, this atmosphere partly reflects public attitudes, but is mostly the product of the continuing dominance of old style abortionists.

16) As women are always in subordinate positions to male staff members their work is consistently derrided, they are

undervalued both as women and workers, and scapegoated in times of stress. Women workers are Subject to all the usual insults in a particularly virulent form owing to the nature of the work, which deals exclusively with womens reproductive processes. The sexual division between men and women is maintained and the prevailing sexist attitudes towards women by the male staff is reflected throughout the entire clinic.

Women feel deeply the carelessness of the treatment they receive at the clinic.

CONCLUSION:

We have all worked at P.S.I., and have all been outraged at the treatment of women. We feel that women cannot have their own specific needs met until they have control of their own health care services, particularly in the areas of sexuality and reproduction. The medical profession needs to see women no longer as second-class citizens. Radical restructuring of medical courses and hospital facilities is mandatory. We now feel that it is not possible to work to change such a unit from within. Therefore, the only recourse is a clinic run by women for women.

RECOMMENDATIONS

(1). Repeal all abortion laws and decriminalise abortion. Abortion will then be covered by medical malpractice laws in the same way as other medical procedures.

(2). Women should be involved at all levels in determining the services that are provided for women, particularly in the area of health care, e.g. Decision making and provision of services.

(3). Medical courses should have more practical experience in all Gynaecology especially the technique of abortion. Doctors who do not perform abortions themselves should be ethically obliged to refer women to others who will, and not try to influence their decision.

(4). Training courses should be instituted to train Paramedics and Nurses to perform menstrual extraction, insert IUDs, dispense O/Cs etc, and investigate the possibility of their performing early abortions.

(5). Gynaecological departments of Public hospitals (Representing half the population, Women) should provide Out-Patient abortion units with minimal delays, choice of Local Anaesthetic or General , and a good counselling service available.

(6). Feminist free- standing abortion clinics. Initial Government financial support would be necessary to establish these clinics, but they should be run on a (real) non-profit basis by a board with community and staff representatives, and salaried staff. The clinics should also provide counselling and help in birth

control, sexual problems , and sexually transmitted diseases.

Encl:-

(A). Statement on counselling submitted to a P.S.I. meeting, preceeding our resignation, and rejected.

(B). One only copy of letter of resignation.

(C). IUD pamphlet.

(A)

There are lots of definitions of the counselling function. One definition can be found in the Preterm manual, a model which Geoff recommended to use. It involves discussion of the abortion decision and preparation for the procedure, contraceptive counselling, assistance and support to the Women.
In fact counselling is made up of two parts:
Giving the woman information about the physical process of the operation; and supporting a woman who is going through an emotional process.

Our prime consideration is toward the women attending the clinic - assisting them to make informed decisions about their own bodies and recognizing the importance of their emotional needs at all times. We consider the personal emotional support and information we give to be vitally important to the experience women have at the clinic, as important to their well being as the medical procedure.

Reaction from women indicates that support is vitally important to them in all medical proceedures. There is an increasing awareness of women about health care facilities, in particular gynocological matters, and their own autonomy. Women are more informed generally about their own bodies. We often hear outraged comments from women expressing their alienation:
"I feel like I've just been through a car wash."
"I feel like I've been put through a sausage machine".

Because of these feelings of alienation women have felt in traditional doctor/patient relationships and the kind of care they have received plus their own increased awareness about their specific needs as women, they have organized their own health centres. The Womens Health Centres were set up by women to get precisely the kind of health care they demand. At this time the Womens Health Centres are not recommending P.S.I., but are recommending women to other doctors and Preterm. Women who have been distressed by their experiences at P.S.I. are also not recommending it to others.

Currently there is a movement towards the demystification of medicine, being led by women. This is ocurring at a time when P.S.I. appears to be moving closer to the worst aspects of the traditional approach to medicine, rather than meeting womens needs and demands. It appears to be that the emphasis is on medical procedure to the detriment of the personal needs of women. Minimizing the counselling function will only increase women's distress at a very emotional time.

Counsellors are the ones most in touch with women, and we are in a position to find out what women want. Because of this counsellors should be able to give advice about the expressed needs of women. Counsellors do not want authority and control, they want to do what is relevant and meaningful for women. Counsellors and women want to get away from the impersonal and the intimidating, and to work with people in a situation that is not controlled by an authoritarian structure.

Overseas trends would indicate that women mobilized over health care issues can get the kind of treatement they demand.

