CONSCIENTIOUS OBJECTION TO ABORTION IN AOTEAROA NEW ZEALAND

A justifiable protection of conscience or a violation of the right to healthcare?

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I INTRODUCTION

Access to abortion services is a human right.[1] Nevertheless, abortion has been the subject of live social, moral, political and legal debates for decades. The recent decriminalisation of abortion in New Zealand represents an important, if long overdue, recognition and advancement of the human rights of women and pregnant people. However, stricter regulation of the exercise of conscientious objection to abortion is necessary to ensure that New Zealand's accommodation of the right to freedom of conscience does not undermine the right to healthcare.

In March 2020, Parliament passed the Abortion Legislation Act 2020 (the ALA) which decriminalised abortion in New Zealand.[2] Section 8 of the ALA amended the Contraception, Sterilisation, and Abortion Act 1977 (the CSA Act) to allow the provision of abortion services to women not more than 20 weeks pregnant.[3] Section 17 of the ALA amended the Health and Disability Commissioner Act 1994 to recognise that abortion services form a part of "health services" in New Zealand.[4]

Section 14 of the CSA Act allows health practitioners to conscientiously object to providing or assisting with providing contraception, sterilisation, abortion or information on the termination of a pregnancy. This means

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1 See Human Rights Committee *General comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life* UN Doc CCPR/C/GC/36 (30 October 2018) at [8].

2 Section 12, which inserted the new s 182(2) into the Crimes Act 1961.

3 Contraception, Sterilisation, and Abortion Act 1977 [CSA Act], s 10.

4 Health and Disability Commissioner Act 1994, s 2(1).

practitioners can refuse to provide or be involved in these lawful health services on the grounds that doing so would conflict with their conscience.[5] The accommodation of conscientious objection in healthcare presents a conflict between the rights of practitioners to object to providing services which are incompatible with their beliefs and the rights of patients to access legal healthcare, when the two intersect.

The CSA Act requires objecting practitioners to, at the earliest opportunity, inform the requesting patient of their conscientious objection as well as how to access the contact details of another person who is the closest provider of the service requested.[6] The provision does not override the duties of practitioners to provide prompt and appropriate medical assistance in medical emergencies.[7] The CSA Act also requires employers to accommodate their employees' conscientious objections, unless it would unreasonably disrupt the employer's provision of health services.[8] Lastly, the Director-General of Health is required to maintain a list of abortion service providers in New Zealand, which must be accessible to any person on request.[9]

This article examines whether the recent reform of abortion law in New Zealand has struck the correct balance between the right to healthcare and the right to freedom of conscience. The right to healthcare is engaged because abortion services have now been recognised as legal healthcare in New Zealand,[10] rather than a criminal act. This article considers that conscientious objection serves to protect the rights of health practitioners who voluntarily choose to work in healthcare, and that this therefore must also be balanced against their professional duty to provide health services. The importance of legalised abortion is paralleled by other rights long protected by the common law, such as bodily autonomy and privacy. These rights also form significant considerations within the context of conscientious objection. The importance of such other rights was considered by Parliament when deciding whether abortion should be decriminalised,[11] and is beyond the scope of this article.

5 Mark R Wicclair *Conscientious Objection in Health Care: An Ethical Analysis* (Cambridge University Press, Cambridge, 2011) at 1.
6 Section 14(2).
7 Section 14(4).
8 Section 15.
9 Section 18.
10 See (b)(ii)(D) of the definition of "health services" in s 2(1) of the Health and Disability Commissioner Act.
11 Comments regarding a woman's right to both bodily autonomy and privacy arose while the Abortion Legislation Bill was debated in Parliament. See, for example, (8 August 2019) 740 NZPD 13071; (3

Protecting conscientious objection upholds the right to freedom of conscience, a right protected by the New Zealand Bill of Rights Act 1990 (NZBORA).[12] Section 15 of the NZBORA gives everyone the right to manifest their beliefs in practice. Unlike healthcare, this right is expressly protected in domestic legislation. New Zealand has, however, committed to protecting the right to healthcare through ratification of the International Covenant of Economic, Social and Cultural Rights,[13] and by incorporating elements of the right to healthcare into domestic legislation.

This article contends that the current balance between the right to healthcare and the right to freedom of conscience is skewed in favour of the practitioner. New Zealand's provision for conscientious objection has the effect of obstructing access to healthcare, stripping pregnant individuals of the dignity and independence they are entitled to as health consumers, and systemically discriminating against women because their rights are impeded disproportionately to men's. The current law is inadequate because it deprives pregnant individuals of their right to healthcare, and therefore, reform requiring stricter regulation of conscientious objection is necessary.

To that end, it is not argued here that the provision for conscientious objection in the CSA Act should be abolished. The right to freedom of conscience should not be unjustifiably limited. However, it is imperative that conscientious objection is sufficiently regulated to ensure that healthcare is accessible. Conscientious objection should be accommodated insofar as one's right to healthcare is not obstructed, and the burden of accommodating it should not fall on the patient who is exercising their right to legal healthcare. This article argues that New Zealand's current law on conscientious objection has not struck a fair and justified balance between the two rights, and as a result, it does not adequately protect the right to healthcare. New Zealand ought to follow in the footsteps of other jurisdictions which have more stringent requirements for objecting practitioners.

March 2020) 744 NZPD 16582; and (18 March 2020) 745 NZPD 17169 and 17193.

12 Section 13. The author recognises that medical practitioners tend in practice to refer to religious grounds for the exercise of conscientious objection to abortion but has focused on freedom of conscience. Along with freedom of conscience, s 13 provides for the right to freedom of religion (and s 15 to manifestation of religion and belief). The rights to freedom of religion and manifestation of that right were important to the context in which Parliament considered the Abortion Legislation Bill: see, for example, (8 August 2019) 740 NZPD 13071 and 13101; and (3 March 2020) 744 NZPD 16561 and 16570.

13 International Covenant on Economic, Social and Cultural Rights 993 UNTS 3 (opened for signature 19 December 1966, entered into force 3 January 1976), art 12.

This article starts by examining the right to healthcare with reference to both international law and domestic legislation. It then discusses the right to freedom of conscience in New Zealand and the circumstances in which it can be limited, before identifying the problems with the current law and establishing why reform is necessary. This article then attempts to find the balance between the two rights, by first analysing recommendations for the regulation of conscientious objection by the World Health Organization (WHO), the International Federation of Gynecology and Obstetrics (FIGO) and the New Zealand Law Commission, and then examining how overseas jurisdictions such as Italy, the United Kingdom, Canada, Australia, Portugal and Sweden have balanced accommodation of conscientious objection with the right to healthcare. Finally, this article offers recommendations and proposed improvements to the regulation of conscientious objection in New Zealand.

This article recognises that abortion is best understood as a pregnant person's right to healthcare: not all who identify as women can or want to become pregnant, and not all who are or can become pregnant identify as women. As such, inclusive terms such as "patient" and "pregnant persons" are used in this article as far as possible. Nevertheless, it is important to note that this issue largely affects women and is therefore also a significant women's rights issue.

