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**THE COMPROMISE OF CONSCIENCE:
CONSCIENTIOUS OBJECTION IN HEALTHCARE**

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Abstract

This paper discusses a medical practitioner's right to conscientiously object to providing a legally available healthcare service in New Zealand, on the grounds of their personal beliefs. Currently, the right to conscientiously object is enshrined in the Health Practitioners Competence Assurance Act 2003 and the Contraception, Sterilisation and Abortion Act. This paper argues the current legislative arrangement regulating a health practitioner's right to conscientiously object under New Zealand law is vague, and risks cementing uncertainty, due to scope of the protection being unclear. In addition, the current protection risks patient safety, as it does not exclude the right to conscientiously object in medical emergencies, or when the efficacy of the treatment is time dependent. To remedy this unsatisfactory situation, it is recommended that the right to conscientiously object in healthcare be rendered impermissible in the aforementioned scenarios. It is further recommended that direct referral to a non-objecting colleague be mandatory in the event a practitioner wishes to exercise their right to conscientiously object. This is because access to healthcare may be compromised by a practitioner exercising the right to conscientiously object, with no corresponding direct referral requirement, a risk borne by patients.

Subjects and Topics

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I Introduction

On 14 July 2013, the Marlborough Express reported Dr Joseph Lee's refusal to renew Melissa Pont's prescription for the oral contraceptive pill.¹ Dr Lee's refusal, coupled with his later statements that he believed women have a "reproductive duty"² to bear children, ignited a controversy about conscientious objection in healthcare. Conscientious objection in healthcare details the situation where a medical practitioner (usually a nurse, doctor or pharmacist) refuses to provide a legally available treatment to a patient requesting it on account of their ethical, moral or religious beliefs. Conscientious objection in healthcare creates a conflict between a patient's right to access legally available healthcare services, and a practitioner's right to refuse to provide services that conflict with their fundamental beliefs.

Conscientious objection in healthcare, therefore, raises the following legal and ethical questions:

- (a) Should a medical practitioner have the right to conscientiously object to providing a treatment if it conflicts with their moral, ethical or religious beliefs?
- (b) Does this answer change in the event of a medical emergency, or where the efficacy of the treatment is time dependent?
- (c) Should New Zealand law continue to permit conscientious objection, and, if so, to what extent?

This paper seeks to answer these questions, by addressing the theory behind conscientious objection in healthcare.

The analysis will predominantly centre on an area of healthcare where conscientious objection is most commonly permissible – reproductive health. This is where most of the existing case law and academic commentary has arisen from. Conscientious objection, however, is potentially much broader than this, encompassing other controversial medical treatments such as euthanasia. In addition, evolving medical developments, such as invitro fertilization and 'designer babies' may raise questions of conscience beyond the traditional bounds in which the right to conscientiously object has been exercised in the past.³ Science and technology may also create further fields where the right to conscientiously object is desirable.

¹ Marlborough Express "GP Refuses Women Contraceptive Pill" *Stuff* (online ed, Wellington, 14 July 2013).

² Cherie Howie "Women have Reproductive Duty, says 'Rhythm Doctor'" *The New Zealand Herald* (online ed, Auckland, 14 July 2013).

³ Mark Wicclair *Conscientious Objection in Health Care* (Cambridge University Press, Cambridge, 2011) at 21.

This paper will address how other jurisdictions have accommodated the right to conscientiously object in healthcare, before considering New Zealand law. In particular, legislation and case law from the United States, the United Kingdom and Europe will be examined as a guide.

Presently under New Zealand law, a practitioner's right of conscientious objection is protected by both section 46 of the Contraception, Sterilisation and Abortion Act 1977 (CSA) and section 174 of the Health Practitioners Competence Assurance Act 2003 (HPCA). Working in tandem with these sections, are guidelines promulgated by organisations such as the Office of the Health and Disability Commissioner and the New Zealand Medical Council.⁴

A better legislative framework for the exercise of conscientious objection in healthcare is required for New Zealand. This paper contends that the current protection is vague, and risks creating legal disputes. More alarmingly, it risks cementing uncertainties about what is the permissible extent of a practitioner's legally protected right to conscientiously object to providing a healthcare service. Consequently, robust legislation regulating the extent of a medical practitioner's right to conscientiously object is necessary for the purposes of clarifying the law, preventing further disputes from arising and ensuring an appropriate balance between the competing rights.

It is problematic that the current legislative framework reinforces a hierarchy of beliefs, by protecting the right to conscientious objection in a single area of healthcare – reproductive health.⁵ Legislative protection of conscientious objection should either be abandoned in its entirety, or expanded to encompass secular conscientious objections that are equally worthy of protection, to provide consistency.

In addition, it is recommended that direct referral to a non-objecting colleague be mandatory and conscientious objection be impermissible in the case of a medical emergency. The reasons for the recommendations are that access to healthcare must assume primacy in any discussion of the appropriate balance to be struck between the competing interests, and the right to conscientiously object risks compounding access issues for those from rural areas, the poor, or the uneducated.

⁴ See: Office of the Health and Disability Commissioner *The Code of Rights* (2004) <www.hdc.org.nz>; and Medical Council of New Zealand *Good Medical Practice* (Medical Council of New Zealand, April 2013).

⁵ See: Contraception, Sterilisation and Abortion Act, s 46; and Health Practitioners Competence Assurance Act 2003, s 174.

II Theory

A Conscience

Philosophical notions of conscience provide important background context to conscientious objection in healthcare. By understanding of the nature of conscience, one is better placed to answer the question of precisely what it is internationally recognised conscientious objection legislation seeks to protect. Conscience is broadly understood as an internal sense of guidance, or morality, as to what is right or wrong.⁶ Conscience is identifiable as a core, rather than ancillary, set of moral or ethical beliefs.⁷ Generally, these beliefs do not change greatly over time, if at all.⁸ Implicit within many understandings of conscience is the idea that conscience is an individual's mechanism for passing judgement on their own action or inactions.⁹ Peter Fuss summarises conscience as "a disposition to act in accordance with one's own ethical beliefs and *corresponding emotional responses* [emphasis added]."¹⁰ This sentence highlights an important aspect of the failure to adhere to conscience: subsequent emotional impact, or what Mark Wicclair refers to as "moral distress."¹¹ To define conscience, it is important to focus "on the relationship between a course of action and one's own ethical convictions."¹² Conscience is, therefore, personal in terms of both origin and impact. External influences, however, often play a role in shaping conscience, for example, religious precepts.

Conscience is extraordinarily difficult to regulate. This fact is especially problematic in the medical field. Conscience almost always involves inherently personal questions. Some theorists have asserted that conscience is simply an internal version of what environmental and cultural factors have led us to believe is right.¹³ For this reason, as Armand Antommaria explains, interpreting conscience on the basis of an internal morality alone "has difficulty accounting for the putative self-sufficiency of claims of conscience."¹⁴ On this basis, definitions of conscience should also give rise to a consideration of what Antommaria terms "social norms."¹⁵ These provide a more robust basis for determining when the law might wish to protect someone exercising their right to freedom of conscience. Focussing on both the personal aspect of

⁶Kimberly Moss "Do No Harm – Unless She Wants an Abortion or Birth Control: The Conscience Movement's Impact of Women's Health" (2010) 19 Texas Journal of Women and the Law 173 at 173.

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⁸Wicclair, above n 3, at 5.

⁹Wicclair, above n 3, at 3.

¹⁰Peter Fuss, cited by Mark Wicclair, above n 3, at 3.

¹¹At 9.

¹²Armand Antonmaria "Conscientious Objection in Clinical Practice: Notice, Informed Consent, Referral and Emergency Treatment" (2011) 9 Ave Maria Law Review 81 at 83.

¹³Wicclair, above n 3, at 2.

¹⁴At 83.

¹⁵At 83.

conscience and wider societal norms has the twin advantage of avoiding, to a certain extent, the creation of a hierarchy of moral beliefs while giving recognition to the uniqueness of the doctor/patient relationship.

In summation, conscience is an important part of an individual's internal belief system. Acting contrary to conscience may have adverse short and long-term mental effects, including harming the practitioner's sense of self-worth.¹⁶ Conscience alone, however, cannot be both the beginning and the end of the question of whether legal protection is necessary. Conscience has often proved itself historically suspect as a method of judgement.¹⁷ For this reason, legislative attempts to encapsulate a cohesive protection of conscience must account for both its inherent individuality and its relationship with broader societal norms. The preceding comments provide an important background to considering whether the current protection of conscientious objection in New Zealand – existing only in the field of reproductive of healthcare – should be extended beyond this. This question will be considered in part eight of this paper.

B Conscientious objection in healthcare

Conscientious objection in healthcare describes the situation where a health practitioner refuses to provide a patient a legally available treatment on the grounds of conscience. As Mark Wicclair explains:¹⁸

In the context of health care, physicians, nurses and pharmacists engage in acts of conscientious objection when they (1) refuse to provide legal and professionally accepted goods and services that fall within the scope of their professional competence, and (2) justify their refusal by claiming it was an act of conscience.

Conscientious objection is most well-known within the field of reproductive health services. While in practice religious beliefs are often the root cause of many practitioners' conscientious objection, the right is not, in theory, this limited. The controversy surrounding euthanasia also prompts conscientious objection to be exercised by a large subset of the medical community.¹⁹

¹⁶Wicclair, above n 3, at 25 -27.

¹⁷Wicclair, above n 3, at 27.

¹⁸At 1.

¹⁹See the discussion on Oregon legalising physician assisted suicide in Mark Wicclair, above n 3, at 20-21.

In this regard, it is worthwhile noting that Maryan Street's End of Life Choice Bill was recently withdrawn from the Member's Bill Ballot.²⁰ As a result, while this paper will primarily discuss conscientious objection through the lens of reproductive health services, conscientious objection may encompass other areas of healthcare, such as euthanasia.

Conscientious objection has historically been viewed favourably in the context of a compulsory draft.²¹ It is perhaps less understood in the context of healthcare, where, in the midst of a fiduciary relationship between doctor and patient, personal, ethical or religious values are perceived to have a lesser status. Conscientious objection is particularly problematic in the field of healthcare as medical practitioners enjoy a monopoly over the provision of medical treatment.²²

Two trends have contributed to the rise of conscientious objection in healthcare; firstly the relative liberalisation of abortion and secondly, an increasing assertiveness on behalf of patients, marking, to an unquantifiable extent, the end of the 'doctor knows best' paternalistic attitude.²³ Patients are more willing to challenge their doctors with regard to proposed treatments, resulting in medical practitioners being pressured into courses of action they might personally disagreeable.²⁴

The right of conscientious objection is aimed at protecting practitioners, rather than practitioners imposing their beliefs on a patient.²⁵ As Armand Antonmaria notes, "claims of conscience should fundamentally be understood as claims of personal integrity."²⁶ In this regard, conscientious objection should be considered as an objection to the particular *treatment* in question, rather than the class of patient. As Mark Wicclair notes, "if a refusal is based on the nature of the good or service, rather than on the characteristics of patients it is not likely to involve invidious discrimination."²⁷ This framing could become problematic, however, when the availability of the treatment in question is so limited that a refusal by one practitioner

²⁰End of Life Choice Bill 2012 (50). At the time of writing, the Bill had just been withdrawn from the members ballot on the 26 September 2013 after concerns it would "become an election year football if drawn" see: Hamish Rutherford "Voluntary Euthanasia Bill Withdrawn" *Stuff* (online ed, Wellington, 26 September 2013).

²¹Julie Canter and Ken Baum "The Limits of Conscientious Objection – May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?"(2004) 351 New Eng J Med 2008 at 2008; Wicclair, above n 3, at 13.

²²T A Cavanaugh "Professional Conscientious Objection in Medicine with Attention to Referral" (2011) 9 Ave Maria Law Review 189 at 196.

²³Bernard Dickens "Conscientious Objection: Shield or a Sword" in Sheila McLean (ed) *First Do No Harm: Ethics and Healthcare* (Ashgate Publishing, Aldershot 2006)337 at 339.

²⁴Dickens, above n 23, at 338.

²⁵Antonmaria, above n 12, at 84.

²⁶At 82.

²⁷At 209.

may effectively result in the imposition of a practitioner's morality or values on a patient. Assuming, however, that the disputed service is readily (and easily) available elsewhere, conscientious objection should not be construed as a medical practitioner imposing their beliefs on a patient.

Conscientious objection encompasses, but goes beyond a refusal on the grounds of morality alone. Wicclair has attempted to demarcate the difference between not dissimilar refusals to treat, by defining conscientious based refusals as occurring:²⁸

If and only when (1) the agent has a core set of moral (i.e. ethical or religious) beliefs; (2) providing the good or service is incompatible with the agent's core moral beliefs; and (3) the agent's refusal is based on her core beliefs.

These criteria are better understood with a practical example. Wicclair uses the example of a medical practitioner refusing to provide "aggressive, life sustaining treatment to a patient who is not intended to survive to discharge."²⁹ The refusal in this case involves a moral reluctance to unduly subject a patient to unnecessary treatment, however, insofar as the treatment sought by family members does not contravene the practitioner's core moral beliefs, the practitioner's refusal to provide it is not a conscientious objection.³⁰

C Moral Complicity and Referral

Practitioners faced with a patient who wishes to receive a healthcare service they conscientiously object to providing cannot simply remove themselves from the situation. A further element of the academic discussion, therefore, comprises arguments about moral complicity and agency.³¹ These arguments are important when addressing an objecting practitioner's obligation to refer a patient seeking a disputed treatment to a colleague who will provide it.

Those opposed to a referral requirement have argued that a practitioner exercising their right to conscientious objection will feel equally morally complicit in referring a patient to a colleague to perform the disputed service, as they would having performed it themselves.³² Under this view, a referral requirement is akin to saying, "I can't kill you, but the guy down the road can."³³ Based on this logic, any legislative

²⁸At 5.

²⁹At 8.

³⁰ Wicclair, above n 3, at 6.

³¹See for example: Wicclair, above n 3, at 36.

³²Wicclair, above n 3, at 37

³³Holly Fernandez Lynch *Conflicts of Conscience in Healthcare: An Institutional Compromise* (Massachusetts Institute of Technology, Massachusetts, 2008) at 231; Wicclair, above n 3, at 38.

protection of conscientious objection that imposes a direct referral requirement effectively offers very little conscience protection for practitioners.