Counsellors make the following demands:

1. Appropriate priority be given to the counselling function.
2. PSI redifine its policy towards women.
3. An in-house training course for staff and counsellors be instituted.

(B)

We, the undersigned, are resigning from Population Services International for the following reasons:

The lack of support given to counsellors in their efforts to provide an emotionally supportive environment for women going through the abortion procedure.

The sexually discriminating attitude of male doctors and staff towards female counsellors. We believe that this affects all female staff and ultimately the women attending the clinic for abortions.

The offensive 'assembly line' process which is particular to Population Services International. The emphasis on abortion as a 'package commodity' makes no allowance for the individual emotional needs of women.

The recent intimidation and victimization of one of the staff members, the refusal of the management to allow staff to hold a meeting about this issue, and the use of the police to remove the staff member from the premises. The use of the police is further indication of the contempt Dr. Davis holds for the staff as well as for the women using the clinic.

Population Services International (Australasia) Limited

A Non-Profit Low Cost Fertility Control Organisation.
A Member of the International Council of Voluntary Agencies.

- Abortion & Menstrual Regulation
- Sterilisation
- All services with General Anaesthesia

THE POTTS POINT CLINIC
25-27 CHALLIS AVENUE,
POTTS POINT PH: 357-2404

THE ARNCLIFFE CENTRE
45-47 FOREST ROAD,
ARNCLIFFE PH: 597-2588
A.H. 59-1557

THE IUD

In 1296 Lanfranchi, in Milan, provided the first modern recommendation for the use of an IUD. They have been in wide use for a very long time. Until the 1960s, most were made of metal. This posed a few problems. These problems created most of the folklore of IUDs. Many of the problems were overcome by the design of the plastic IUD. But not all. Now there has been another revolution in IUD design and nearly all of the problems have gone. About 15 million women currently have IUDs.

The new IUDs have active ingredients. The best of these is made of silicone rubber and has two active ingredients, copper and zinc. Other types have different slow release chemicals.

The one we use most is the Anderson leaf.* It is silicone rubber plus slow release copper and zinc. Present indications are that it leaves all other IUDs for dead. So we use it.

The main reason IUDs provide better fertility control than any other contraceptive goes like this —

- you can't leave it at home when you go away for the weekend or holidays
- you can't run out of it on Sunday
- If you don't get home from work it is still with you and not in the bathroom cabinet
- it works perfectly when you are smashed out of your mind and have no hope of using anything else even if you remembered

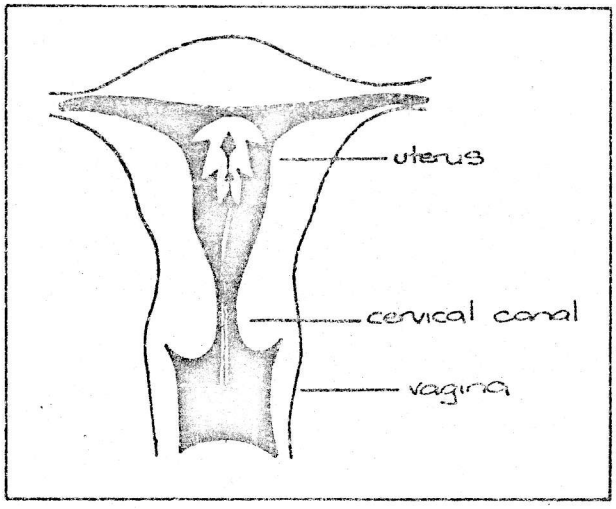
Other advantages are: — IUDs have only local effects, they don't louse up your metabolism, your clothes still fit, you stay the same shape and stay well.

- everything still works normally, you produce ova, some of them get fertilised but they don't cause any trouble — they just fall out unnoticed. Incidentally much the same happens each month with about 6 in every 10 non-contracepting women. They shed fertilised ova. This was first described in 1956.

It is the remaining 4 in 10 ova that contraception is aimed at.

- IUDs require no forethought and don't interfere with any activity.
- in the long run they are very economical.

How it works: IUDs are put inside the cavity of the uterus. See diagram:



IUDs work in a variety of ways. The main one now seems to be by producing increased intrauterine levels of a chemical called prostaglandin. This makes the inside of the uterus hostile to ova, sperm and fertilised ova.

The use of this IUD is no longer experimental. It has been field trialed in many parts of the world. It's use is, however, being monitored as part of an ongoing surveillance research programme.