II THE RIGHT TO HEALTHCARE

A Recognition of the right to healthcare

1 International Law

The right to health is a fundamental human right that includes the right to access healthcare.[14] The narrower term "right to healthcare" is used in this article where appropriate because abortion is a "health service" in New Zealand.

New Zealand's legislation does not expressly provide for a right to healthcare but this right has been affirmed through the ratification of international human rights treaties. Of the international treaties New Zealand is eligible to ratify, it has ratified all five of the treaties recognising this right.[15] Other jurisdictions such as Australia, Canada and the United Kingdom have

14 Alison J Blaiklock "The Right to Health: An Introduction" The University of Auckland <www.auckland.ac.nz> 1.

15 Gunilla Backman and others "Health systems and the right to health: an assessment of 194 countries" (2008) 372 Lancet 2047 at 2066.

also recognised the right to healthcare through international treaties and have not specifically incorporated the right in domestic legislation.[16]

The right to health is included in the Universal Declaration of Human Rights (the UDHR),[17] and most explicitly stated in the International Covenant on Economic, Social and Cultural Rights (ICESCR).[18] The right to health under the ICESCR includes access to timely and appropriate healthcare.[19] New Zealand's ratification of the ICESCR in 1978 demonstrates that the Government has recognised the right to health and has committed to undertaking the obligations required under the treaty. This is a social right, and States have committed to its progressive realisation.[20] Article 12(1) of the ICESCR states:

> The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The work of the United Nations Committee on Economic, Social and Cultural Rights has developed a right-to-health analytical framework to guide the application of the right to health to relevant policies.[21] The framework highlights the autonomy of individuals and holds that individuals must be able to participate in decision-making relative to their own health. The right to health also provides that healthcare must be "physically and economically accessible to everyone without discrimination".[22]

2 *Domestic Law*

Although the right to healthcare is notably absent from the NZBORA, some statutes in New Zealand help promote the right to health, albeit in a limited manner.[23] The Government has indicated initiatives to continue to achieve

16 At 2062 and 2070.
17 *Universal Declaration of Human Rights* GA Res 217A (1948), art 25.
18 International Covenant on Economic, Social and Cultural Rights, art 12.
19 Committee on Economic, Social and Cultural Rights *CESCR General Comment No 14: The Rights to the Highest Attainable Standard of Health* UN Doc E/C.12/2000/4 (11 August 2000) [*General Comment No 14*] at [11].
20 International Covenant on Economic, Social and Cultural Rights, art 2(1).
21 Health Promotion Forum of New Zealand "The Right to Health" (February 2012) <www.hauora.co.nz> at 12–14.
22 At 13.
23 New Zealand Public Health and Disability Act 2000; Health and Disability Commissioner Act; and Health Act 1956.

greater realisation of the right to health in the future, such as by addressing outcome disparities for Māori,[24] and recently by creating a centralized national health system to make healthcare more accessible for all New Zealanders.[25] It has also been argued that Te Tiriti o Waitangi guarantees hauora (health and wellbeing) to all New Zealanders.[26] Although Te Tiriti o Waitangi is not legally enforceable itself, it is widely accepted as the "founding document of New Zealand" and a central tenet of New Zealand's constitution.[27]

For the purposes of this article, the definition and standard for the broad right to healthcare expected in New Zealand will be that contained within art 12(1) of the ICESCR as it applies to access to health services. Further elements of this right can be derived from the domestic law's recognition of art 12(1) by way of incorporation of elements of the right into statute.

First, the New Zealand Public Health and Disability Act 2000 purports to facilitate access to and deliver effective and timely health services.[28] Secondly, the Health and Disability Commissioner Act authorises the Governor-General to regulate a Code of Health and Disability Services Consumers' Rights (the Code).[29] Section 20(1)(g) of the Act states that the Code must contain provisions relating to the duties of health care providers to provide services in a manner that respects the dignity and independence of the individual. The term "independence" signifies that individuals must be free to make their own decisions without the influence or control of others. The Medical Council of New Zealand has also recognised that patients have the right to make their own decisions about their treatment.[30] This upholds their dignity.

24 *Implementation of the International Covenant on Economic, Social and Cultural Rights: Third periodic report submitted by States parties under articles 16 and 17 of the Covenant* Un Doc E/C.12/NZL/3AUV (17 January 2011) at [429].
25 "The new health system" (23 September 2021) Department of the Prime Minister and Cabinet <www.dpmc.govt.nz>.
26 Blaiklock, above n 14, at 2.
27 Cabinet Office *Cabinet Manual* 2017 at 1.
28 Section 3(1)(d).
29 Section 74(1).
30 "Your rights as a patient" (5 November 2019) Medical Council of New Zealand <https://www.mcnz.org.nz>.

The Code recognises that health consumers have the following relevant rights:[31]

i) Right 1: Right to be treated with respect.

ii) Right 2: Right to freedom from discrimination, coercion, harassment and exploitation.

iii) Right 3: Right to dignity and independence.

iv) Right 7: Right to make an informed choice and give informed consent.

These elements provide a fuller picture of what the right to healthcare in New Zealand is comprised of. The right to healthcare in domestic legislation therefore includes healthcare that is timely and effective, respectful, free from discrimination, harassment and coercion, and that respects the independence and dignity of patients by allowing them to make their own decisions.

3 Summary of Elements of the Right to Healthcare

The table below sets out a summary of the essential characteristics of the right to healthcare that can be derived from both the United Nations Committee on Economic, Social and Cultural Rights (in relation to the ICESCR) and domestic legislation.

1. The United Nations' Right–to–Health Analytical Framework	2. New Zealand Legislation
1.1 Physically and economically accessible to everyone	2.1 Timely and effective
1.2 Individuals must be able to participate in decision–making relative to their own health	2.2 Includes abortion services
	2.3 Respects the dignity and independence of the individual
	2.4 Free from discrimination, harassment and coercion
	2.5 Freedom to make an informed choice

B Reproductive rights

Reproductive rights, including legal and accessible abortion services, are

31 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch 1, cl 2 [The Code].

a fundamental component of the human right to healthcare.[32] Access to reproductive healthcare has a clear impact on women's health, but it also has wider social and cultural effects, such as improving and facilitating access to education and work.[33] In decriminalising abortion, Parliament has legislated for women and pregnant persons to make their own reproductive choices with dignity and freedom.[34]

New Zealand has also ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),[35] which affirms reproductive rights. First, art 12(1) requires States to take all appropriate measures to ensure equal access to healthcare services, including those related to family planning. Secondly, art 16(1)(e) states that women should be given the same rights "to decide freely and responsibly on the number and spacing of their children".

There is growing recognition of the fact that these rights are a routine component of the right to healthcare.[36] The United Nations Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women have both expressed that women's health rights include reproductive rights.[37] Importantly, the recognition of abortion services as health services in New Zealand legislation signifies Parliament's acceptance of abortion as healthcare.[38] Abortion services must therefore be provided in accordance with the essential characteristics of the right to healthcare to reflect this recognition.