It is important at this point to distinguish between direct and indirect referral, as differing levels of moral complicity arise from each.³⁴ Direct referral is where the practitioner exercising their right to conscientiously object communicates, as indicated, directly, with a colleague to assure that the patient receives the treatment in question.³⁵ For example, in the case of abortion, an objecting practitioner would contact a colleague in person to transfer the case, thereby ensuring the women in question was under the care of a colleague willing to perform the procedure. Indirect referral, on the other hand, is limited to simply informing the patient that they can receive the disputed treatment elsewhere.³⁶ For example, in the case of a patient seeking contraceptives, by stating that Family Planning offers the contraceptives sought.

Direct referral is typically understood as involving higher levels of moral complicity.³⁷ Frank Chervenak and Laurence McCullough have argued that while “it might be plausible to ascribe moral complicity in relation to direct referral,”³⁸ a practitioner:³⁹

... cannot reasonably be understood to be a party to, or complicit in, a subsequent decision that is the sole province of the patient’s subsequent exercise of autonomy in consultation with a referral physician.

This view was also alluded to by the Inner House of the Scottish Court of Session in *Doogan v National Health Services Greater Glasgow and Clyde Health Board (Doogan)*,⁴⁰ where the midwives in question “did not accept that they could avoid moral responsibility for a task by asking others to carry it out.”⁴¹ These might seem philosophically fine distinctions to draw. In practice, however, it makes intuitive sense that directly facilitating access to a treatment to which one is opposed would cause practitioners increased moral distress, when compared with the mere act of informing the patient that this treatment could be sought elsewhere.

³⁴Wicclair, above n 3, at 38.

³⁵Wicclair, above n 3, at 37.

³⁶Wicclair, above n 3, at 37.

³⁷Wicclair, above n 3, at 37.

³⁸Frank Chervenak and Laurence McCullough, quoted in Wicclair, above n 3, at 37.

³⁹Frank Chervenak and Laurence McCullough, quoted in Wicclair, above n 3, at 37.

⁴⁰*Doogan v NHS Greater Glasgow & Clyde Health Board* [2013] CSIH 36.

⁴¹*Doogan v NHS Greater Glasgow & Clyde Health Board*, above n 40, at [13].

The preceding discussion introduces some of the reasons why referral requirements continue to be one of the most difficult areas of conscientious objection legislation. This will be discussed further in part eight of this paper, where options for a reform of New Zealand's conscientious objection legislation are discussed, including mandatory direct referral. The questions a referral requirement raises are not easily resolvable. Answering them may be narrowed down to a question of whether it is more important to protect practitioners' consciences, or whether ensuring access to legally available treatments should take preference. This begs the question of whether the right to conscientiously object in healthcare is something the law should wish to protect in the first place.

III Should the right to conscientiously object be protected?

A Academic Views

Academics have struggled to provide a theoretical basis for discussing conscientious objection in the medical field.⁴² Mark Wicclair has remedied this with his recent work on conscientious objection in healthcare.⁴³ This section will discuss Wicclair's two contrasting theories, conscious absolutism and the incompatibility thesis, which encapsulate the bulk of the arguments for and against the right of conscientious objection.⁴⁴

1 Conscience absolutism

The first of Wicclair's theories is termed "conscious absolutism."⁴⁵ This theory maintains that a medical practitioner should never be forced to do any action professionally that compromises his or her conscience, including referring a patient.⁴⁶ Supporters of conscience absolutism argue it is harmful for practitioners to provide a treatment that goes against their conscience.⁴⁷ As Wicclair explains "acting contrary to core moral beliefs is perceived by the agent as an act of self-betrayal."⁴⁸ On this basis, supporters of conscious absolutism assert that a person forced to perform an action contrary to their conscience could suffer adverse mental health effects as a result of feeling that their integrity has been compromised.⁴⁹ At the very least, a

⁴²See for example: Michael E Duffy "Good Medicine: Why Pharmacists Should Be Prescribed a Right of Conscience" (2010) 44 Valparaiso University Law Review 509.

⁴³Wicclair, above n 3.

⁴⁴ Wicclair, above n 3, at 34-37 and 44-46.

⁴⁵Wicclair, above n 3, at 34.

⁴⁶Wicclair, above n 3, at 34.

⁴⁷See Armand Antonmaria, above n 12, at 83.

⁴⁸Wicclair, above n 3, at 5.

⁴⁹Wicclair, above n 3, at 26.

person might feel belittled, humiliated or suffer from a sense of decreased self-worth on account of their actions. These are not desirable outcomes.

Conscious absolutism has found some support within the next generation of the medical profession.⁵⁰ In a study published by the Journal of Medical Ethics, 42.5% of the medical students surveyed agreed with the statement “doctors should be entitled to object to any procedure for which they have moral, cultural or religious disagreement.”⁵¹ These results raise questions about whether, if no right to conscientiously object in healthcare existed, potentially valuable members of the profession would be excluded.

The importance of having a diverse range of practitioners with different moral, ethical and religious beliefs should not be understated. Disallowing practitioners the opportunity to exercise a right to conscientiously object risks this diversity.⁵² This is likely to most affect those with religious beliefs.⁵³ Excluding religious people from the medical profession, aside from being problematic from a human rights perspective, could be considered bad for patients, as a diverse and thriving medical profession is a desirable goal. The American Medical Student Association has recently stated that “having a diverse physician workforce is a critical component in making healthcare available to those who need it the most.”⁵⁴ Accordingly, promoting a plurality of beliefs in the medical sector is a worthwhile endeavour.

It may also be unwise to exclude those with strong moral, ethical or religious beliefs entering into healthcare.⁵⁵ Medicine should not be bereft of personal morality.⁵⁶ Some assert that personal moral and ethical guidelines are, in fact, an essential part of a practitioner’s skillset, which are not severable.⁵⁷ As Charles Hepler notes “we would be naïve to expect a pharmacist to forsake his or her ethics in one area ... while applying them for the patient’s welfare in every other area.”⁵⁸ Capitalising on a practitioner’s morality to care for patients, while excluding their personal morality in other areas, appears to be an odd trade off. Proponents of the right of practitioners to

⁵⁰Sydney Morning Herald “Next Generation of Doctors Vote on Right to Refuse Treatment” *Sydney Morning Herald* (online ed, Sydney, 19 July 2011).

⁵¹Sydney Morning Herald, above n 50.

⁵²Wicclair, above n 3, at 30.

⁵³ See: Edmund D Pellegrino “The Physician’s Conscience, Conscience Clauses and Religious Beliefs: A Catholic Perspective” (2002) 30 *Fordham Urban Law Journal* 221 at 242.

⁵⁴ American Medical Student Association “Enriching Medicine Through Diversity” American Medical Student Association <www.amsa.org>.

⁵⁵Some reasons for this are discussed by Maya Noronha “Removing Conscience from Medicine: Turning the Hippocratic Oath into a Hypocrite’s Pledge” (2010) 23 *The Georgetown Journal of Legal Ethics* 733 at 737.

⁵⁶Lynch, above n 33, at 8.

⁵⁷Charles Hepler, quoted in: Wicclair, above n 3, at 27.

⁵⁸Charles Hepler, quoted in: Wicclair, above n 3, at 27.

conscientiously object argue that the practice of medicine would be impossible without these moral or ethical guidelines, on account of the discretionary decision-making, involving a consideration of complex moral and ethical issues.⁵⁹

A related concern is the risk of encountering difficulties if a practitioner's personal moral judgement is excluded from medicine. Practitioners will always encounter moral dilemmas in the course of their work, and when these occur, they should be entrusted to rely upon their moral compass to determine the best course of action for their patients. These arguments are flawed insofar as that they assume a practitioner's conscience provides a sufficient compass for solving these kinds of dilemmas, superior to that of professional ethical standards. Personal ethical standards may be less reliable than professional ones. As Wicclair notes, "depending on the content of a person's core moral beliefs, maintaining moral integrity can require invidious discrimination, genocide, cruelty, and so forth."⁶⁰ This ultimately leads back to the conundrum of conscience: its inherent individuality, and correspondingly, the difficult task of formulating a conception of conscience protection that is capable of accommodating vastly disparate beliefs. Those opposed to conscientious objection submit these problems as reasons for excluding conscientious objection from the practice of medicine.

2 *Incompatibility thesis*

At the opposite side of the continuum, Wicclair's "incompatibility thesis"⁶¹ states that if a practitioner is unwilling to provide any legally available treatment, simply put, they should not become a doctor.⁶² The fiduciary duty a practitioner owes to patients provides a compelling reason for excluding conscientious objection from healthcare.⁶³ The nature of a fiduciary duty suggests that a practitioner is obliged to place their patients' interests ahead of their own in the event of a conflict. This view is outlined by Kimberly Moss, who writes that "doctors have fiduciary duties to their patients to act in good faith to protect their health, particularly to the extent that the patient's interest conflicts with the physician's self-interest."⁶⁴

While a practitioner's fiduciary duty is undoubtedly important, it is already subject to limits. Practitioners will not work tirelessly at all hours, nor should we expect them to abandon their holidays or personal time for a patient in need.⁶⁵ In this regard,

⁵⁹Wicclair, above n 3, at 26.

⁶⁰Wicclair, above n 3, at 27.

⁶¹Wicclair, above n 3, at 43.

⁶²Wicclair, above n 3, at 33.

⁶³Kimberly Moss, above n 6, at 179.

⁶⁴At 179.

⁶⁵Lynch, above n 33, at 44-45.

practicalities dictate that they will not always put their patients ahead of themselves, nor can a medical practitioner's fiduciary duty provide a complete answer to the vexed question of whether conscientious objection in healthcare should be permissible.

Critics of the right to conscientiously object further argue that a practitioner's professional obligations should prevent them from refusing to provide legally available treatments.⁶⁶ Julian Savulescu, a renowned medical ethicist, puts forward the following scenario:⁶⁷

Imagine an epidemic of bird flu or other infectious disease that a specialist decided she valued her own life more than her duty to treat her patients. Such a set of values would be incompatible with being a doctor.

Savulescu uses this example to indicate that conscientious objection could become a shield for doctors who do not want to treat patients for reasons of self-preservation.⁶⁸ This argument could be taken further, as the exercise of conscientious objection could become a backdoor way of permitting discriminatory practices, allowing doctors to refuse to treat patients whose perceived lifestyles or beliefs they did not agree with.

Allowing some form of conscientious objection inevitably creates staffing problems, in the form of administrators having to work around any number of objecting practitioners. A corresponding point is that any increase in workloads as a result of conscientious objection will be borne by other practitioners who do not object. This may create a sense of ill-will on behalf of practitioners who are forced to perform additional tasks. This inefficiency dictates against permitting conscientious objection in healthcare.

Healthcare is already extraordinarily expensive, whether publically or privately funded. Figures released by the New Zealand Treasury project the cost of healthcare rising from 6.8% of gross domestic product in 2010, to 10.8% in 2060.⁶⁹ Hospitals are always pressed for resources, and medical practitioners already suffer under strenuous workloads. Working around conscientiously objecting practitioners may increase the cost of healthcare as a whole, as hospitals are forced to hire more staff members who do not conscientiously object.⁷⁰ More empirical evidence is necessary

⁶⁶Julian Savulescu "Conscientious Objection in Medicine" (2006) 332 British Medical Journal 294 at 295.

⁶⁷At 295; see also Wicclair, above n 3, at 59-60.

⁶⁸At 295.

⁶⁹The Treasury *Affording Our Future: Statement on New Zealand's Long-Term Fiscal Position* (July 2013) at 4.

⁷⁰ See the argument in Doogan, above n 40, at [27].

before any conclusions can be drawn. The right of conscientious objection however, remains an important public interest consideration.

3 *Specialties*

There is a middle ground between the polarising concepts of conscious absolutism and the incompatibility thesis. This middle ground proposes that if the disputed treatment forms an integral part of the particular specialty the objecting practitioner wishes to partake in, they should not become a member of that specialty.⁷¹ Judicially, this approach was alluded to by the Outer House in the Scottish Court of Session, where Lady Smith reasoned that “nurses and midwives should give careful consideration when deciding whether or not to accept employment in an area that carries out treatment or procedures to which they object”, in response to a claim of statutory conscientious objection protection.⁷²

This approach seems a valid compromise, in that it allows objecting practitioners to continue the practice of medicine, without their objections becoming an undue hindrance on employers or access to legally available treatments. However, it is not without problems. For example, a practitioner may wish to enter the gynaecology field, because of a strong interest in the aspects of the speciality, yet be strongly opposed to providing abortions. Under this middle ground, she would be forbidden to do so. There would always be issues at the margins, as it will never be entirely clear whether a disputed treatment forms an essential part of the specialty, rendering it difficult to legislate. To summarise, no academic theory provides a comprehensive answer to the whether conscientious objection in healthcare should ultimately be permissible.

IV *Competing Human Rights*

A *International Conventions*

Turning to international human rights conventions provides little help in determining how the issues surrounding conscientious objection might be satisfactorily resolved. There is support for both positions in international conventions. New Zealand is a party to international instruments regulating both the right to receive adequate medical treatment and the right to religious freedom.⁷³ On one hand, article 18 of the

⁷¹Wicclair, above n 3, at 82-83.

⁷²*Doogan v NHS Greater Glasgow & Clyde Health Board* [2012] CSOH 32 at [15].

⁷³See: International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976); *Universal Declaration of Human Rights* GA Res 217A (III) A/80 (1948); and United Nations Convention on the Elimination of All Forms of

Universal Declaration of Human Rights guarantees that “everyone has the right to freedom of thought, conscience and religion,”⁷⁴ a hallmark right in democratic societies.⁷⁵ On the other hand, article 12 of the International Covenant on Economic, Social and Cultural Rights states parties must “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁷⁶

Because conscientious objection is currently exercised in the context of reproductive health services, it is worthwhile considering human rights legislation aimed at women. Article 12(1) of the International Convention on the Elimination of all Forms of Discrimination Against Women (“CEDAW”) states that parties should “ensure on a basis of equality of men and women, access to health care services, including those related to family planning.”⁷⁷ As New Zealand is a party to CEDAW, it is important to ensure that legislation regulating reproductive health does not unduly impact on women’s equal access to healthcare. The CEDAW Committee, in its last report, raised concerns about New Zealand’s abortion law.⁷⁸

B Pichon and Sajous v France

Recently, the European Court of Human Rights had the opportunity to consider conscientious objection in healthcare in *Pichon and Sajous v France*.⁷⁹ Two pharmacists were prosecuted under the French Consumer Code for refusing to supply contraceptives.⁸⁰ The pharmacists argued that the conviction infringed their article 9 rights (freedom of thought, conscience and religion)⁸¹ under the European Convention on Human Rights.⁸² The Court rejected this.⁸³ Mark Campbell has cautioned against interpreting this judgment as an authority for article 9 providing no protection for the right to conscientiously object in healthcare.⁸⁴ Campbell suggests two reasons for

Discrimination against Women 1249 UNTS 13 (opened for signature 18 December 1979, entered into force 3 September 1981).

⁷⁴ *Universal Declaration of Human Rights* GA Res 217A (III) A/80 (1948), art 18.

⁷⁵ Mark Campbell “Conscientious Objection, Health Care and Article 9 of the European Convention of Human Rights” (2011) 11 Med L Int 284 at 286.

⁷⁶ *International Covenant on Economic, Social and Cultural Rights* 993 UNTS 171 (opened for signature 16 December 1966, entered into force 3 January 1993), art 12.

⁷⁷ *United Nations Convention on the Elimination of All Forms of Discrimination against Women* 1249 UNTS 13 (opened for signature 18 December 1979, entered into force 3 September 1981), art 12(1).

⁷⁸ *Committee on the Elimination of All Forms of Discrimination Against Women Concluding Observations on New Zealand* (27 July 2012).

⁷⁹ *Pichon and Sajous v France* (49853/99) Section III, ECHR 2 October 2001.

⁸⁰ *Pichon and Sajous v France*, above n 79, at 1.

⁸¹ *Convention for the Protection of Human Rights and Fundamental Freedoms (The European Convention)* 213 UNTS 222 (opened for signature 4 November 1950, entered into force 21 September 1953), art 9.

⁸² *Pichon and Sajous v France*, above n 79, at 2.

⁸³ At 4.

⁸⁴ At 288-289.

this.⁸⁵ Firstly *Pichon* concerned admissibility and did not consider the merits, and secondly, the case involved a criminal law prosecution.⁸⁶ As Campbell explains “the approach of the Court has been that criminal laws of general application do not usually amount to an interference with article 9 rights.”⁸⁷ Campbell concludes, therefore, that *Pichon* should not be read “as laying out a definitive Strasbourg position on conscientious objection and article 9.”⁸⁸ The judgment does, however, indicate reluctance on the part of the Court to assert that article 9 protects the right to conscientiously object within the medical field.

C *Doogan v NHS Greater Glasgow and Clive*

Similarly, in the United Kingdom, the *Doogan*⁸⁹ decision gave short shrift to article 9 in the context of the right to conscientiously object in healthcare.⁹⁰ Lady Smith, in the Outer House of the Scottish Court of Session, began by noting that, while the right to hold beliefs was not subject to limits, the right to manifest them was qualified.⁹¹ Her Honour reasoned that because article 9 rights were already essentially qualified by a specific conscientious objection provision in the United Kingdom Abortion Act 1967,⁹² it was unnecessary to undertake the balancing exercise Article 9 required.⁹³ The plaintiffs’ Article 9 argument appears to have been abandoned on the appeal to the Inner House.⁹⁴ Both cases will be discussed in part five.

As the preceding section indicates, conscientious objection in healthcare raises valid competing policy concerns. There are strong academic arguments and important human rights implications on both sides of the divide. The moral distress objecting practitioners may feel if forced to undertake medical treatments, which fly in the face of their deeply held moral, religious or ethical beliefs is worth considering. On this basis, conscientious objection in healthcare is *prima facie* worth protecting. The right of patients to access legally available medical treatments, however, must take precedence if an appropriate compromise cannot be reached. Accordingly, any legislative reform of conscientious objection must ensure that if the right remains protected, it is not at the expense of legal treatments being readily available in a

⁸⁵At 289.

⁸⁶At 289.

⁸⁷At 289.

⁸⁸At 290.

⁸⁹*Doogan*, above n 72.

⁹⁰*Doogan*, above n 72, At [72].

⁹¹At [48]; see Convention for the Protection of Human Rights and Fundamental Freedoms (The European Convention) 213 UNTS 222 (opened for signature 4 November 1950, entered into force 21 September 1970), art 9(2).

⁹²Abortion Act 1967 (UK), s 4(1).

⁹³At [80].

⁹⁴See: *Doogan*, above n 40.

timely manner, without the creation of barriers by objecting practitioners. Autonomy of practitioners cannot be evaluated without considering autonomy of patients.

V International Conscientious Objection Legislation and Case Law

Other jurisdictions have taken a similar view that medical practitioners' right to conscientiously object should be protected to the extent it does not unduly impact patients' rights to receive legally available medical treatments. Beyond this, specific legislative protections of a practitioners' right to conscientiously object vary. This section will briefly consider how both the United States and the United Kingdom have enshrined the right to conscientiously object in their legislation, to explore how other jurisdictions have struck a balance between the aforementioned competing rights.

The surge in conscientious objection case law and legislation is most predominant in the United States of America.⁹⁵ While a discussion of each State's statutory protection of conscience is beyond the scope of this paper,⁹⁶ the State which provides a liberal protection of a practitioner's right to conscientiously object, Mississippi, will briefly be discussed.⁹⁷ The discussion will then turn to the United Kingdom, which has a similar statutory framework to New Zealand, to demonstrate where courts have encountered difficulties in applying conscientious objection legislation, due to the lack of New Zealand case law on the subject.

A The United States of America: Broad Protection

A large proportion of the case law on conscientious objection has arisen in the United States. This is due, in part, to the fact that the Supreme Court's decision in *Roe v Wade*, (effectively legalising abortion)⁹⁸ has been vigilantly opposed by a strong religious lobby, resulting in both state and federal legislation allowing practitioners to refuse to partake in abortion procedures.⁹⁹ This included the 1973 Church Amendment, one of the first widespread conscience clauses in healthcare.¹⁰⁰ The difference in legislation, however, renders most of the case law inapplicable for the purposes of comparison with New Zealand.

⁹⁵JudyAnn Bigby et al "Health Care Refusals: Undermining Quality Care for Women" (2010) National Health Law Program <www.healthlaw.org> at 7.

⁹⁶For a good summary see: Thaddeus Pope "Legal Briefing: Conscience Clauses and Conscientious Refusal" (2010) 21 The Journal of Clinical Ethics 163.

⁹⁷Health Care Rights of Conscience Act Mississippi Code § 41107-5 (2013).

⁹⁸Kimberly Moss, above n 6, at 175; Wicclair, above n 3, at 15.

⁹⁹Dickens, above n 23, at 338-339.

¹⁰⁰TA Cavanaugh, above n 22, at 198.

Presently, 46 States have some form of conscientious objection legislation protecting healthcare professionals.¹⁰¹ One of the broadest statutory protections of conscientious objection in the United States is Mississippi's Health Care Rights of Conscience Act.¹⁰² The Act allows practitioners to refuse to participate in "any phase of patient medical care, treatment or procedure."¹⁰³ Participation is defined in section 2(f) as including referring, counselling, or advising.¹⁰⁴ The Act also protects institutions.¹⁰⁵ Section 3(1), however, forbids any objection on the basis of "race, colour, national origin, ethnicity, religion, creed or sexual orientation."¹⁰⁶ The initial protection is as wide as possible, while ensuring objection on discriminatory grounds is impermissible.

B The United Kingdom

The United Kingdom's legislative protection of the right to conscientiously object is comparatively limited. The United Kingdom has a very similar legislative framework to New Zealand (discussed in part six) including a specific, statutory right of conscientious objection applicable to reproductive health. Section 4(1) of the Abortion Act 1967 (UK) (Abortion Act) states "no person shall be under any duty ... to participate in any treatment authorised by this Act to which he has a conscientious objection."¹⁰⁷ The person wishing to utilise this protection bears the burden of proof.¹⁰⁸ Subsection 3 adds that in Scottish court proceedings, a statement on oath is sufficient to discharge this burden.¹⁰⁹ The legislation, while similar to New Zealand's, has led to more court disputes about the scope and extent of legally permissible conscientious objection in healthcare.

The Abortion Act itself is clear that the right to conscientiously object has no effect when a termination is necessary to "save the life, or prevent grave permanent physical injury to the physical or mental health of a pregnant woman."¹¹⁰ Differences in judicial opinion have arisen regarding in what other circumstances the Abortion Act renders conscientious objection impermissible.¹¹¹ In *Doogan*, Lady Smith, in the Outer House of the Scottish Court of Sessions considered that the right to conscientiously object did not apply to section 1(b) or (c) of the Abortion Act.¹¹²

¹⁰¹Mark Wicclair, above n 3, at 206.

¹⁰²Health Care Rights of Conscience Act Mississippi Code § 41 107-5 (2013).

¹⁰³Section 2(a).

¹⁰⁴Section 2(f).

¹⁰⁵Section 4(1).

¹⁰⁶Health Care Rights of Conscience Act Mississippi Code § 41 107-5 (2013), s 3(1).

¹⁰⁷Abortion Act 1967 (UK), s 4(1).

¹⁰⁸Section 4(1).

¹⁰⁹Section 4(3).

¹¹⁰Section 4(2).

¹¹¹Compare: *Doogan*, above n 72, at [75] with *Doogan*, above n 40, at [15].

¹¹²At [75].

These subsections outline that an abortion may be performed when it is necessary to “prevent grave permanent injury to the physical or mental health of the woman”¹¹³ and where “the continuance of the pregnancy would involve risk to the life of a pregnant woman, greater than if the pregnancy were terminated.”¹¹⁴ The Inner House considered that Her Honour had erred in this interpretation,¹¹⁵ despite the similar wording in sections 4(2) and 1(b) of the Abortion Act.

One of the first cases concerning the Abortion Act was *Royal College of Nursing of the United Kingdom v Department of Health and Social Security* (The RCN case).¹¹⁶ While this case was not directly concerned with conscientious objection, the observations made by the House of Lords are important, as they have been relied on to support later judicial interpretations of section 4 in the Abortion Act. This case concerned the extent of legislative protection available for nurses administering prostaglandin induction methods (a less invasive method of abortion) a causative part of the termination.¹¹⁷ The nurses were concerned that the words “when the pregnancy is terminated by a registered medical practitioner,” (operating to legalise abortion in certain circumstances)¹¹⁸ would not offer the same statutory protection to nurses assisting in the procedure, rendering their acts illegal, as abortion remains criminal aside from the circumstances provided for in the Abortion Act.¹¹⁹

The legal question divided judges. At first instance, Woolf J held the acts of the nurses were lawful.¹²⁰ However, the Court of Appeal reversed this, on the basis that the entire procedure had to be carried out by the doctor if it was to come within the bounds of what was legal under section 1(1) of the Abortion Act.¹²¹ The case was appealed to the House of Lords. The majority in the House of Lords held that if a registered medical practitioner took charge of the procedure, the nurses’ involvement was not illegal.¹²² Lord Keith emphasised the fact that the registered medical practitioner was “in charge” throughout.¹²³ Lord Roskill agreed, noting that the nurses’ involvement was “at all times under the control of the doctor, even though the doctor was not present at the time.”¹²⁴ Lord Diplock reiterated these statements, by noting that “Parliament contemplated (conscientious objections aside) like other

¹¹³Abortion Act 1967 (UK), s 1(1)(b).

¹¹⁴Abortion Act 1967 (UK), s 1(1)(c).

¹¹⁵At [15].

¹¹⁶*Royal College of Nursing v Department of Health and Social Security* [1981] AC 800.

¹¹⁷*Royal College of Nursing v Department of Health and Social Security*, above n 116, at 804 (CA).

¹¹⁸Abortion Act 1967 (UK), s 1(1).

¹¹⁹Offences Against the Person Act 1861, ss 58 and 59.

¹²⁰*Royal College of Nursing v Department of Health and Social Security*, above n 116, at 806 (CA).

¹²¹At 814.

¹²²At 838.

¹²³At 835.

¹²⁴At 838.

hospital treatments, it [termination] would be undertaken as a team effort.”¹²⁵ Later cases heavily relied on this part of the judgment.

Following this case was *R v Salford Area Hospital Authority ex parte Janaway*¹²⁶ (*Janaway*). The case involved a secretary, Barbara Janaway, who was dismissed for refusing to type a referral letter for abortion after she sought the protection that s 4(1) of Abortion Act 1967 provided.¹²⁷ Janaway sought judicial review of the Salford Health Authority’s decision that her dismissal was justified.¹²⁸ The case turned on the simple question of whether, by typing the letter, she was “being asked to ‘participate in any treatment authorised by the Act.’”¹²⁹ How the word ‘participate’ was interpreted was, therefore, crucial.

In the Court of Appeal, the majority considered that the conscience section should be interpreted in light of the law prior to statutory legal abortions and the previous criminal consequence of assisting with abortions.¹³⁰ The partial legalisation of abortion in section 1(1) was therefore to be read with section 4(1).¹³¹ Slade LJ, in the majority, reasoned that Janaway was not participating in any treatment authorised by the Act, as her action in typing the letter would not have been a criminal offence prior to abortion being legalised in some circumstances.¹³²

The House of Lords, however, took a different approach, and agreed with the minority in the Court of Appeal that the word ‘participate’ did not import a consideration of the prior criminal status of abortion, but should be interpreted according to its “ordinary and natural meaning.”¹³³ In this case, according to the House of Lords, this meant “actually taking part in treatment administered in a hospital or other approved place.”¹³⁴ The situation seemed relatively settled by this judgment, and remained so until recently.

Janaway, however, was not the final word on the issue. In the *Doogan* litigation, the issue again arose as to how broadly the words “participate in any treatment authorised by the [Abortion] Act” should be interpreted.¹³⁵ Two midwives sought confirmation that the protection section 4(1) offered encompassed “an entitlement to refuse to

¹²⁵At 828.

¹²⁶ *R v Salford Area Hospital Authority ex parte Janaway* [1989] 1 AC 537.

¹²⁷*R v Salford Area Hospital Authority*, above n 126, at 537.

¹²⁸*R v Salford Area Hospital Authority*, above n 126 at 542 (CA).

¹²⁹*R v Salford Area Hospital Authority*, above n 126, at 546 (CA).

¹³⁰At 548-551.

¹³¹At 570.

¹³²At 551.

¹³³At 570.

¹³⁴At 570.