III THE RIGHT TO FREEDOM OF CONSCIENCE

The right to freedom of conscience is a fundamental human right in any democratic society. New Zealand is a pluralist country in which the right to hold and manifest our various individual beliefs is one that is highly valued and

32 "Abortion" World Health Organization <https://www.who.int>; *General Comment No 14*, above n 19, at [8]; and Committee on Economic, Social and Cultural Rights *General Comment No 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* Un Doc E/C.12/GC/22 (2 May 2016) [*General Comment No 22*] at [1].

33 Sheelagh McGuinness and Jonathan Montgomery "Legal Determinants of Health: Regulating Abortion Care" (2020) 13 Public Health Ethics 34 at 37.

34 See, for example, (8 August 2019) 740 NZPD 13082 and 13092.

35 Convention on the Elimination of All Forms of Discrimination against Women 1249 UNTS 13 (opened for signature 1 March 1980, entered into force 3 September 1981) [CEDAW].

36 Blaiklock, above n 14, at 6.

37 "Sexual and reproductive health and rights" United Nations Human Rights Office of the High Commissioner <https://www.ohchr.org>.

38 Health and Disability Commissioner Act, s 2(1).

protected. Unlike the right to healthcare, the NZBORA expressly protects the right to freedom of conscience and religion[39] and its manifestation.[40] Section 13 gives everyone the right to freedom of conscience and religion and s 15 gives everyone the right to manifest their religion or belief in practice.

The right to freedom of conscience has also been recognised in the UDHR[41] and through New Zealand's ratification of the International Covenant on Civil and Political Rights (ICCPR).[42] The ICCPR provides that the right to manifest one's beliefs is subject to limitations prescribed by law which are necessary to protect the fundamental human rights of others.[43] The NZBORA also provides that rights can be limited, if doing so is prescribed by law and demonstrably justified in a free and democratic society.[44]

While the NZBORA, the UDHR and the ICCPR all jointly protect both the right to freedom of conscience and religion, this article focuses primarily on the former. This is to reflect that the provision for conscientious objection in the CSA Act allows providers to object on the grounds of their conscience.[45] It is worth noting, however, that both are complex rights which are closely related and often interdependent.[46] The fundamental difference is that conscience protects a person's moral beliefs and obligations instead of their religious views.[47] In reality the distinction is not always so clear; it may well be the case that a person's conscience is informed by their religious beliefs, and vice versa.

A Objecting on the grounds of conscience

In the recent case of *Hospice v Attorney-General*, the High Court considered the interpretation of the conscientious objection provisions in the End of Life Choice Act 2019 in relation to assisted-dying.[48] It held that the right to conscientiously object encompasses when a practitioner holds a deeply-felt belief that it is wrong for them to provide the assistance for personal, moral

39 Section 13.
40 Section 15.
41 *Universal Declaration of Human Rights*, art 18.
42 International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976), art 18(1).
43 Article 18(3).
44 Section 5.
45 See the definition of "conscientious objection" in s 2 of the CSA Act.
46 Rafael Domingo "Restoring freedom of conscience" (2015) 30 J L & Relig 176 at 181.
47 At 176–177.
48 *Hospice New Zealand v Attorney-General* [2020] NZHC 1356.

reasons, internal to them.[49] The Court acknowledged a distinction between conscientious objection and clinical judgement, recognising that conscience reflects personal values, whereas a practitioner's ethical, clinical or professional judgement is informed by their training, experience, and clinical standards.[50] Ultimately, however, the Court left open the possibility that the scope for conscientious objection could be broadened or justifiably limited in light of future circumstances.[51]

One academic has put forward that a health practitioner's refusal to provide abortions should only be characterised as *conscientious* objection if:[52]

i) the practitioner has a core set of moral beliefs;

ii) providing the abortion would be incompatible with these beliefs; and

iii) the practitioner's refusal is on the grounds of their beliefs.

B The need for protection

Failing to protect the right to freedom of conscience in the abortion services context can be harmful for medical practitioners, particularly when their conscientious (or religious) views against participating in abortion are sincerely and deeply held.[53] Performing an act that contradicts a practitioner's fundamental life views may have grave personal consequences for the practitioner, and can result in guilt, shame[54] and self–betrayal.[55] Matters of individual conscience are "intensely personal",[56] and will differ significantly between practitioners. In *Hallagan v Medical Council of NZ*, the High Court accepted that the act of arranging a referral may also violate the conscience of some objecting practitioners, which if required would nonetheless contravene their right to freedom of conscience under the NZBORA.[57]

Additionally, s 15 of the CSA Act requires employers to accommodate conscientious objection unless it would unreasonably disrupt their provision of

49 At [214(e)].
50 At [197].
51 At [215].
52 Wicclair, above n 5, at 5.
53 See, for example, Edmund D Pellegrino "The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective" (2002) 30 Fordham Urb L J 221.
54 At 227.
55 Wicclair, above n 5, at 10–11.
56 *Hallagan v Medical Council of NZ* HC Wellington CIV–2010–485–222, 2 December 2010 at [17].
57 *Hallagan v Medical Council of NZ*, above n 56.

health services. Such a provision could arguably lead to unlawful discrimination against practitioners on the grounds of their conscientious and religious beliefs.[58] In *New Zealand Health Professionals Alliance Inc v Attorney-General,* a judgment delivered as this article was being published, the High Court held that s 15 of the CSA Act did not limit an objecting practitioner's right to be free from discrimination, but even if it did, those limits would be demonstrably justified in a free and democratic society under s 5 of the NZBORA.[59] This issue is too substantial to discuss here in depth. Other jurisdictions in which there are more stringent conscientious objection provisions have also considered the issue. For example, the European Court of Human Rights has held in Swedish cases that the refusal to employ objecting practitioners does not constitute unlawful discrimination when balanced against the importance of the right to access to abortion services.[60]

C Reasonable and justified limits

In *New Zealand Health Professionals Alliance Inc*, Ellis J held that the s 13 right to freedom of conscience is an absolute, internal right, whereas the s 15 right of every person to manifest their beliefs is subject to reasonable and justifiable limits under s 5 of the NZBORA.[61] To determine what constitutes a reasonable and justified limit on a right under s 5, the Supreme Court in *R v Hansen* adopted the Canadian *Oakes* test.[62] The stages of the *Oakes* test are:

i) Does the proposed limit serve a purpose sufficiently important to justify limiting a right?

ii) If so,

    a) Is the limiting provision rationally connected to its purpose?

    b) Does the proposed limit impair the right no more than is reasonably necessary for sufficient achievement of the purpose?

    c) Is the limit proportionate to the importance of the objective?

58 See New Zealand Bill of Rights Act 1990, s 19; and Human Rights Act 1993, s 21(c) and (d).

59 *New Zealand Health Professionals Alliance Inc v Attorney-General* [2021] NZHC 2510 at [152]–[167] and [187]–[190].

60 See *Grimmark v Sweden* ECHR 43726/17, 12 March 2020; and *Steen v Sweden* ECHR 62309/17, 12 March 2020. These cases are also discussed later in this article.

61 *New Zealand Health Professionals Alliance Inc v Attorney-General*, above n 59, at [65]–[70].

62 *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 at [103]–[104] per Tipping J, citing *R v Oakes* [1986] 1 SCR 103.

This article now moves to consider how the current regulation of conscientious objection does not sufficiently protect and prioritise the right to healthcare. If the above test can be satisfied, further reasonable limits should be placed on the right to freedom of conscience in order to minimise its intrusion on the right to healthcare.

IV THE NEED FOR REFORM

The United Nations treaty monitoring bodies have stated that if conscientious objection is allowed, States must establish effective regulations so that it does not obstruct the right to access legal healthcare.[63] This section of the article lays out the issues with New Zealand's current law on conscientious objection under the CSA Act and argues that the right to healthcare is obstructed because of insufficient regulation of conscientious objection. This article argues that if conscientious objection is not properly regulated, it can result in the following three key problems:

i) obstruction of access to health care;

ii) a lack of dignity and independence for patients; and

iii) a health system that is discriminatory on the grounds of sex.

A Obstruction of access to healthcare

Research on the impact of conscientious objection on access to abortion in New Zealand is limited. However, a 2019 survey conducted in New Zealand among the New Zealand Fellows and trainees of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists found that 14.6 per cent of practitioners were totally opposed to abortions on religious or conscientious grounds.[64] Similarly, an Australian study found that 15 per cent of health care professionals were reported as objecting to abortion in Australia.[65] The New

63 "Law and Policy Guide: Conscientious Objection" Center for Reproductive Rights <https://maps.reproductiverights.org >, citing, amongst other sources, *General Comment No 22*, above n 32, at [43].

64 Emma MacFarlane and Helen Paterson "A survey of the views and practices of abortion of the New Zealand Fellows and trainees of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists" (2020) 60 Aust N Z J Obstet Gynaecol 296 at 298.

65 Louise Anne Keogh and others "Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers" (2019) 20(11) BMC Medical Ethics 1 at 2.

Zealand Law Commission's 2018 report on abortion law reform also noted that:[66]

> While there are no official records of the number of general practitioners (GPs) who are conscientious objectors, anecdotally the Commission heard from health practitioners that *it is quite common*. The Commission was told that in some parts of the country *it can be difficult to find a GP who will make a referral*.

Additionally, a recent report by Family Planning on the use of contraception found that one in four women reported not using their preferred method of contraception for reasons including barriers in accessing healthcare, such as the costs and time involved.[67] The survey found that 290 respondents (five per cent of the group) had experienced conscientious objection from healthcare practitioners when trying to access contraception.[68] While comprehensive statistical data on the prevalence of conscientious objection to abortion in New Zealand is scarce, it is likely that rates of objection will be higher for abortion than contraception, since it is generally seen as a more contentious issue and has only recently been decriminalised. For example, a study from the United States of America conducted among pharmacists found that 17.2 per cent of respondents were unwilling to provide medical abortifacients and 7.5 per cent unwilling to provide emergency contraceptives, compared with only 0.5 per cent unwilling to provide oral contraceptives.[69]

In Victoria, Australia, legislation regulating abortion services has a similar but more stringent provision to the CSA Act for conscientious objection.[70] A Victorian study conducted into the impact of conscientious objection on access to healthcare found that access was obstructed by:[71]

i) doctors commonly failing to refer the patient to another provider;

66 Law Commission *Alternative Approaches to Abortion Law: Ministerial briefing paper* (NZLC MB4, October 2018) at 111 n 66 (emphasis added).

67 New Zealand Family Planning "Contraception Use Survey 2020" (2020) <https://familyplanning.org.nz> at 8–9.

68 At 19.

69 Laura A Davidson and others "Religion and conscientious objection: A survey of pharmacists' willingness to dispense medications" (2010) 71 Social Science and Medicine 161 at 163.

70 Abortion Law Reform Act 2008 (Vic), s 8.

71 Keogh and others, above n 65, 5–6.

ii) doctors attempting to deter or delay the patient from obtaining access;

iii) doctors attempting to make the patient feel guilty; and

iv) doctors objecting on grounds other than conscience.

This highlights the problematic nature that conscientious objection can have on access to healthcare, insofar as allowing for the situation in which patients experience conscientious objection from their practitioner. The study also noted that some objecting practitioners felt they would still be conscientiously complicit in the provision of abortion if they complied with their statutory duty to refer.[72]

Another study into the impact of conscientious objection in Italy found that it obstructed access by increasing costs, waiting times and travel distances for those seeking abortion services. Those who were economically disadvantaged were found to face higher barriers to accessing healthcare.[73] Similarly, in Ireland, limited access to abortion services was found to place significant financial burdens on pregnant persons because they then had to travel abroad to access abortions.[74] The availability of legal abortion in Ireland was also found to be compromised because of unregulated conscientious objection.[75]

At the very least, conscientious objection inevitably causes delays in healthcare to the patient seeking it,[76] which contravenes the requirement for healthcare to be delivered in a timely and effective manner.[77] Abortion is a time-sensitive health service, and in some cases, delaying access can prevent access altogether.[78] In New Zealand, unlike Victoria, practitioners only have to inform patients on how to access the contact details of the closest provider of the requested service (an *indirect* referral); they do not have to ensure that

72 At 3.

73 Tommaso Autorino, Francesco Mattioli and Letizia Mencarini "The impact of gynecologists' conscientious objection on abortion access" (2020) 87(102403) Social Science Research 1 at 14.

74 Máiréad Enright and others "Abortion Law Reform in Ireland: A Model for Change" (2015) 5 feminists@law 1 at 7.

75 At 15.

76 See Wendy Chavkin and others "Conscientious objection and refusal to provide reproductive healthcare: A White Paper examining prevalence, health consequences, and policy responses" (2013) 123 International Journal of Gynecology & Obstetrics S41.

77 New Zealand Public Health and Disability Act, s 3(1)(d).

78 *Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario* 2019 ONCA 393, 147 OR (3d) 398 at [122].

the provider is also willing and available to provide it. Systemic delays in healthcare already exist in New Zealand: one study, conducted before the 2020 reforms, found that patients waited an average of 25 days between the date they first contacted the health system and their abortion procedure.[79] These delays are exacerbated for patients who encounter objecting practitioners, which means they must then arrange to see a different practitioner and experience compounded delays in the process. The duty of indirect referral does not sufficiently mitigate the further delay arising from objecting practitioners.

Although empirical research is scarce, New Zealand is already known to have comparatively long delays in access to abortion stemming from the referral process.[80] Barriers to abortion, such as these delays, disproportionally impact minorities and those living in rural areas.[81] The Law Commission also noted that conscientious objection can disproportionately obstruct access in smaller or remote communities because pregnant persons would have to travel to find a non–objecting practitioner,[82] and bear the financial cost of such travel.