¹³⁵*Doogan*, above n 40, at [12].

delegate, supervise and/or support staff providing care to patients undergoing termination of pregnancy or feticide.”¹³⁶ This would allow the midwives to have no contact whatsoever with patients seeking a termination. The respondents argued that participation only involved “activities that directly brought about the termination of a pregnancy”¹³⁷ and the right to conscientiously object “was not available to [the midwives] in respect of their duties of delegation, supervision and support.”¹³⁸

In the Outer House of the Scottish Court of Session, Lady Smith considered that ‘treatment’ meant “those activities which directly bring about the termination of the pregnancy”¹³⁹ Likewise, the word ‘participate,’ “did not extend to all those involved in the chain of causation.”¹⁴⁰ Lady Smith distinguished the *RCN* case on the basis that the nurses in that case all had a “direct involvement” in the abortion.¹⁴¹ In her Honour’s view, section 4(1) of the Abortion Act did not apply to those who “did not take part in the objectionable activity.”¹⁴² On this basis, the midwives appeal was dismissed.¹⁴³

The case was appealed, and the Inner House of the Court of Session adopted a different view, holding that the right to object encompassed the activities the midwives contended it did.¹⁴⁴ The Court cited the *RCN* case in support of its view, by noting that the word ‘treatment’ encompassed not simply those directly involved in the abortion, “but to all those involved in the process of termination.”¹⁴⁵ In the Court’s view, therefore, “the right of conscientious objection extends not only to the actual medical or surgical termination but to the whole process of treatment for that purpose.”¹⁴⁶

The Inner House reasoned that the right to conscientiously object was enshrined in the legislation because “the process of abortion is felt by many people to be morally repugnant.”¹⁴⁷ The Court viewed this fact as justification for a wide interpretation of the conscientious objection section, stating “it is consistent with the reasoning that allowed such an objection in the first place that it should extend to any involvement in the process of treatment.”¹⁴⁸ The discernible logic seems to be that, because the

¹³⁶*Doogan*, above n 40, at [12].

¹³⁷*Doogan*, above n 40, at [53].

¹³⁸*Doogan*, above n 40, at [53].

¹³⁹At [9].

¹⁴⁰At [9].

¹⁴¹At [79].

¹⁴²At [79].

¹⁴³At [89].

¹⁴⁴At [30].

¹⁴⁵At [35].

¹⁴⁶At [37].

¹⁴⁷At [38].

¹⁴⁸At [38].

subject matter is controversial, the conscience clause should be interpreted as broadly as possible.

The Inner House dismissed concerns that this interpretation would have an adverse impact on staffing in hospitals.¹⁴⁹ Instead, they noted the problems those who exercised their right to conscientiously object currently faced.¹⁵⁰ The Court explained:¹⁵¹

It is debatable whether safety would be compromised more by what [the midwives] proposed than by a system which places on those who may already be struggling with their conscience the additional burden of having to assess whether each task comes within the scope of their conscientious objection and of having to re-state that objection, possibly on a daily basis.

With respect, this analysis does not address the question of what impact their favoured interpretation would have on hospital staffing arrangements.

It is of concern that the Inner House did not factor in the impact that their interpretation might have on access to healthcare. Nowhere in the judgment does the Inner House consider the impacts of its decision on accessibility to abortions. Perhaps it was because abortion remains legal only in certain circumstances (a status that New Zealand law mirrors)¹⁵² that the Court did not consider the wider public interest implications of their decision. National Health Services Greater Glasgow and Clyde are appealing the decision.¹⁵³ The Supreme Court's view on the topic will be interesting to see, if leave to appeal is given.

The interpretation favoured by the Inner House hugely broadens the scope of legally exercisable conscientious objections in the United Kingdom to encompass seemingly all aspects of the 'treatment' of a woman undergoing an abortion, including pre and post-operative care, along with supervision of delegation responsibilities of staff caring for a woman undergoing an abortion. As Louise Finer notes, the question arises as to "how far up the hierarchy of a health service does the ability to conscientiously object to playing a supervisory role reach?"¹⁵⁴ Aside from creating staffing difficulties for hospitals, the decision raises questions about how a New Zealand court faced with

¹⁴⁹At [34].

¹⁵⁰At [34].

¹⁵¹At [34].

¹⁵²Crimes Act 1961, s 182.

¹⁵³BBC News "Supreme Court to Hear Appeal in Midwives Abortion Case" *BBC News* (online ed, United Kingdom, 25 June 2013).

¹⁵⁴Louise Finer "Conscientious Objection in Scotland: A Worrying Precedent" RHM Blog: The Blog for Reproductive Health Matters (14 May 2013) <<http://rhmmatters.wordpress.com>>.

similar circumstances might rule. The phrase “assist in the performance”¹⁵⁵ in section 46 of the Contraception, Sterilisation and Abortion Act 1977, could theoretically be interpreted broadly, in a similar way to how “participation in any treatment” was by the Inner House.

Doogan encapsulates a trend toward a resurgence of conscientious objection litigation and legislation.¹⁵⁶ From an access to healthcare perspective, this trend is worrying in its ability to effectively limit women’s ability to access legally available reproductive health services. Case law from the United Kingdom also demonstrates the difficulties courts have had in interpreting conscientious objection sections. Difficulties have arisen in delineating who, and what activities, are protected by legislation’s conscience section. The issues are primarily linked to the scope of protection, a matter New Zealand conscientious objection law is also unclear on.

VI *Current New Zealand Law Relating to Conscientious Objection*

New Zealand’s conscience protection legislation currently exists on an ad hoc basis. The legislature has incorporated conscience clauses when they have been considered necessary, seemingly only in the context of reproductive health.¹⁵⁷ Women, therefore, tend to be most affected by practitioners exercising this right. The right to conscientiously object to the provision of healthcare in New Zealand is governed by two key Acts: the Contraception Sterilisation and Abortion Act 1977 and the Health Practitioners Competence Assurance Act 2003. Guidelines promulgated by professional bodies are also used to regulate practitioners exercising their right to conscientiously object.¹⁵⁸

A *Contraception, Sterilisation and Abortion Act 1977*

An explicit conscience clause is contained in the Contraception, Sterilisation and Abortion Act 1977 (“CSA”). Section 46 sets out that:¹⁵⁹

¹⁵⁵Contraception, Sterilisation and Abortion Act, s 46(1)(a).

¹⁵⁶See the comments of the British Medical Association: British Medical Association “Expressions of Doctor’s Beliefs” (26 August 2012) British Medical Association <www.bma.org.nz>.

¹⁵⁷See for example: Contraception, Sterilisation and Abortion Act 1977, s 46 and the Health Practitioners Competence Assurance Act 2003, s 174.

¹⁵⁸ Office of the Health and Disability Commissioner *The Code of Rights* (2004) <www.hdc.org.nz>; and Medical Council of New Zealand *Good Medical Practice* (Medical Council of New Zealand, April 2013).

¹⁵⁹Section 46.

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

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

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

if he objects to doing so on grounds of conscience.

While subsection 1 does not expressly include advice, subsection 1(b) is clear that the protection encompasses giving contraceptive advice.

Section 46 expressly states it has no effect on section 5 of the CSA.¹⁶⁰ The latter section mandates that sexual violation complainants must be informed of the availability of contraception (presumably the emergency contraceptive pill (ECP)) to “avoid the risk of pregnancy”¹⁶¹ This contraception may be supplied by the practitioner themselves, a colleague, or family planning clinic.¹⁶² The wording of the section suggests that the medical practitioner is still under no personal duty to provide the contraception themselves, as section 5(1)(b) recognises the secondary option of advising the patient of her right to seek the contraception elsewhere. The only exceptions are where the medical practitioner is satisfied that there was no penetration, or if the complainant “expresses a contrary wish.”¹⁶³ The fact that section 5 sets out a statutory duty to advise about contraceptives when section 46 does not do so suggests that, aside from sexual violation cases, conscientiously objecting medical practitioners have *no legal duty* to advise patients about any of the matters set out in section 46.

The legal position as a result of these sections is that, even in the case of medical emergency, a New Zealand medical practitioner is permitted to object to performing an abortion, and medical practitioners and any other persons (including pharmacists, or nurses) are able to object to supplying any contraceptive, with no correlative duty to directly refer, including in sexual violation cases.

B Health Practitioners Competence Assurance Act 2003

¹⁶⁰ Section 46.

¹⁶¹ Section 5(1)(a).

¹⁶² Section 5(1)(a).

¹⁶³ Contraception, Sterilisation and Abortion Act 1977, s 5.

The case law suggests that section 46 of the CSA should be read in tandem with section 174 of the HPCA.¹⁶⁴ Section 174 sets out that a health practitioner who objects to providing reproductive health service must inform the patient requesting the service that it can be obtained from another health practitioner.¹⁶⁵ Health practitioner is defined in section 5 as “a person who is ... registered with an authority as a practitioner of a particular health profession.”¹⁶⁶ It is therefore broader than the definition of ‘medical practitioner’ under the CSA, encompassing pharmacists and nurses.¹⁶⁷

Judicial interpretation of section 174 has reinforced that it has a broader effect than section 46 alone.¹⁶⁸ In the *Hallagan v New Zealand Medical Council* case, Mackenzie J noted that:¹⁶⁹

An objection on grounds of conscience is not confined to the right of conscientious objection conferred by Parliament in s 46, or specifically recognised in some other way. The reference extends to any conscientious objection held by a doctor relating to abortion, and the section does not limit or confine the extent of such a conscientious objection.

Exactly how wide this section can be interpreted remains to be fully determined.

Section 174 imposes a duty on a health practitioner exercising the right to conscientiously object to inform a patient *requesting* a disputed service of this objection.¹⁷⁰ Accordingly, it is only when a patient specifically requests the disputed treatment that the duty is engaged. When this occurs, the practitioner must inform the person seeking the particular treatment of their right to attain it elsewhere. This demonstrates that when seeking to strike a balance between the deeply held moral, ethical or religious beliefs of practitioners and the rights of patients to receive legally available healthcare, the legislature deemed that indirect referral was preferable. Indirect referral is a good starting point as it ensures that the patient is aware of their right to receive the disputed treatment elsewhere. However, section 174 is problematic as it assumes the patient has the requisite knowledge to request the disputed service.

¹⁶⁴*Hallagan v New Zealand Medical Council* [2010] HC Wellington Civ-2010-485-222, 2 December 2010 at [10].

¹⁶⁵Section 174.

¹⁶⁶Health Practitioners Competence Assurance Act 2003, s 5.

¹⁶⁷‘Medical practitioner’ is defined as a person registered with the Medical Council: Contraception, Sterilisation and Abortion Act, s 2.

¹⁶⁸*Hallagan v New Zealand Medical Council*, above n 164, at [19].

¹⁶⁹At [19].

¹⁷⁰Section 174(1)(a).

C Other Relevant Law

(i) Domestic human rights legislation

Beyond these two specific statutory sections, conscientious objection is subject to broader legislative protection. As previously indicated, conscientious objection raises human rights arguments. Part of the protection for the right, therefore, is found in domestic human rights instruments. This includes sections 13 and 15 of the New Zealand Bill of Rights Act 1990 (BORA). Section 13 sets out that “everyone has the right to freedom of thought, conscience, religion and belief, including the right to adopt and to hold opinions without interference.”¹⁷¹ Additionally, section 15 states that “every person has the right to manifest that person’s religion or belief in worship, observance practice or teaching, either individually or in community with others, and either in public or in private.”¹⁷² Section 6 is an important interpretative provision, which sets out that “where an enactment can be given a meaning that is consistent with the rights and freedoms contained in the Bill of Rights Act,” this is preferred.¹⁷³ On this approach, a broader interpretation of the conscientious objection provision may be preferred. This was affirmed in the *Hallagan* case concerning conscientious objection, discussed shortly.¹⁷⁴

These provisions *prima facie* form part of the background protection of the right to conscientiously object in healthcare. The right may be subject to a section 5 test (whether any limitation on the right is demonstrably justified in a free or democratic society).¹⁷⁵ What a New Zealand court would decide in a case based on BORA is difficult to predict. It is safe to assume that the importance of access to legally available medical services would be an important public interest consideration. Furthermore, case law from the United Kingdom has suggested that courts should be reluctant to intervene when employment purports to infringe on religious rights, or where a balance has already been struck by the legislature.¹⁷⁶

(ii) Guidelines

Guidelines promulgated by medical bodies are also an important regulatory mechanism. Conscientious objection in healthcare is an area where practice may be of greater importance than the law. Medical professional bodies have set standards for

¹⁷¹New Zealand Bill of Rights Act 1990, s13.

¹⁷²Section 15.

¹⁷³Section 6.

¹⁷⁴At [17].

¹⁷⁵New Zealand Bill of Rights Act 1990, s 5.

¹⁷⁶See the discussion in *Doogan*, above n 40, at [48]-[58].

what should occur where a practitioner feels his or her personal beliefs conflict with a patient, either personally or in terms of treatment sought. For example, the Medical Council of New Zealand's *Good Medical Practice* guidelines state that a practitioner's personal beliefs, "including political, religious and moral beliefs" should not affect the doctor patient relationship.¹⁷⁷ If the practitioner fears that his or her personal beliefs might affect treatment, this must be explained, whilst informing the patient that they have the right to see another doctor.¹⁷⁸ In this respect, it mirrors section 174 of the HPCA. This guideline seems to leave it to practitioners to determine whether or not their personal beliefs will affect the doctor/patient relationship. This has the potential to create problems, given that it assumes the practitioner will be aware of any discomfiture felt by the patient.

The Health and Disability Commissioner's Code of Rights also contains rights which are relevant to a discussion of conscientious objection.¹⁷⁹ Right 3 states that "every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual."¹⁸⁰ Right 4 also sets out that "every consumer has the right to have services provided in a manner consistent with his or her needs,"¹⁸¹ while right 6 sets out the right to be fully informed.¹⁸² These provisions are important in any disciplinary proceeding against a practitioner.

The bulk of the guidelines suggest that the patient's health is paramount and if there is any conflict with the doctor's moral, ethical or religious beliefs it is the practitioner's responsibility to take appropriate action to curtail any potential risk to the patient, by informing them of their right to seek another practitioner.

Guidelines are primarily effective as a measure of medical practice. They may, accordingly, be most effective as an ambulance at the bottom of the cliff, in measuring bad medical conduct after the fact of a complaint. Interestingly, the *Doogan* case raised questions about the legitimacy of such guidelines. The Inner House stated that:¹⁸³

Great respect should be given to the advice provided hitherto by the professional bodies, but prior practice does not necessarily dictate interpretation. Moreover, when

¹⁷⁷Medical Council of New Zealand *Good Medical Practice* (Medical Council of New Zealand, April 2013) at [20].

¹⁷⁸Medical Council of New Zealand *Good Medical Practice*, above n 177, at [20].

¹⁷⁹Office of the Health and Disability Commissioner *The Code of Rights* (2004), above n 4.

¹⁸⁰At 1.

¹⁸¹At 1.

¹⁸²At 1.

¹⁸³*Doogan*, above n 40, at [33].

the subject of the advice concerns a matter of law, there is always the possibility that the advice from the professional body is incorrect,”

Case law, therefore, remains paramount in interpreting legislation.

D The Legal Status of Abortion in New Zealand

Understanding the significance of the sole case on the right to conscientiously object in New Zealand, *Hallagan v New Zealand Medical Council* necessitates a brief discussion of the legal status of abortion in New Zealand. As in the United Kingdom, abortion in New Zealand is legal in relatively limited circumstances. The starting point is section 187A of the Crimes Act 1961. This section sets out the precise circumstances under which it is not a crime to procure an abortion.¹⁸⁴ These include where the child is a result of incest,¹⁸⁵ where the pregnancy is the result of sexual violation,¹⁸⁶ or where the pregnancy would result in “serious danger ... to the life, or the physical or mental health of the women.”¹⁸⁷ While the CSA permits abortion in these limited circumstances, it has, as Mark Rankin notes “failed to change the fundamental criminal status of abortion.”¹⁸⁸

Practice has, however, diverged from the law in this area, with the Abortion Supervisory Committee reporting that 15,863 abortions occurred in the 2011 calendar year.¹⁸⁹ Of this number, 97.6% were performed under the danger to mental health ground.¹⁹⁰ The number of women receiving abortions under this ground suggests a shift from the original legislative purpose of the CSA.¹⁹¹ Both sides of the abortion debate believe that the mental health ground is being misused for “abortion on request.”¹⁹²

This situation led to pro-life group, Right to Life, taking the Abortion Supervisory Committee to court over its alleged failure to properly supervise how abortions were performed in New Zealand.¹⁹³ While a full discussion of this case is beyond the scope

¹⁸⁴Crimes Act 1961, s 187A. It is criminal in other circumstances, see Crimes Act 1961, see s 182.

¹⁸⁵Crimes Act 1961, s 187A(1)(b).

¹⁸⁶Crimes Act 1961, s 187(1)(c).

¹⁸⁷Crimes Act 1961, s 187A(1).

¹⁸⁸Mark Rankin “The Disappearing Crime of Abortion and the Recognition of a Woman’s Right to Abortion: Discerning a Trend in Australian Abortion Law?” (2011) 13 Flinders Law Journal 1 at 4.

¹⁸⁹Abortion Supervisory Committee, *Report of the Abortion Supervisory Committee for 2012* (2012).

¹⁹⁰ Abortion Supervisory Committee, above n 189, at 19.

¹⁹¹For a discussion of the debate over the legality of abortions performed under the danger to mental health ground see: Amy Dixon “Authorisation of Abortion for a ‘Serious Danger to Mental Health’: Would the Practice Stand up to the Judicial Test?” (2012) 48 VUWLR 289.

¹⁹² *Right to Life New Zealand Incorporated v The Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) at [2].

¹⁹³ *Right to Life New Zealand Incorporated v The Abortion Supervisory Committee*, above n 192, at [4].

of this paper,¹⁹⁴ the majority of the Supreme Court dismissed the appeal, believing that the task of abortion law reform was best left for Parliament.¹⁹⁵ However, Parliament seems reluctant to do so, leading to the current “impasse,”¹⁹⁶ recognised by the Court of Appeal in the *Right to Life* case. The disjoint between law and practice is particularly important for regulating conscientious objection in the field of reproductive healthcare.

E Case law: Hallagan v Medical Council of New Zealand

The sole case on conscientious objection arose when the New Zealand Health Practitioners Alliance, a body formed to protect the rights of medical practitioners opposed to certain medical practices, challenged the New Zealand Medical Council’s decision to circulate a document entitled *Beliefs and Medical Practice*.¹⁹⁷ This document sought to better regulate situations where a medical practitioner’s personal beliefs conflicted with a patient’s medical procedure or treatment in the context of abortion.¹⁹⁸ The case centred upon the duty to refer in circumstances where the practitioner objected to abortion. In particular, section 32(1) of the CSA was considered, which states:¹⁹⁹

“Every medical practitioner ... who is consulted by ... a female who wishes to have an abortion shall, if requested to do so ... arrange for the case to be considered and dealt with.”

This section raises questions about whether referral was required.

Differences of opinions arose in *Hallagan* as to precisely what section 32(1) mandated.²⁰⁰ The Medical Council argued that where a medical practitioner opposed to abortion was faced with a patient seeking an abortion, they could exercise their right to conscientiously object, but must “arrange for the case to be considered and dealt with.”²⁰¹ The Medical Council was essentially asserting that section 32(1) of the CSA imposed a direct referral requirement.²⁰² In support of this proposition, the

¹⁹⁴For more details see: Shang-Chin Lai “The Scope of the Abortion Supervisory Committee’s Functions and Powers in *Right to Life New Zealand Inc. v The Abortion Supervisory Committee* (LLB (Hons) Seminar Paper, Victoria University of Wellington, 2013).

¹⁹⁵*Right to Life New Zealand Incorporated v The Abortion Supervisory Committee* [2012] NZSC 68, [2012] 3 NZLR 762 at [53].

¹⁹⁶*The Abortion Supervisory Committee v Right to Life New Zealand Incorporated* [2011] NZCA 246; [2012] 1 NZLR 176 at [120].

¹⁹⁷*Hallagan v New Zealand Medical Council*, above n 164, at [2].

¹⁹⁸*Hallagan v New Zealand Medical Council*, above n 164, at [2].

¹⁹⁹Section 32(1).

²⁰⁰At [2].

²⁰¹At [10].

²⁰²At [10].

Medical Council argued arranging for the case to be considered did not constitute ‘assisting’ in the abortion, therefore, section 46 had no application.²⁰³ By contrast, counsel for Dr Hallagan argued that the only duty imposed by the section on a conscientiously objecting medical practitioner faced with a woman requesting an abortion was to inform her of her right to have her case considered by a colleague.²⁰⁴

Mackenzie J considered that section 32(1) contained “an obligation, expressed in mandatory terms, imposed on a women’s own doctor who is consulted by a woman to have an abortion, if the request is made,”²⁰⁵ to consider the case, which section 46 did not exempt doctors from.²⁰⁶ However, his Honour reasoned that section 174 of the HPCA provided a wider protection than section 46 of the CSA, and entitled doctors to refuse to consider the case.²⁰⁷ Mackenzie J did not believe Parliament had intended to impose a direct referral requirement on medical practitioners who chose to conscientiously object in this circumstance.²⁰⁸ In support of this view, His Honour noted that “matters of conscience are intensely personal.”²⁰⁹

As a result, Mackenzie J stated that objecting doctors faced with a woman seeking an abortion had two options:²¹⁰

- (a) If the conscience of the doctor would be infringed by arranging for the case to be considered and dealt with under ss 32 and 33, the doctor may decline the patient’s request to do so. The doctor must in that event give the information required by s 174(2). The duty to give that information is a statutory one, not one which is subject to additional professional obligations.
- (b) If the conscience of the doctor would not be infringed by arranging for the case to be referred to another doctor for consideration, the doctor must take that step. The making of that referral is a matter of medical practice, to be performed in accordance with proper professional standards.

This approach defers to the doctor in question to determine which course of action is best, according to the bounds of their own conscience.

In addition, the previously discussed disjoint between the legal situation and practice in regard to abortion has the effect of creating a potential lacuna in the CSA. A doctor, opposed to abortion, after considering the case, believing that none of the

²⁰³At [10].

²⁰⁴At [9].

²⁰⁵At [12].

²⁰⁶At [12].

²⁰⁷At [19] and [23].

²⁰⁸At [17].

²⁰⁹At [17].

²¹⁰At [20].

grounds in section 187A apply, refuses to refer the women seeking an abortion onwards, whereas a doctor who was not opposed would have referred. This issue arose in the *Hallagan* case, where the plaintiffs asserted: “if the doctor does not consider that any of those [section 187] grounds may apply then no further action is required. Good medical practice may commend that the doctor consider informing the woman that she may consult another medical practitioner but that is not mandated by the section.”²¹¹ Mackenzie J disagreed with this interpretation.²¹²

His Honour considered that once a practitioner engaged with the consultation, they had to see that consultation through to its completion, including any referral.²¹³ Mackenzie J commented that “a doctor who engages medically with the case by considering it also undertakes a responsibility, both statutory and professional to deal with it in accordance with section ss 32 and 33.”²¹⁴ His Honour considered that:²¹⁵

The proper course for a doctor who has a conscientious objection to carrying to its conclusion the statutory process of considering and if appropriate referring the case is to decline to embark upon that process.

This reinforces the duty of non-abandonment.

To summarise, a medical practitioner is under a mandatory duty to arrange to have the case considered under section 32(1), a duty that section 46(1) of the CSA had no effect on.²¹⁶ Despite this, section 174 of the HPCA had a broader effect, and allowed a doctor to refuse to consider the case from the outset.²¹⁷ In this event, the doctor must give the information under section 174(2). If a doctor chose to engage with considering the case however, they had an obligation to see the process through, including any referral necessitated as a result.²¹⁸

The result of the case was that the Medical Council’s document, *Beliefs and Medical Practice*, insofar as it mandated a referral requirement in all circumstances, was subject to a direction issued by the Court requiring it to be reconsidered,²¹⁹ in light of the finding that section 174(2) was “a maximum obligation, and not one which may be supplemented by the imposition of professional standards.”²²⁰

²¹¹At [9].

²¹²At [10].

²¹³At [22].

²¹⁴At [22].

²¹⁵At [29].

²¹⁶At [12].

²¹⁷At [19] and [23].

²¹⁸At [22].

²¹⁹At [37].

²²⁰At [27].

The fact that there has only been one case in New Zealand on conscientious objection during the thirty-five years it has been in operation seems to suggest a lack of problems with the regulation of conscientious objection. The Ministry of Health reported that it had received no complaints from a member of the public about a practitioner exercising his or her right to conscientiously object to providing any form of reproductive health services.²²¹ Lack of complaints, however, does not necessarily indicate a lack of problems.

Reproductive health services, particularly abortion, are a highly sensitive area. Women may feel unable to question the legitimacy of their practitioner's refusal to provide the disputed treatment for a variety of reasons: most notably, the power imbalance between practitioners and patients, a lack of education, embarrassment, or, in the case of abortion, social stigma. Because of the sensitivities of some of the issues involved, the law alone can never be a complete answer in the area of conscientious objection, but it can provide an impetus to good practice, which is essential. These points will be considered further in part eight.

VII Discussion

A Too Narrow, and too Broad

As the prior analysis sets out, the protection of conscientious objection in New Zealand is both too narrow and too broad. Arguably, it is too broad in allowing practitioners to conscientiously object in situations of medical emergency that necessitate immediate action, or where the efficacy of the treatment is time dependent, such as the ECP. The consequences range from death, to minor inconvenience when patients cannot get contraception from their nearest pharmacies, with unintended pregnancies lying somewhere in the middle. The death of Savita Halappanavar as a result of septicaemia after being denied an abortion when miscarrying, albeit under a different legislative framework,²²² provides a tragic reminder to consider the need to properly address the status of conscientious objection in New Zealand before a similar tragedy occurs here.

Simultaneously, it is too narrow. By limiting conscientious objection to reproductive health services administered pursuant to sections 46 of the CSA and 174 of the HPCA, the legislature has failed to take into account the fact that there are very real

²²¹Statistics Relating to Conscientious Objection and Hospitals Exercising this Right in New Zealand (13 August 2013) (Obtained under Official Information Act 1982 Request to the Ministry of Health).

²²² Henry McDonald "Ireland's First Legal Abortion Carried Out" *The Guardian* (online ed, United Kingdom, 23 August 2013).

moral and ethical dilemmas arising every day in healthcare outside of the reproductive health arena, namely euthanasia, should it be legalised.²²³ If we subscribe to the opinion that conscientious objection is worthy of protection as a result of the risk of moral distress to practitioners, any conscience clause in legislation should be drafted in a manner which is sufficiently robust to deal with new developments in medicine that create ethical issues. Interestingly, the British Medical Association has recently stated it supported practitioners exercising a right to refuse to withdraw life saving treatment, suggesting that the law is not keeping pace with the advent of new medical technologies.²²⁴ More pressingly, the current, limited, protection may stall what some view as favourable legislative developments, such as euthanasia, because the protection for medical practitioners who conscientiously object is perceived to be insufficient.

B Imprecision

Difficulties with imprecise conscience clauses have led to litigation in other jurisdictions. Disputes have arisen about whether activities such as pre and post-operative care,²²⁵ supervision and delegation,²²⁶ or typing referral letters²²⁷ are protected by conscientious objection legislation. This case law arises from a lack of legislative precision. While no section can prevent the risk of litigation entirely, the current New Zealand provision increases it.

Imprecise conscience clauses may also raise practical problems. Hospitals or other medical organizations may have difficulty knowing whether a particular activity is protected by conscientious objection legislation, and staffing accordingly. This point was alluded to by the National Health Services in the *Doogan* case, whose counsel argued that:²²⁸

The interpretation argued for by [the midwives] would lead to difficult clinical and legal distinctions in practice. The practical outcome would be almost impossible to manage, could compromise safety and would lead to dual standards of nursing care. Any form of conscientious objection had obvious effects on the running of hospitals in terms of costs, staffing and the increased burden on staff who did not have such an objection.

²²³See: End of Life Choice Bill 2012 (50).

²²⁴British Medical Association, above n 156.

²²⁵*Doogan v NHS Greater Glasgow & Clyde Health Board*, above n 40.

²²⁶*Doogan v NHS Greater Glasgow & Clyde Health Board*, above n 40.

²²⁷*R v Salford Area Hospital Authority*, above n 126.

²²⁸*Doogan v NHS Greater Glasgow & Clyde Health Board*, above n 40, at [27].

A conscience clause that is clear about the extent to which any of these activities are included within the scope of that which might be conscientiously objected to might avoid some of these difficulties. However, the first task is to uncover precisely what a new conscientious objection clause in New Zealand should seek to protect.

VIII Reform

Reform of the law around conscientious objection is urgently needed. At present, the law relating to conscientious objection is simultaneously too specific, and too encompassing. The following suggestions seek to remedy this. The decision in *Hallagan* rendered section 46 of the CSA redundant. Accordingly, this paper recommends removing section 46 from the CSA. A single clause based on section 174 of the HPCA, incorporating the following recommendations will be compiled in part nine. The Ministry of Health is currently undertaking a review of the HPCA, providing ideal timing for a concurrent review of the right to conscientiously object enshrined in the legislation.²²⁹

A legislative framework should be flexible enough to accommodate development, whilst ensuring a balance between practitioners' rights to adhere to their conscience, and patients' rights to receive legally available medical treatments, where appropriate. In the event of irreconcilable conflict, a patient's rights should take precedence.