A lack of oversight mechanisms with respect to practitioners conscientiously objecting can result in doctors abusing their right to object and not providing referrals as required.[83] Surveys in the United States of America found that 15 per cent of objecting doctors did not comply with their duty to refer, and sought to delay or deny access to abortion services.[84] Further research in the United States of America found that in 2017:[85]

i) only 18 per cent of objecting practitioners would facilitate a referral;

ii) 39 per cent would just offer the name of a clinic or a doctor;

iii) 29 per cent would provide nothing; and

iv) 15 per cent would give misleading information.

79 Martha Silva, Rob McNeill and Toni Ashton "Ladies in waiting: the timeliness of first trimester services in New Zealand" (2010) 7 Reproductive Health 19 at 5.
80 Angela Ballantyne, Colin Gavaghan and Jeanne Snelling "Doctors' rights to conscientiously object to refer patients to abortion service providers" (2019) 132 NZMJ 64 at 69.
81 At 69.
82 Law Commission, above n 66, at 158.
83 See Christian Fiala and Joyce H. Arthur "'Dishonourable disobedience' – Why refusal to treat in reproductive healthcare is not conscientious objection" [2014] 1 Woman - Psychosomatic Gynaecology and Obstetrics 12 at 13.
84 Keogh and others, above n 65, at 17.
85 At 12.

In Victoria, conscientious objection was also found to be invoked by doctors who did not hold religious or conscientious beliefs that opposed abortion, and in some cases, was viewed as an opportunity to simply opt out of providing such services.[86] The scope of conscientious objection must be adequately regulated and enforced in order to ensure compliance with the broadly recognised duties that a doctor has to their patient.[87]

Conscientious objection can therefore create significant barriers for pregnant persons exercising their right to access legal healthcare, particularly when the exercise of conscientious objection is not appropriately regulated. Its disproportionate impact on those from disadvantaged, rural or minority backgrounds indicates that reproductive healthcare is not physically and economically accessible to everyone in the first instance, as required by the United Nation's right to health framework,[88] let alone in circumstances where medical practitioners conscientiously object and cause further delays. Moreover, delays within the referral process indicate that conscientious objection can effectively restrict healthcare from being provided in a timely and effective manner, as required by New Zealand law. Such barriers significantly infringe upon the right to access healthcare.[89]

B Lack of dignity and independence for health consumers

Everyone has the right to make decisions about their healthcare with dignity and independence.[90] Laws allowing conscientious objection deepen and legitimise the stigma that a person's reproductive rights are something which can be objected to.[91] A study in the United States of America found that 63 per cent of physicians felt they were ethically permitted to describe their objection to their patients.[92] When people seek abortion services, they are

86 At 16.

87 See, for example, Council of Europe Parliamentary Assembly *Women's access to lawful medical care: the problem of unregulated use of conscientious objection (Draft report)* (Social, Health and Family Affairs Committee, 2010) at [2].

88 Health Promotion Forum of New Zealand, above n 21, at 13.

89 For further comments on barriers for pregnant people, and the disproportionate effect on vulnerable people, see Law Commission, above n 66, at 121; and *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* UN Doc A/66/354 (3 August 2011) at [24].

90 The Code, above n 31, Right 3.

91 *Interim report of the Special Rapporteur*, above n 89, at [24].

92 Farr A Curlin and others "Religion, Conscience, and Controversial Clinical Practices" (2007) 356 N Engl J Med 593 at 593.

often already experiencing stress and trauma.[93] Experiencing conscientious objection from a provider may add to the stress and stigma that they encounter[94] and may result in psychological, emotional and even physical harm to the patient.[95]

A study in the United States of America, known as the Turnaway Study, examined the mental health and wellbeing of people who had been denied an abortion. The study found that both those who had been turned away but did not give birth (either due to getting an abortion elsewhere, or a miscarriage) and those who had been turned away and did give birth, had significantly more anxiety, less self–esteem and less life satisfaction than those who were not denied an abortion. Importantly, even those who were able to access an abortion after the initial refusal suffered negative effects on their mental health, when compared with the group who did not experience a denial at all.[96] This indicates that merely instating a duty to refer on those who conscientiously object is not sufficient to protect patients from the psychological harm that the initial objection can cause.

The currently high cost of conscientious objection should not be borne by the person who is simply exercising their right to healthcare. This practice compromises the patient's rights to bodily autonomy and the dignity and independence they are entitled to as health consumers.[97] Making legal provisions for health practitioners to refuse their professional obligations based on their personal views necessarily undermines the autonomy and independence of the patient, who is entitled to request that service.[98]

Medical practitioners are also in a position of power and authority compared to patients. Patients who are seeking clinical care are inherently more vulnerable than their health practitioners, who are well and carrying out their professional duties.[99] Disparities in health literacy and privilege between health practitioners and patients would also exacerbate this power imbalance.

93 Law Commission, above n 66, at 158.
94 At 158–159.
95 International Women's Health Coalition "Unconscionable: When Providers Deny Abortion Care" (2018) <iwhc.org> at 8.
96 Antonia M Biggs and others "Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study" (2017) 74 JAMA Psychiatry 169.
97 The Code, Right 3.
98 International Women's Health Coalition, above n 95, at 11.
99 Ballantyne, Garaghan and Snelling, above n 80, at 67.

This dynamic opens the door to misuses of conscientious objection,[100] which patients are not adequately protected against or necessarily able to recognise.

C Systemic discrimination on the grounds of sex

As noted at the outset, this article recognises that abortion services affect all pregnant persons, including those who may not identify as women. While the focus of this section remains on discrimination on the grounds of sex, discrimination against women, as recognised below in CEDAW, is also discussed where appropriate.

Article 12(1) of CEDAW states:

> States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

By ratifying CEDAW, New Zealand has committed to ensuring that everyone, regardless of their sex or gender, has equal access to healthcare services, including those relating to family planning. This principle can also be found in domestic law. The NZBORA gives everyone the right to be free from discrimination.[101] This includes discrimination on the grounds of sex, ethical beliefs and political opinions.[102] The Code also gives all health consumers the right to be free from discrimination when it comes to the provision of health services.[103]

By its nature, only those who are pregnant require access to abortion services. The accommodation of conscientious objection therefore creates barriers of access to health for women and pregnant persons which do not exist for those who cannot be pregnant.[104]

100 International Women's Health Coalition, above n 95, at 5.
101 Section 19.
102 Section 21(1)(a), (d) and (j).
103 The Code, Right 2.
104 See Reva B Siegel "Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression" (2007) 56 Emory L J 815.

In its General Recommendation No 24, the Committee on the Elimination of Discrimination against Women noted that:[105]

> It is discriminatory for a State Party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.