A Broader Conscience Protection

The current legislative framework in New Zealand for conscientious objection reinforces a hierarchy of beliefs. The current law is applicable only within the area of reproductive health services. A more cogent and fair solution would be broadening protection to encompass other areas of healthcare, where equally valid personal, moral and ethical grounds for conscientious objection arise. As TA Cavanaugh notes "a sensible conscience clause does not take an ad hoc approach to objection by singling out specific currently and widely recognised controverted interventions."²³⁰

As previously discussed in part three, the main rationales for protecting the right to conscientiously object in healthcare are protecting freedom of conscience and avoiding practitioners' moral distress. To properly achieve this, the current protection needs to be broadened beyond that of protecting predominantly Christian religious

²²⁹ Ministry of Health 2012 *Review of the Health Practitioners Competence Assurance Act 2003: A Discussion Document* (August 2012).

²³⁰ TA Cavanaugh, above n 22, at 202.

beliefs.²³¹ As Julian Savulescu notes “to treat religious values differently from secular moral values is to discriminate unfairly against the secular, a practice not uncommon in medical ethics.”²³² This paper therefore argues that the protection of conscientious objection should be broadened to be applicable to all healthcare services, to encompass secular moral, ethical or cultural beliefs beyond that of an opposition to contraception or abortions.

Broadening the legislation has the added advantage of providing an already established framework for euthanasia, if legalised. Currently, clause 27 of the End of Life Choice Bill outlines that neither practitioners nor solicitors are obligated to participate, but must provide “alternative sources of medical assistance and legal advice.”²³³ In this respect, it does not differ greatly from the recommendations in this paper. As euthanasia will almost always be a planned medical treatment, this paper predicts it would be unlikely that a practitioner would be forced to participate in a euthanasia procedure against their will, as may arise in the context of emergency abortions.

It may, however, be preferable to keep euthanasia contained within its own legislative framework. The End of Life Choice Bill sets out its own regulatory framework; including a Registrar who will keep records of “End of Life Directives,”²³⁴ and a statutory review body. As a result, the legislature may wish to keep records of the number of practitioners choosing to conscientiously object to the practice of euthanasia. In either case, the point remains that broadening the initial statutory scope of the areas of healthcare in which the right to conscientiously object is available has the advantage of establishing a well-understood framework for practitioners wishing to object to future controversial healthcare services. This may in turn make law reform easier for Parliament, leading to less stagnated legislation such as the arguably outdated framework for abortion in New Zealand.

Broadening the initial scope of protection to encompass healthcare services outside of reproductive health is a more equitable approach. It is not, however, without risk, namely in rendering the scope of protection unjustifiably wide. As Fred Zacharias has noted, in a different context, systems would collapse if professionals only adhered to “idiosyncratic unbounded notions of right and wrong.”²³⁵ However, there are mechanisms available to prevent this. If the broadening of conscientious objection

²³¹See the comments in Tasha LaSpina “Eliminating the Need for a ‘Plan B’ When Trying to Obtain *Plan B*: The Need for a Federal Law Requiring Pharmacists to Dispense Emergency Contraception” (2013) 12 Georgetown Journal of Gender and the Law 213 at 219.

²³²At 295.

²³³Clause 27.

²³⁴Clause 32.

²³⁵Fred Zacharias “The Lawyer as Conscientious Objector” (2002) 54 Rutgers Law Review 191 at 208.

protection was implemented in tandem with the other recommendations contained in this paper, there would be sufficient safeguards to ensure access to legally available medical services was not compromised. This paper argues that while there is value in a broadly based protection of conscience, there should be correspondingly clear limits on the circumstances in which it can be exercised.

B Stronger Caveats

1 Scope of protection

The clause should make it clear who is protected. Difficulties arise when conscience sections do not clearly demarcate whose rights are protected. This paper argues that only those directly involved in providing the disputed health treatment should fall within the bounds of the legislative protection. This would encompass being part of the surgical team conducting a termination, but exclude pre or post-operative care, activities which it is contended take the protection too far.

2 Beliefs should not make the practice of medicine impossible

The first caveat of the new, broader, conscience clause should ensure that the belief in question does not create insurmountable difficulties for employers of conscientiously objecting practitioners. The protected conscientious belief should not be fundamentally inconsistent with the practitioner's ability to fulfil their professional duties. This inevitably incorporates some elements of Mark Wicclair's incompatibility thesis.²³⁶ As TA Cavanaugh notes "a sensible conscience clause must be grounded in a professed account of medicine ... it does not cover, for example, objecting to relieving a patient's pain based on one's religious beliefs in pain's redemptive value or one's experiential belief that pain builds character."²³⁷ This also incorporates some elements of what Antonmaria termed "social norms."²³⁸

Practicalities dictate that if the belief in question renders the practice of medicine impossible or hugely difficult for employers, that belief should be excluded. While broadening out the scope of protection is desirable, it cannot come at the expense of a practitioner being able to practice medicine. For example, under this rule, a Jehovah's Witness who is a medical practitioner, and according to those beliefs, refused to provide blood transfusions, would not be protected.

An example closer to the cusp of what might be protected is a pharmacist who objected to providing any form of contraceptives. This paper argues that, as 93,809

²³⁶Wicclair, above n 3, at 43.

²³⁷At 191.

²³⁸At 83.

consultations for contraception occur per year,²³⁹ pharmacists who object to providing any contraceptives should be excluded from protection, due to their objection creating staffing difficulties beyond what should reasonably be accommodated by employers.

This argument could be taken further by asserting that conscientious objection should only be permissible where the belief is supported by science. Kimberly Moss outlines this viewpoint:²⁴⁰

Looking to pharmacists who refuse to dispense Plan B [the ECP] emergency contraceptives on the belief that this type of contraceptive prevents implantation and is a type of embryocide, the Ethics Committee ... looked to a large body of published evidence which supports the proposition that emergency contraceptives actually prevent ovulation and lead to the release of ova that are resistant to fertilization. These misconceptions should not be disseminated by acting on beliefs that are not based in scientific truths

Essentially, Moss argues that any conscientious objection should be firmly backed up by science. This requirement risks uncertainty at the edges, as science is continually evolving. In addition, this viewpoint misunderstands the rationale of conscientious objection, which is to protect a practitioner whose conscience dictates against participating in the particular treatment, regardless of its scientific base. Personal values may not be compatible with scientific knowledge.²⁴¹ This paper, therefore, rejects this approach.

3 *Objection should be on the basis of the healthcare service*

The proposed protection of the right to conscientiously object should focus on the particular service, not the type of patient²⁴² Conscience should be focussed on the practitioner's beliefs and not on objecting to a particular class of patient. The British Medical Association has stated that:²⁴³

Where it comes to classes of people, there is usually no doubt that the intervention could be clinically beneficial: the objection arises from the perceived nature of the patient, not the intervention. Objecting in principle to the termination of a pregnancy is very different to objecting to providing fertility treatment to same sex couples. In our view the latter would always be unacceptable.

²³⁹Statistics Relating to Conscientious Objection and Hospitals Exercising this Right in New Zealand (13 August 2013) (Obtained under Official Information Act 1982 Request to the Ministry of Health).

²⁴⁰At 173.

²⁴¹Pelligrino, above n 53, at 241.

²⁴²See: Mark Wicclair, above n 3, at 210.

²⁴³British Medical Association, above n 156.

In this regard, the State of Mississippi's conscience clause provides a good example of a conscience clause that provides broad initial protection, while ensuring it does not enable discrimination, through a subsection.²⁴⁴ A subsection similar to the Mississippi legislation may be worth implementing to avoid conscientious objection becoming a shield for discriminatory medical practices.

Courts would not find it difficult to distinguish between a genuine conscientious objection and one based on discriminatory beliefs. In a different context, the *Totara Hill Farms v Davidson* decision recently indicated a willingness on behalf of courts to look behind the substantive decision making of an employer,²⁴⁵ a precedent which could be relevant in the context of conscientious objection, in the way that it looks behind the purported rationale for the decision.

4 *Veracity of the objection*

A protection to ensure the veracity of any practitioner claiming to hold a conscientious objection to providing legally available medical treatments might also be beneficial. Section 4(1) of United Kingdom's Abortion Act 1967 states that "in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it."²⁴⁶ Accordingly, it is up to a practitioner to prove that their objection falls within the bounds of what could be considered 'conscientious' in the event of any subsequent disciplinary proceedings or litigation. While this may seem an easy threshold to satisfy, the risk of penalties for making a false declaration or lying on oath provide powerful incentives for remaining honest and, correspondingly, may deter those who do not have a genuine objection from any subsequent court proceedings.

This paper considers this approach to be worthwhile. As Christopher Meyers and Robert Woods have argued, engaging conscience protection should not be "so simplistic as to trivialise moral decision making"²⁴⁷ Conscientious objection based on genuine, deeply held beliefs is the essence of what the current protections exist for. In determining veracity, courts could consider factors such as the length of time the practitioner had held the belief, and whether the practitioner had disclosed this belief, among other things.

C *Notice*

²⁴⁴Health Care Rights of Conscience Act Mississippi Code § 41107-5 (2013), s 3(1).

²⁴⁵*Totara Hills Farm v Davidson* [2013] NZEmpC 39 at [53]-[54].

²⁴⁶Section 4.

²⁴⁷Christopher Meyers and Robert Woods "An Obligation to Provide Abortion Services: What Happens When Physicians Refuse?"(1994) 22 Journal of Medical Ethics 115 at 117.

At a bare minimum, any statutory protection of conscientious objection in healthcare should be underpinned by a requirement that all objecting practitioners give notice of any ethical or moral objection to the provision of a legal healthcare service. This could be simply and easily done in the form of a leaflet or sign in a general practice, or, in hospitals, to an employer.

Giving notice of any objection at the outset may prevent problems arising. In Dr Lee's case, had he informed Miss Pont from the beginning about his objection to providing the contraceptive pill, or other reproductive treatments, she may not have faced the inconvenience of having to wait for a doctor's appointment, only to be denied her medication.²⁴⁸ Disclosure of a conscientious objection to employers, or patients is vital. Transparency has the potential do most of the ground work towards ensuring patient safety, particularly for general practitioners.

Notice also ensures that relationships of trust and confidence are preserved, and a patient is not surprised by a practitioner's subsequent objection. In this way, disclosure is important for informed consent.²⁴⁹ Notice would benefit new patients, as they would already be aware of any difficulties they might face in seeking a particular healthcare service.

D Register

To increase the effectiveness of disclosure requirements, an established body should keep a register of practitioners who conscientiously object to the provision of certain healthcare services. There is already an organisation dedicated to the protection of practitioners who exercise the right to conscientiously object in New Zealand,²⁵⁰ suggesting structures exist to implement this requirement. Cost, however, is a factor for consideration. Accordingly, more discussion with the Ministry of Health about how feasible this requirement is would be necessary before any concrete recommendations could be made.

A register could attain statistics about the number of medical professionals in New Zealand who conscientious object, as there is currently limited information about how prevalent conscientious objection in healthcare is under the current law, or how many practitioners would wish to exercise this right under a broader version of section 174 of the HPCA.

²⁴⁸In the article, Melisa Pont notes she had waited for an hour to see a doctor, see: Marlborough Express, above n 1.

²⁴⁹TA Cavanaugh, above n 22, at 204-205.

²⁵⁰New Zealand Health Professionals Alliance "About NZHPA" New Zealand Health Professionals Alliance <www.nzhpa.org>.

A register would assist in ensuring that patient care is not compromised by conscientious objection. By comparing a record of objecting practitioners with the number of practitioners willing to perform the problematic treatment, numbers could be monitored to ensure that there are sufficient practitioners conveniently located to provide treatment when necessary. The Ministry of Health could thereby ensure an adequate number of health professionals within the area (or hospital) who were willing to provide the treatment in question.

Simultaneously, a register may insulate practitioners from having to provide treatments that go against their conscience. If numbers of objection practitioners were monitored, and corresponding pre-emptive action taken, the risk of a medical practitioner being forced to form an objectionable treatment in an emergency would decrease.

Both disclosure requirements and a register may raise privacy concerns for objecting practitioners, who might feel targeted on account of their beliefs. A possible solution is that the list of objecting practitioners (excluding general practitioners, who should publically disclose the healthcare services they object to) would be only available and managed by the Ministry of Health. If practitioners are willing to refuse a legally available treatment on the basis of conscientious objection, they should be willing to disclose this fact to the Ministry of Health in the interests of patient safety.

E Disclosure of all Available and Appropriate Medical Options

Practitioners should be obliged to inform a patient of all the appropriate medical options, even if they do not specifically request the disputed treatment. This requirement ensures the patient is informed of all their available options, whilst protecting the medical practitioner's right to conscientiously object to providing the treatment in question.

For example, consider the situation of a female patient going to her doctor with a concern about the risk of a sexually transmitted infection as a result of unprotected sex. The practitioner should be obligated to inform the patient of the availability of the ECP as a possible treatment, even if they personally object to providing it. Receiving medical advice should never be contingent on the individual patient's knowledge of recommended treatments. Currently, section 174 of the HPCA focuses

on the act of requesting to trigger the obligation.²⁵¹ Concomitantly, section 174 specifically states that giving advice is included within the protection.²⁵²

Evidence suggests advice is given in practice. A study in the New England Journal of Medicine suggested a large majority of medical practitioners considered disclosure important.²⁵³ Specifically, when asked whether a physician had “an obligation to present all possible options to the patient, including information about obtaining the requested procedure,” where the physician objected to that procedure, 86% of those surveyed believed they did.²⁵⁴ However, in a field subject to high regulation this requirement should be legally mandatory.

F Obligation to Refer

Referral has consistently been a vexed area of conscientious objection legislation. As previously discussed in part three of this paper, referral is problematic. Practitioners who exercise the right to conscientiously object dispute that any legislative provision of conscientious objection can protect them, while simultaneously rendering them complicit by forcing them to directly refer a patient to a non-objecting practitioner.²⁵⁵ Indirect referral is less contentious, as commentators have suggested it involves less moral complicity.²⁵⁶ Current New Zealand law relating to conscientious objection supports indirect referral as an appropriate balance. The practitioner seeking the protection of section 174 of the HPCA must disclose their objection and inform the patient of their right to seek the disputed service elsewhere.²⁵⁷

This paper argues that indirect referral alone is insufficient. While indirect referral may be adequate where there is no emergency situation, and the patient is able to freely and conveniently access the service elsewhere, it is risky to assume that this will be always be the case. This view is supported by the Abortion Supervisory Committee, who, in its 2012 report commented on the worryingly “uneven regional availability of certifying consultants.”²⁵⁸ Indirect referral risks compounding access issues for women from rural areas, potentially leading to an institutional form of discrimination. It also may reduce access to legally available healthcare services for those who are poor, unaware of other places the disputed service is available, or unable to travel to get it for a variety of reasons.