In New Zealand, in order for a practice to be discriminatory, there must be a distinction based on one of the prohibited grounds of discrimination, and the distinction must impose a material disadvantage on the group.[106]

Importantly, discrimination can arise indirectly.[107] Although the basis for conscientious objection may not be in itself based on the prohibited grounds of discrimination — for example, practitioners are not denying the service *because* of a patient's sex or ethical beliefs — the systemic impact of the law allowing such refusal to abortion services inevitably affects the rights of women and pregnant people in a way which it does not affect the rights of men,[108] thus providing a clear distinction on the grounds of sex.

Conscientious objection indirectly imposes a material disadvantage on the discriminated group by systemically obstructing their right to health. For example, abortion is one of the most common health procedures undertaken by women, with about 30 per cent of women in New Zealand having experienced it in their lifetime.[109] One of the few gender diverse pregnancy studies found that of the 12 per cent of respondents who had been pregnant, 20 per cent of those pregnancies ended in abortion.[110] Allowing conscientious objection to such a common service obstructs the ability of women and pregnant persons to access healthcare, whereas the rights of those who cannot be pregnant

105 Committee on the Elimination of Discrimination against Women *CEDAW General Recommendation No 24: Article 12 of the Convention (Women and Health)* UN Doc A/54/38/Rev.1, chap I (1999) at [11].

106 *Ministry of Health v Atkinson* [2012] NZCA 184, [2012] 3 NZLR 456 at [109].

107 See *Northern Regional Health Authority v Human Rights Commission* [1998] 2 NZLR 218 (HC).

108 Siegel, above n 104.

109 Abortion Supervisory Committee *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand* (Report of a Standards Committee to the Abortion Supervisory Committee, January 2018) at 1.

110 Heidi Moseson and others "Pregnancy intentions and outcomes among transgender, nonbinary, and gender-expansive people assigned female or intersex at birth in the United States: Result from a national, quantitative survey" (2020) 20 International Journal of Transgender Health 30.

remain unaffected. It is therefore institutionally discriminatory for health care providers to refuse to provide health services that disproportionally restrict the right to access healthcare in this way.[111]

Notably, the right to freedom from discrimination in New Zealand is also subject to the *Hansen* test for reasonable limits.[112] While the protection of the practitioner's right to freedom of conscience is likely to justify limiting the patient's right to freedom from discrimination to some extent, further regulations should be introduced to reduce the disadvantages faced by the discriminated group in order to satisfy the *Hansen* requirement for "minimum impairment".

Additionally, as discussed earlier, conscientious objection also creates substantially greater barriers to healthcare for patients in rural areas and those from minority or economically disadvantaged backgrounds. The negative impact of conscientious objection on access to healthcare must be minimised to ensure that the current practice does not continue to have these discriminatory effects, as prohibited by the NZBORA.[113] As it stands, the current provision for conscientious objection[114] does not minimise its disproportionate impact on women's right to access healthcare as required by art 12(1) of CEDAW.

D Shortcomings of section 14 of the CSA Act

This analysis has highlighted how the accommodation of conscientious objection can obstruct access to healthcare, impede patients' right to dignity and independence as health consumers, and result in a discriminatory system which disproportionally restricts access to healthcare on the grounds of sex. These effects must be examined alongside s 14 of the CSA Act in order to analyse how this specific provision fails to prevent these negative impacts.

This article argues that there are three key shortcomings of the CSA Act's current regulation of conscientious objection:

i) conscientious objection occurs *after* request for abortion services;

111 Gustavo Ortiz-Millán "Abortion and conscientious objection: rethinking conflicting rights in the Mexican context" (2018) 29 Global Bioethics 1 at 7. The same institutional discrimination of course would be true if men were commonly denied access to a healthcare service that was sex/gender specific to them.

112 This was common ground in *Atkinson*, above n 106, at [143].

113 Section 19.

114 CSA Act, s 14.

ii) all health practitioners who are *assisting* with the provision of abortion can object; and

iii) there is no duty of *direct* referral.

1 *The timing of conscientious objections*

First, s 14(2)(a) of the CSA Act provides that the health practitioner must inform the person requesting abortion services about their conscientious objection at the earliest opportunity. This creates a system where patients must first request the service from a potential objector without knowing of the objection and bear the emotional, mental, financial and operational cost of being refused the service.[115] The patient should not have to experience a refusal of their personal choice and the detrimental effects that accompany it. As is the case in some other jurisdictions, such as Italy for example, the burden should instead be on the healthcare authorities to ensure that practitioners register their conscientious objections in advance.[116]

2 *All health practitioners 'assisting' with abortion may object*

Secondly, s 14(1) allows practitioners who are merely assisting with the provision of abortion services to conscientiously object. The scope of this provision is broad and risks allowing conscientious objection from practitioners who are not directly involved in contraception or abortion services. It is unclear, however, what the effect of such a provision may be in practice. *Medical Law in New Zealand* suggests that the term "assisting" includes "any preparation for the abortion".[117] However, in *Hallagan v Medical Council of NZ,* the High Court took the view that "assisting" did not extend to arranging for the case to be dealt with and considered by another practitioner.[118] Other jurisdictions, such as the United Kingdom, Australia (Victoria) and Portugal, have narrowed the scope for the exercise of conscientious objection in order to protect against ambiguity and broad application, and accordingly mitigate the risk of further obstruction of access to healthcare. These jurisdictions are discussed further on in this article.

115 See International Women's Health Coalition, above n 95, at 27.

116 Autorino, Mattioli and Mencarini, above n 73, at 2–4.

117 PDG Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) as cited in *Hallagan v Medical Council of NZ,* above n 56, at [13].

118 *Hallagan v Medical Council of NZ,* above n 56, at [10]

3 *The duty of indirect referral*

Section 14(2)(b) of the CSA Act requires the health practitioner to inform the patient of how to access the contact details of the closest provider of the requested service at the earliest opportunity. They are under no obligation to actually provide those details, and they do not have to ensure that the closest provider is also willing and able to perform the service. Indirect referrals have been considered to present less of a conflict with the beliefs of objecting practitioners, because they are thought to be less or indirectly morally complicit in the provision of the service.[119] However, indirect referrals are not sufficient to protect access to healthcare because they can result in some patients being unable to navigate the health system on their own,[120] or being refused service more than once. These issues and the potential resulting delays are particularly problematic as abortion is a time-sensitive treatment, and barriers to access are more pronounced for vulnerable people, such as those who are economically disadvantaged or located in rural areas.[121]

The United Nations treaty monitoring bodies have stated that in order to guarantee access to abortion services where conscientious objection is allowed, States must at least require referrals to practitioners who are both willing and able to provide the requested service.[122]

These three shortcomings demonstrate that New Zealand's current regulation of conscientious objection is insufficient to protect the rights of patients to access healthcare, and the law should therefore be reformed to address these issues.

V THE BALANCING ACT

The balance between two fundamental human rights is always a delicate one. On the one hand, everyone has the right to access healthcare and medical practitioners have a duty to uphold their professional obligations to patients. On the other hand, all individuals have the right to freedom of conscience and its manifestation which should not be infringed upon unless the limitation can be demonstrably justified in a free and democratic society, under s 5 of the NZBORA. Likewise, at the international level, the ICCPR provides that the

119 Wicclair, above n 5, at 37.

120 Law Commission, above n 66, at 158.

121 Louise Newman "The Compromise of Conscience: Conscientious Objection in Healthcare" (LLM Research Paper, Victoria University of Wellington, 2013) at 42–43.

122 Center for Reproductive Rights, above n 63.

right to manifest one's beliefs is subject to limitations which are necessary to protect the fundamental human rights of others.[123] Therefore, if conscientious objection is allowed, it should be sufficiently regulated so that it does not interfere with or obstruct the right of others to access healthcare.[124]

In order to find the correct balance, this article considers the *Hansen* test regarding reasonable limits. Secondly, it analyses regulatory guidance from FIGO, the WHO and the Law Commission to determine how conscientious objection should be regulated in order to better protect the right to healthcare. Lastly, it outlines the relevant law in Italy, the United Kingdom, Canada, Australia, Portugal and Sweden to observe how conscientious objection has been regulated in different countries and to compare the strength of their regulations with New Zealand's CSA Act.

A The Hansen test for reasonable limits

In order to justify the imposition of further regulations on conscientious objection, the *Hansen* test for "reasonable limits" on freedom of conscience must first be satisfied.[125]

In *New Zealand Health Professionals Alliance Inc*, Ellis J held that s 14 of the CSA Act does not engage the right to freedom of conscience nor the right to manifest one's beliefs under ss 13 and 15 of the NZBORA.[126] Specifically, freedom of conscience was not engaged by the duty to provide indirect referrals because s 13 absolutely protects a person's *internal* thought processes, unlike s 15 which provides qualified protection to the manifestations of one's beliefs through their actions or inactions.[127] Ellis J held that the provision of information (an indirect referral), as required under s 14 of the CSA Act, did not engage the notions of practice and observance of one's beliefs under s 15 of the NZBORA.[128] Her Honour went on to say that, even if s 15 were engaged, being required to comply with s 14 of the CSA Act does not interfere materially or significantly with the ability of practitioners to manifest their beliefs because the duty to provide an indirect referral is minimal and, at best, only remotely

123 International Covenant on Civil and Political Rights, above n 42, art 18(3).
124 World Health Organization *Safe abortion: technical and policy guidance for health systems* (2nd ed, 2012) at 96.
125 *Hansen*, above n 62, at [104].
126 *New Zealand Health Professionals Alliance Inc v Attorney-General*, above n 59, at [88] and [115].
127 At [86].
128 At [111].

connected to any abortion that may or may not follow.[129] Given that neither ss 13 or 15 of the NZBORA were found to be engaged by s 14 of the CSA Act, the issue of whether any limits upon them were justified did not arise. Out of an abundance of caution, her Honour addressed justification briefly, with relevant obiter dicta set out as appropriate in the *Hansen* analysis below.

1 A sufficiently important purpose

First, the proposed limits must serve a purpose sufficiently important to justify limiting a right. In its 2018 report on abortion law reform, the Law Commission considered the application of *Hansen* in relation to conscientious objection. It held that ensuring access to abortion services without delay, inconvenience and stress is likely to satisfy the requirement for a "sufficiently important" purpose to restrict conscientious objection.[130] In *New Zealand Health Professionals Alliance Inc*, Ellis J stated, obiter, that the objective of facilitating access to abortions in a timely way supports a number of fundamental and internationally recognised human rights.[131] Similarly, in the case of *Christian Medical and Dental Society of Canada*, the Ontario Court of Appeal held that the facilitation of equitable access to healthcare was a sufficiently important purpose.[132]

2 Rational connection

Secondly, the limiting provisions must be rationally connected to their purpose. The Law Commission report noted that the obstruction of access to healthcare caused by conscientious objection can impede upon women's rights.[133] The rational connection between strengthening the regulation of conscientious objection and ensuring access to abortion services is therefore sufficiently clear. If the issue had arisen, Ellis J in *New Zealand Health Professionals Alliance Inc* would have held that the duty of indirect referral under s 14 is rationally connected to the protected rights because it reduces the delay that would otherwise be caused by an objecting healthcare provider.[134]

3 Minimum impairment

Thirdly, the proposed limits must only impair the right to the extent reasonably

129 At [121]–[124].
130 Law Commission, above n 66, at 160.
131 *New Zealand Health Professionals Alliance Inc v Attorney-General*, above n 59, at [179].
132 *Christian Medical and Dental Society of Canada*, above n 78, at [101] and [106]–[108].
133 Law Commission, above n 66, at 160.
134 *New Zealand Health Professionals Alliance Inc v Attorney-General*, above n 59, at [180].

necessary for their purpose to be sufficiently achieved. The Law Commission noted that the key issues here with the *Hansen* test were likely to be minimum impairment and proportionality.[135] These were also the two contested issues in *Christian Medical and Dental Society of Canada*.[136] On the minimum impairment issue, the Law Commission expressed the view that the wider legal context of abortion law should be considered. For instance, other reforms, such as allowing the patient to self–refer, could reduce the harm of conscientious objection on access to abortion.[137] Nevertheless, the Law Commission still proposed imposing a requirement on objecting practitioners to provide direct referrals, recognising that this would provide a balance between the rights of objecting practitioners to refrain from participating, and the rights of the patients requesting abortions.[138]

4 *Proportionality*

Lastly, the limit must be proportionate to the importance of the objective. If the issue had arisen, Ellis J in *New Zealand Health Professionals Alliance Inc* would have held that, if s 14 did limit the s 15 NZBORA right, the limit was proportionate to the objective of s 14 of the CSA Act, which is to "further and enhance the enjoyment of indisputable and fundamental rights".[139] The issue of proportionality is difficult to analyse in depth because of the lack of substantial data on the degree to which conscientious objection actually impacts access to healthcare in New Zealand. One study, discussed earlier in this article, found that around 14.6 per cent of practitioners were completely opposed to providing abortion services.[140] However, this presents an area where further research is required to understand the scale of impact and allow for a more comprehensive proportionality analysis. In *Christian Medical and Dental Society of Canada*, the Ontario Court of Appeal held that the requirement to refer patients directly to a non-objecting practitioner, rather than the default medical process of a *formal* referral (where practitioners provide a formal letter of referral to, and arrange an appointment for their patient with, another practitioner), provides a reasonable compromise between the rights of patients and practitioners.[141]

135 Law Commission, above n 66, at 160.
136 *Christian Medical and Dental Society of Canada*, above n 78, at [108].
137 Law Commission, above n 66, at 160.
138 At 162.
139 *New Zealand Health Professionals Alliance Inc v Attorney-General*, above n 59, at [186].
140 MacFarlane and Paterson, above n 64, at 298.
141 *Christian Medical and Dental Society of Canada*, above n 78, at [26] and [187].