²⁵¹Section 174(1)(a).

²⁵²Section 174(1)(a).

²⁵³Farr A Curlin, M.D Ryan, Marshall H Chin and John D Lantos “Religion, Conscience, and Controversial Clinical Practices” (2007) 354 New Eng J Med 594 at 597.

²⁵⁴Curlin, Ryan, Chin Lantos “Religion, above n 253, at 597.

²⁵⁵Wicclair, above n 3, at 37.

²⁵⁶Frank Chervenak and Laurence McCullough quoted in Wicclair, above n 3, at 37.

²⁵⁷Section 174.

²⁵⁸Abortion Supervisory Committee, above n 189, at 3.

In these circumstances, it is the objecting practitioners' responsibility to ensure that patient is able to access the disputed service elsewhere. In most cases, this will be easy to satisfy, by referring to a colleague nearby. A direct referral requirement would protect New Zealand's most vulnerable women and ensure that they too, have access to easily available reproductive health services.

G Emergency Situations and Time-Dependent Treatment

In medical emergencies, or where a treatment is only effective within a specific timeframe (such as the ECP) conscientious objection should not be permissible unless another practitioner willing to provide the disputed treatment is immediately available. This is because refusal in these circumstances places patient safety and welfare at risk. When striking a balance between the competing rights may no longer be possible, patient safety should receive preference.

It is of concern that there is presently no specific provision forbidding conscientious objection in these circumstances. This may place women at risk, if an abortion is necessary as a consequence of a medical emergency and the only practitioner available to provide it conscientiously objects to doing so. The effects of a refusal to provide an abortion in these circumstances have already been demonstrated by the death of Savita Halappanavar in Ireland.²⁵⁹ This death lead Ireland to change its abortion law, with the Protection of Life During Pregnancy Act passed recently.²⁶⁰ In addition, the European Court of Human Rights has recently had cause to consider the adverse effects unregulated institutional conscientious objection has on patients.²⁶¹

There is a risk of similar occurrences in New Zealand. A women presenting to an emergency department with an urgent need for an abortion to save her life might be faced with a surgeon in a rural hospital who conscientiously objects to abortion in all circumstances. Under the current law, the doctor would be well within his rights to refuse to perform the abortion. It is arguable that a doctor may see this as falling outside the bounds of conscientious objection, due to the risk of the mother's death presumably trumping that of the foetus. Nevertheless, it is not sufficient to rely on a practitioner's willingness to put aside their deeply held conscientious objection in an emergency.

²⁵⁹Henry McDonald "Ireland's First Legal Abortion Carried Out" *The Guardian* (online ed, United Kingdom, 23 August 2013).

²⁶⁰McDonald, above n 259.

²⁶¹See: *RR v Poland* (2011) 53 EHRR 31 (Section IV, ECHR).

Similarly, where the efficacy of the treatment is time dependent, the right to conscientiously object should also be precluded. A common example of this is where a patient presents to a pharmacist or doctor after unprotected intercourse requesting the ECP. In this situation, time is, quite literally, of the essence and the women in question should be immediately given the treatment regardless of the doctor or pharmacist in question conscientiously objecting. Any delay within this crucial period exposes the patient to a greater risk of an unwanted pregnancy and corresponding adverse mental consequences.

In these circumstances, provision of the ECP should be mandatory unless there is a practitioner directly proximate (in essence, in the same practice) or, in the case of a pharmacist, at a conveniently accessible distance who will do so. Indirect referral in this circumstance is an inadequate substitute, as there is no guarantee that patient will be able to find someone to prescribe them the ECP in a timely manner, due to barriers such as appointment waiting times.

It is important to note that information about the ECP must be provided to victims of sexual assault under section 5 of the CSA. This paper contends, however, that section 5 remains insufficient insofar as it still allows medical practitioners to conscientiously object to providing contraceptives in these circumstances. Victims of sexual violation, a horrific and traumatic experience, should in no circumstances be forced to go through the rigmarole of finding preventative contraception themselves in the aftermath of an assault, in the event the medical practitioner examining them conscientiously objects to providing it. People in this situation are in a vulnerable state and this vulnerability might be compounded by other factors such as age. Mandatory provision of the ECP in these circumstances (aside from the current sensible exceptions in section 5)²⁶² is essential to avoiding further trauma for victims of sexual assault.

H Institutions

Forty four states in U.S. allow institutions to refuse to provide abortions on the basis of a conscientious objection protection.²⁶³ This explicit protection for institutions goes well beyond that which is currently protected under New Zealand law. An Official Information Act request revealed that all New Zealand hospitals are required to provide the emergency contraceptive pill and abortions, even if they object to doing

²⁶²Where the medical practitioner is satisfied there was no penetration or the complainant expresses a contrary wish see: Contraception, Sterilisation and Abortion Act, s 5(1).

²⁶³Wicclair, above n 3, at 206.

so.²⁶⁴ This raises the question of whether the approach of the United States is worth following.

The question of whether institutions should also be permitted to conscientiously object to certain forms of treatment is a difficult one. It is particularly important for pharmacists, who often in practice are the heart and soul of their pharmacies, particularly sole charge ones. In this circumstance the owner's values are difficult to sever from the organisation. As Henry Thoreau noted "it is truly enough said; that a corporation has no conscience but a corporation of conscientious men is a corporation with a conscience."²⁶⁵ This observation was recently put to the test in the United States.

In the United States, 60 cases have been filed seeking clarification about whether the mandatory provision of reproductive health in insurance, a facet of 'Obamacare' impinges on religious freedom rights.²⁶⁶ This paper will discuss one of these cases; *Cornestoga v Sebelius*.²⁶⁷ Preliminary injunctive relief was sought by Cornestoga, a company owned by the Hahns, a family of Mennonite Christians,²⁶⁸ against aspects of the Patient Protection and Affordable Care Act.²⁶⁹ This Act, to summarise mandated that employers with over fifty employees must provide them with "a minimum level of health insurance;"²⁷⁰ Later guidelines promulgated by the Institute of Medicine stated that this included reproductive health such as the ECP and contraceptives.²⁷¹ Cornestoga argued that being forced to provide this compromised their right to freely exercise their religion, a right they asserted was available to corporations.²⁷²

The Court disagreed, stating "it would be entirely inconsistent to allow the Hahns to enjoy the benefits of incorporation, while simultaneously piercing the corporate veil for the limited purpose of challenging these regulations."²⁷³ The Court also rejected the argument that the Hahns' free exercise rights were impinged, noting that "the fact that one person owns all the stock does not make him and the corporation one and the

²⁶⁴Statistics Relating to Conscientious Objection and Hospitals Exercising this Right in New Zealand (13 August 2013) (Obtained under Official Information Act 1982 Request to the Ministry of Health).

²⁶⁵Henry David Thoreau, quoted in TA Cavanaugh, above n 22, at 195.

²⁶⁶ Dahlia Lithwick "All Corporations Go To Heaven" (1 August 2013) Slate <www.slate.com>.

²⁶⁷ *Cornestoga Wood Specialties Corporation v Sebelius* 674 F Supp 2d (ED Pa 2013).

²⁶⁸At 1.

²⁶⁹At 14.

²⁷⁰At 11.

²⁷¹At 3.

²⁷²At 12.

²⁷³At 16.

same.”²⁷⁴ Other courts have, however, ruled differently and the matter seems set to go to the United States Supreme Court.²⁷⁵

This paper has concluded that there should be no right of institutional conscientious objection. New Zealand is a vastly different political and social environment to the United States. In addition, the primacy of access to healthcare dictates that allowing an institution to refuse to provide legally available services and treatments would unduly affect patient welfare.

IX Proposed Draft Clause

The following recommendations have been incorporated in a draft clause, modelled on section 174 of the HPCA:

174 Duty of health practitioners in respect of conscientious objection to providing health services:

- (1) This section applies whenever a health practitioner has a personal, moral, religious, or ethical conscientious objection to providing any health service (excluding advice)
- (2) When this section applies, the health practitioner must:
 - (a) Inform patients, employers, and the Ministry of Health of their objection to providing the health service at the earliest opportunity, and;
 - (b) Refer the patient to another health practitioner, whom the objecting practitioner believes on reasonable grounds is willing to provide the health service they conscientiously object to.
- (3) This section only applies to health practitioners who would be directly involved in the provision of the health service they object to.
- (4) This section has no application in an emergency situation or where the efficacy of the health service is time dependent.
- (5) This section does not allow a healthcare practitioner to refuse to provide a healthcare service to a patient on the basis of any of the grounds listed in section 21 of the Human Rights Act 1993.
- (5) In any subsequent proceedings, the objecting practitioner bears the burden of proving the veracity of the objection.
- (6) This section has no effect on section 5 of the Contraception, Sterilisation and Abortion Act 1977.

²⁷⁴At 27.

²⁷⁵For a good discussion of the conflicting case law see: Mike Appleton “The Corporate Veil Meets the First Communion Veil” (1 March 2013) Jonathan Turley <www.jonathanturley.org>.

This clause will clarify the legal status of conscientious objection in healthcare in New Zealand and ensure patients' rights are not compromised by unregulated conscientious objection.

X Other Options

A Patient matching

Holly Fernandez Lynch has criticised the divisive “winner takes all”²⁷⁶ approach to finding a solution to conscientious objection in healthcare. Lynch advocates doctor-patient matching based on moral viewpoints as a potential solution, which might eliminate the need for conscientious objection altogether.²⁷⁷ An advantage of Lynch's proposal is that it provides an institutional solution, which might be better placed to solve what is a highly-charged moral conflict that law alone is not well placed to resolve.²⁷⁸ However, the patient matching model is inherently flawed in that it assumes demand for disputed services would match supply, where evidence suggests that this is not the case.²⁷⁹ A recent study of 733 medical students in the United Kingdom found that a quarter of these students would not provide a pre-24 week abortion as a result of failed contraception.²⁸⁰ In addition, it assumes both practitioners and patients will be willing to disclose their personal beliefs.²⁸¹ Finally Lynch's thesis does not address the fundamental question of conscientious objection; which is what should occur in the event of any conflict between a practitioner's right to conscientiously object to providing treatment and a patient's right to object, which this paper has argued should come out in favour of the patient.

XI Conclusion

Conscientious objection, far from being a relic of the past, is a very real area of concern in the face of the ever-shifting medical landscape. New treatments raise new moral and ethical concerns, and the law has a key role in regulating this area. The right to conscientiously object is worth protecting; but only to the extent it does not impinge on a patients' health. It may be unjust to exclude certain members of the

²⁷⁶At xi.

²⁷⁷At 13.

²⁷⁸Lynch, above n 33, at 1-10.

²⁷⁹ Denis Campbell “Doctors Anti-Abortion Views Could Impact on Women's Access to Service” *The Guardian* (online ed, United Kingdom, 18 July 2011).

²⁸⁰Campbell, above n 279.

²⁸¹Leonard Long “Can Health Care Conscientious Objectors Thread the Needle?” (2010) 13 *Quinnipiac Health Law* 51 at 82.

medical profession from practicing on account of their beliefs. Additionally, medical practitioners cannot simply become bereft of any personal sense of morality. Conscientious objection, however, cannot be permitted to interfere with a patient's right to receive legally available treatments.

Comparable jurisdictions have had the benefit of more case law to shed light on how contentious conscientious objection legislation has been interpreted. This case law has recently shifted toward a broader interpretation of the right to conscientiously object. Due to how recently the case was decided, it is difficult to assess the potential implications of the *Doogan* decision on staffing arrangements in hospitals, or women's access to abortion.²⁸² In any event, the controversy indicates that it has the potential to be important for New Zealand to attempt to reform its conscientious objection legislation, to prevent disputes arising and to clarify precisely who is able to legally exercise the conscientious objection right, and in what circumstances.

This paper has recommended a variety of possible reforms to the current legislative framework on abortion. Ultimately, any decisions will need to be made by the legislature, a body which does not seem inclined to engage with the issues conscientious objection raises. In the event that the legislature does engage with these issues, this paper has concluded that direct referral is necessary if a practitioner objects on grounds of conscience. This is because, in a comparatively small country like New Zealand, any doctor exercising their right to conscientiously object risks rendering the disputed service unavailable by such a refusal, a risk that is ultimately borne by patients, who are reliant on health practitioners to provide care.

²⁸²Doogan, above n 40.

XII Appendix

Contraception, Sterilisation and Abortion Act 1977

46 Conscientious objection:

- (1) Notwithstanding anything in any other enactment, or any rule of law, or the terms of any oath or of any contract (whether of employment or otherwise), no medical practitioner, nurse, or other person shall be under any obligation—
 - (a) to perform or assist in the performance of an abortion or any operation undertaken or to be undertaken for the purpose of rendering the patient sterile;
 - (b) to fit or assist in the fitting, or supply or administer or assist in the supply or administering, of any contraceptive, or to offer or give any advice relating to contraception,—

if he objects to doing so on grounds of conscience.

(2) It shall be unlawful for any employer—

- (a) to deny to any employee or prospective employee any employment, accommodation, goods, service, right, title, privilege, or benefit merely because that employee or prospective employee objects on grounds of conscience to do any act referred to in subsection (1); or
- (b) to make the provision or grant to any employee or prospective employee of any employment, accommodation, goods, service, right, title, privilege, or benefit conditional upon that other person doing or agreeing to do any thing referred to in that subsection.

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

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

Health Practitioners Competence Assurance Act 2003

174 Duty of health practitioners in respect of reproductive health services

(1) This section applies whenever—

- (a) a person requests a health practitioner to provide a service (including, without limitation, advice) with respect to contraception, sterilisation, or other reproductive health services; and
- (b) the health practitioner objects on the ground of conscience to providing the service.

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

XIII Bibliography

A Cases

1 New Zealand

Hallagan v New Zealand Medical Council [2010] HC Wellington Civ-2010-485-222, 2 December 2010.

Right to Life New Zealand Incorporated v The Abortion Supervisory Committee [2008] 2 NZLR 825 (HC).

Right to Life New Zealand Incorporated v The Abortion Supervisory Committee [2012] NZSC 68, [2012] 3 NZLR 762.

Totara Hills Farm v Davidson [2013] NZEmpC 39.

The Abortion Supervisory Committee v Right to Life New Zealand Incorporated [2011] NZCA 246; [2012] 1 NZLR 176.

2 Australia

CES v Superclinics Australia Pty Ltd (1995) 38 NSWLR 47 (NSWSC).

3 Europe

A v Ireland (2011) 53 EHRR 13 (Grand Chamber, ECHR).

RR v Poland (2011) 53 EHRR 31 (Section IV, ECHR).

Pichon and Sajous v France (49853/99) Section III, ECHR 2 October 2001.

4 United Kingdom

Barr v Matthews (1999) 52 BMLR 217 (QB).

Doogan v NHS Greater Glasgow & Clyde Health Board [2013] CSIH (E Div) 36.

Doogan v NHS Greater Glasgow & Clyde Health Board [2012] CSOH 32.

R v Bourne (1939) 1 KB 687.

R v Salford Area Hospital Authority ex parte Janaway [1989] 1 AC 537.

Royal College of Nursing v Department of Health and Social Security [1981] AC 800.

5 *United States*

Cornestoga Wood Specialties Corporation v Sebelius 6744 F Supp 2d (ED Pa 2013).

Hobby Lobby Stores Inc v Sebelius 870 F Supp 2d (WD Okla 2012).

B Legislation

1 *New Zealand*

Crimes Act 1961.

Contraception, Sterilisation and Abortion Act 1977.

Health Practitioners Competence Assurance Act 2003.

Human Rights Act 1993.

New Zealand Bill of Rights Act 1990.

End of Life Choice Bill 2012 (50).

2 *United Kingdom*

Abortion Act 1967 (UK).

Offences Against the Person Act 1861 (UK).

3 *United States of America*

Health Care Rights of Conscience Act Mississippi Code § 41 107-5 (2013).

C Treaties

Convention for the Protection of Human Rights and Fundamental Freedoms (The European Convention) 213 UNTS 222 (opened for signature 4 November 1950, entered into force 21 September 1970).

International Covenant on Economic, Social and Cultural Rights 993 UNTS 171 (opened for signature 16 December 1966, entered into force 3 January 1976).

International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976).

Universal Declaration of Human Rights GA Res 217A (III) A/80 (1948).

United Nations Convention on the Elimination of All Forms of Discrimination against Women 1249 UNTS 13 (opened for signature 18 December 1979, entered into force 3 September 1981).

D *Books and Chapters in Books*

Thomas Beauchamp and James Childress *The Principles of Biomedical Ethics* (5th Ed, Oxford University Press, Oxford, 2001).

Alastair Campbell, Grant Gillett and Gareth Jones (eds) *Medical Ethics* (3rd ed, Oxford, Oxford University Press, 2001).

Rebecca Cook, Bernard Dickens and Mahmoud Fathalla *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law* (Oxford University Press, Oxford, 2003).

Bernard Dickens *Medicine and the Law* (Dartmouth Publishing, Aldershot, 1993).

Walter Glannon *Biomedical Ethics* (Oxford University Press, Oxford, 2005).

Jonathan Herring *Medical Law and Ethics* (2nd ed.) (Oxford University Press, Oxford, 2008).

John Keown *Abortion, Doctors and the Law: Some Aspects of the Legal Regulation of Abortion in England from 1803-1982* (Cambridge University Press, Cambridge, 1988).

Holly Fernandez Lynch *Conflicts of Conscience in Health Care: An Institutional Compromise* (Massachusetts Institute of Technology, Massachusetts, 2008).

Sheila McLean (ed) *First Do No Harm: Ethics and Healthcare* (Ashgate Publishing, Aldershot 2006).

Jose Miola *Medical Ethics and Medical Law: A Symbiotic Relationship* (Hart Publishing, Oxford, 2007).

Mark Wicclair *Conscientious Objection in Health Care* (Cambridge University Press, Cambridge, 2011).

Elizabeth Wicks *Human Rights and Healthcare* (Oxford and Portland, Oregon, 2007).

E Journal Articles

Y.A.O Akorede “Legal and Ethical Issues in Physicians’ ‘Right’ of Conscientious Objection in Healthcare Service Delivery: A Comparative Reflection” (2009) 3 Indian Journal of International Law 357.

Armand Antonmaria “Conscientious Objection in Clinical Practice: Notice, Informed Consent, Referral and Emergency Treatment” (2011) 9 Ave Maria Law Review 81.

Julie Canter and Ken Baum “The Limits of Conscientious Objection – May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?”(2004) 351 New Eng J Med 2008.

Mark Campbell “Conscientious Objection, Health Care and Article 9 of the European Convention of Human Rights” (2011) 11 Med L Int 284.

TA Cavanaugh “Professional Conscientious Objection in Medicine with Attention to Referral” (2011) 9 Ave Maria Law Review 189.

Rebecca Cook and Bernard Dickens “Access to Emergency Contraception” (2003) 25 Journal of Obstetrics and Gynaecology 914.

Rebecca Cook and Bernard Dickens “The Scope and Limits of Conscientious Objection” (2000) 71 International Journal of Gynaecology and Obstetrics 71.

Rebecca Cook, Bernard Dickens, Monica Olaya “Healthcare Responsibilities and Conscientious Objection” (2009) 104 International Journal of Gynaecology and Obstetrics 249.

Farr A Curlin, M.D Ryan, Marshall H Chin and John D Lantos “Religion, Conscience, and Controversial Clinical Practices” (2007) 354 *New Eng J Med* 594.

Lachlan De Crespigny, Anne O’Rourke, Amanda Pyman “Abortion and Conscientious Objection: The New Battleground” (2012) 38 *Mon LR* 87.

Bernard Dickens “Ethical Misconduct by Abuse of Conscientious Objection Laws” (2006) 25 *Medicine and Law* 513.

Bernard Dickens “Reproductive Health Services and the Law and Ethics of Conscientious Objection” (2001) 20 *Medicine and Law* 283.

Bernard Dickens “The Legal Protection and Limits of Conscientious Objection: Where Conscientious Objection is Unethical” (2009) 28 *Law and Medicine* 337.

Amy Dixon “Authorisation of Abortion for a ‘Serious Danger to Mental Health’: Would the Practice Stand up to the Judicial Test” (2012) 48 *VUWLR* 289.

Michael E Duffy “Good Medicine: Why Pharmacists Should Be Prescribed a Right of Conscience” (2010) 44 *Valparaiso University Law Review* 509.

Martha Field “Problems of Proof in Conscientious Objector Cases” (1972) 120 *University of Pennsylvania Law Review* 870.

Ronald Flowers “Withholding Medical Care for Religious Reasons” (1984) 23 *Journal of Religion and Health* 268.

Andrew Grubb “Participating in Abortion and the Conscientious Objector” (1988) 47 *The Cambridge LJ* 162.

Adriana Lamackova “Conscientious Objection in Reproductive Health Care: Analysis of *Pichon and Sajous v France*” (2008) 15 *European Journal of Health Law* 7.

Tasha LaSpina “Eliminating the Need for a ‘Plan B’ When Trying to Obtain *Plan B*: The Need for a Federal Law Requiring Pharmacists to Dispense Emergency Contraception” (2013) 12 *Georgetown Journal of Gender and the Law* 213.

Leonard Long “Can Health Care Conscientious Objectors Thread the Needle?” (2010) 13 *Quinnipiac Health Law* 51.

Emily Marcus “Conscientious Objection as an Emerging Human Right” (1998) 38 Virginia Journal of International Law” 507.

Danuta Mendelson “Decriminalisation of Abortion Performed by Qualified Health Practitioners under the Abortion Law Reform Act 2008 (Vic)” (2012) 19 Journal of Law and Medicine 651.

Christopher Meyers and Robert Woods “An Obligation to Provide Abortion Services: What Happens When Physicians Refuse?” (1994) 22 Journal of Medical Ethics 115.

Kimberly Moss “Do No Harm – Unless She Wants an Abortion or Birth Control: The Conscience Movement’s Impact of Women’s Health” (2010) 19 Texas Journal of Women and the Law 173.

J.S O’Neill “Conscientious Objection” (1984) New Zealand Law Journal 272.

Maya Noronha “Removing Conscience from Medicine: Turning the Hippocratic Oath into a Hypocrite’s Pledge” (2010) 23 The Georgetown Journal of Legal Ethics 733.

Edmund D Pelligrino “The Physician’s Conscience, Conscience Clauses and Religious Beliefs: A Catholic Perspective” (2002) 30 Fordham Urban Law Journal 221.

Thaddeus Pope “Legal Briefing: Conscience Clauses and Conscientious Refusal” (2010) 21 The Journal of Clinical Ethics 163.

Mark Rankin “The Disappearing Crime of Abortion and the Recognition of a Woman’s Right to Abortion: Discerning a Trend in Australian Abortion Law?” (2011) 13 Flinders Law Journal 1.

Mark Rankin “The Offence of Child Destruction: Issues for Medical Abortion” (2013) 35 Sydney Law Review 1.

Julian Savulescu “Conscientious Objection in Medicine” (2006) 332 British Medical Journal 294.

Danny Sullivan “The Moral Costs of Health Care” (1999) 7 Journal of Law and Medicine 156.

Jessica Waters “Beyond Religious Refusals: The Case for Protecting Health Care Workers’ Provision of Abortion Care” (2011) 34 *Harvard Journal of Law and Gender* 463.

Mark Wicclair “Conscientious Refusals by Hospitals and Emergency Contraception” (2011) 20 *Cambridge Quarterly of Healthcare Ethics* 130.

Fred Zacharias “The Lawyer as Conscientious Objector” (2002) 54 *Rutgers Law Review* 191.

F *Government Materials*

Abortion Supervisory Committee, *Report of the Abortion Supervisory Committee for 2012* (2012).

Medical Council of New Zealand *Good Medical Practice* (Medical Council of New Zealand, April 2013).

Human Rights Commission *Human Rights in New Zealand today* (2009) Human Rights Commission <www.hrc.co.nz>.

Office of the Health and Disability Commissioner *The Code of Rights* (2004) <www.hdc.org.nz>.

Ministry of Health *2012 Review of the Health Practitioners Competence Assurance Act 2003: A Discussion Document* (August 2012).

Statistics Relating to Conscientious Objection and Hospitals Exercising this Right in New Zealand (13 August 2013) (Obtained under Official Information Act 1982 Request to the Ministry of Health).

The Treasury *Affording Our Future: Statement on New Zealand’s Long-Term Fiscal Position* (July 2013).

G *Reports*

Royal Commission of Inquiry *Contraception, Sterilisation and Abortion in New Zealand* (E.C Keating, Wellington, 1977).

Committee on the Elimination of All Forms of Discrimination Against Women *Concluding Observations on New Zealand* (27 July 2012).

H Unpublished Material

Shang-Chin Lai “The Scope of the Abortion Supervisory Committee’s Functions and Powers in *Right to Life New Zealand Inc. v The Abortion Supervisory Committee* (LLB (Hons) Seminar Paper, Victoria University of Wellington, 2013).

I Internet Resources

Abortion Rights “Training Doctors to Perform Abortions: A Slow Burning Crisis” <www.abortionrights.org.uk>.

American Medical Student Association “Enriching Medicine Through Diversity” American Medical Student Association <www.amsa.org>.

Mike Appleton “The Corporate Veil Meets the First Communion Veil” (1 March 2013) Jonathan Turley <www.jonathanturley.org>.

British Medical Association “Expressions of Doctor’s Beliefs” (26 August 2012) British Medical Association <www.bma.org.nz>.

Leslie Cannold “The Questionable Ethics of Unregulated Conscientious Refusal” (25 March 2011) ABC Religion and Ethics <www.abc.net.au>.

Capital and Coast District Health Board “Tikanga Maori – A Guide for Healthcare Workers” <www.ccdhb.org.nz>.

Louise Finer “Conscientious Objection in Scotland: A Worrying Precedent” RHM Blog: The Blog for Reproductive Health Matters (14 May 2013) <<http://rhmmatters.wordpress.com>>.

Catherine Hallagan “Conscientious Objection in New Zealand: Its Legal Status and Significance” (April 2013) New Zealand Health Professionals Alliance <www.nzhpa.org>.

Dahlia Lithwick “All Corporations Go To Heaven” (1 August 2013) Slate <www.slate.com>.

JudyAnn Bigby et al “Health Care Refusals: Undermining Quality Care for Women” (2010) National Health Law Program <www.healthlaw.org>.

New Zealand Health Professionals Alliance “Best Practice Guide” New Zealand Health Professionals Alliance <www.nzhpa.org>.

New Zealand Medical Association “Code of Ethics” (May 2008) <www.nzma.org.nz>.

Elizabeth Prochaska “Abortion and Conscientious Objection: What about Human Rights?” (22 May 2013) United Kingdom Human Rights Blog <www.ukhumanrightsblog.com>.

Chelsea Torrance “Young Labour Declares Abortion Reform Imperative” (13 May 2013) Young Labour <www.younglabour.org.nz>.

The Supreme Court “New Appeals before the Supreme Court” (25 June 2013) The Supreme Court <www.supremecourt.gov.uk>.

J Newspaper Articles

BBC News “Catholic Midwives Lose Abortion ‘Conscientious Objection’ Case” *BBC News* (online ed, United Kingdom, 29 February 2012).

BBC News “Supreme Court to Hear Appeal in Midwives Abortion Case” *BBC News* (online ed, United Kingdom, 25 June 2013).

Denis Campbell “Doctors Anti-Abortion Views Could Impact on Women’s Access to Service” *The Guardian* (online ed, United Kingdom, 18 July 2011).

Hannah Fleming “Euthanasia Bill close to MP’s Heart” *Stuff* (online ed, Wellington, 12 August 2013).

Cherie Howie “Women have Reproductive Duty, says ‘Rhythm Doctor’” *The New Zealand Herald* (online ed, Auckland, 14 July 2013).

Marlborough Express “GP Refuses Women Contraceptive Pill” *Stuff* (online ed, Wellington, 14 July 2013).

Henry McDonald “Ireland’s First Legal Abortion Carried Out” *The Guardian* (online ed, United Kingdom, 23 August 2013).

Hamish Rutherford “Voluntary Euthanasia Bill Withdrawn” *Stuff* (online ed, Wellington, 26 September 2013).

Sydney Morning Herald “Next Generation of Doctors Vote on Right to Refuse Treatment” *Sydney Morning Herald* (online ed, Sydney, 19 July 2011).