Similarly, it is argued that other proposals discussed later in this article, such as a requirement to register as an objector, are unlikely to impose any disproportionate restrictions on the rights of objecting practitioners.

B Guidelines and recommendations

1 FIGO's ethical guidelines

FIGO's position is that a practitioner's primary duty is to treat their patient, and their conscientious objections are secondary to this duty.[142] This is an important consideration, not because a strict interpretation of it arguably means objecting practitioners should be required to perform abortions in non-emergencies, but because it supports the view that practitioners should, at the very least, assist their patients in more easily accessing to healthcare by providing direct referrals. FIGO's ethical guidelines include the following:[143]

i) Practitioners are required to provide timely access to services.

ii) Practitioners have professional duties to abide by scientific and professional definitions of reproductive health services and must not misrepresent them based on their personal views.

iii) Practitioners have a right to have their conscientious objections respected, and to not be discriminated against on the basis of their views.

iv) Patients have the right to be referred in good faith to practitioners who do not object to their requested services.

v) Practitioners must provide timely care where referral is not possible, and delay would be harmful to the health and wellbeing of the patient.

142 FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health *Ethical Issues in Obstetrics and Gynecology* (FIGO, October 2012) at 26.

143 At 26–27.

2 *Recommendations by the WHO*

The WHO has also offered the following recommendations on conscientious objections:[144]

i) Nations should establish national standards and guidelines on conscientious objection.

ii) A provider's right to conscientiously object should not entitle them to delay or deny access to legal healthcare.

iii) Objecting healthcare practitioners must refer the patient to a provider who is both willing and able to provide the service, in the same or another facility which is easily accessible.

3 *Recommendations by the New Zealand Law Commission*

The Law Commission's 2018 report on abortion law reform provided guidance for the CSA Act. The report offered two proposals for the accommodation for conscientious objection. Option A entailed retaining the previous law on conscientious objection, which only required objecting practitioners to inform patients that the requested abortion services could be accessed elsewhere.[145] There was no requirement to provide a referral in Option A.

Option B, which was supported by the majority of health professional bodies that had made submissions, imposed a requirement on objecting practitioners to refer the woman to another health practitioner or abortion service provider who is able to provide the service.[146] This option would have created a duty of direct referral.

The CSA Act has enacted Option A and only imposes a duty of indirect referral.

C Overseas jurisdictions

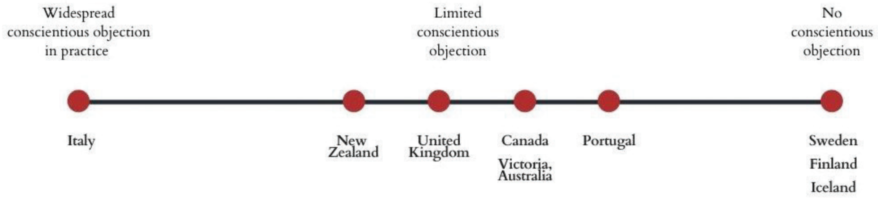
Examining the regulation of conscientious objection in other countries provides guidance for how New Zealand legislation can better protect the right to healthcare. Jurisdictions around the world have dealt with conscientious objection to abortion in a range of different ways. It is helpful to view some of

144 World Health Organization *Safe abortion*, above n 124, at 8 and 96.

145 Law Commission, above n 66, at 161.

146 At 162.

these different approaches on a spectrum based on stringency of regulations, as set out below:



The following countries are discussed because, unlike New Zealand, they have each implemented specific regulation of conscientious objection in order to ensure the right to healthcare is sufficiently protected.

1 Italy

Conscientious objection is concerningly widespread in Italy.[147] In 2016, 71 per cent of gynaecologists, and over 85 per cent in certain regions, were registered as objectors and only 60 per cent of hospitals with obstetrics and gynaecology wards were performing abortions.[148] Despite abortion being legal, access to abortion services in Italy is severely restricted because of conscientious objection.[149] The European Committee of Social Rights declared that Italy had violated the right to health and non-discrimination by not sufficiently regulating conscientious objection.[150]

However, Italy's current regulations on conscientious objection require all objecting practitioners to formally register their objection to the local health authority and to the facility at which they work.[151] This registration process allows patients to avoid being assigned doctors that object to abortion. It also provides important statistical data on the prevalence of conscientious objection in the country, which can be used to monitor the extent to which access to healthcare is obstructed in practice.

Objecting practitioners in Italy have no obligation to refer patients to

147 Autorino, Mattioli and Mencarini, above n 73, at 4–5.
148 At 1.
149 International Women's Health Coalition, above n 95, at 10 and 14.
150 *International Planned Parenthood Federation – European Network (IPPF EN) v Italy* European Committee of Social Rights, Complaint No 87/2012, 10 September 2013.
151 See Autorino, Mattioli and Mencarini, above n 73, at 2.

another provider. In 2017, the Human Rights Committee recommended that Italy establish regulations to ensure an effective referral system.[152]

2 *The United Kingdom*

The Abortion Act 1967 (UK) explicitly allows for conscientious objection, but there is no express duty to refer, nor a formal registration process.[153] However, practitioners are required by professional obligations and the common law to refer patients to another provider.[154] The courts have held that conscientious objection may only be invoked by practitioners directly involved in the provision of the service, and the service must be directly related to abortion care.[155] Employers are allowed to require performance of abortion services in job descriptions.[156]

3 *Canada*

Abortion law in Canada is unique compared with the other jurisdictions discussed in this article because there is no specific abortion legislation. However, conscientious objections still occur.[157] In *Christian Medical and Dental Society of Canada*, the Ontario Court of Appeal unanimously upheld a professional policy which requires objecting physicians to provide an "effective referral" to patients.[158] Effective referral is "a referral made in good faith, to a *non–objecting*, available, and accessible [practitioner]".[159]

4 *Victoria, Australia*

Abortion is allowed in every Australian jurisdiction, although specific legal provisions vary.[160] In Victoria, s 8(1) of the Abortion Law Reform Act 2008 (Vic) provides:

> If a woman requests a registered health practitioner to *advise* on a proposed

152 Human Rights Committee *Concluding observations on the sixth periodic report of Italy* UN Doc CCPR/C/ITA/CO/6 (1 May 2017) at [17].

153 Abortion Act 1967 (UK), s 4.

154 Chavkin, Swerdlow and Fifield, above n 76, at 58.

155 *Greater Glasgow Health Board v Doogan* [2014] UKSC 68, [2015] AC 640; and *Janaway v Salford Health Authority* [1989] AC 537 (HL).

156 Chavkin, Swerdlow and Fifield, above n 76, at 58.

157 Dorothy Shaw and Wendy V Norman "When there are no abortion laws: A case study of Canada" (2020) 62 Best Practice & Research Clinical Obstetrics and Gynaecology 49 at 56.

158 *Christian Medical and Dental Society of Canada*, above n 78.

159 At [2] (emphasis added).

160 Ashleigh Seiler and Nicole Woodrow "In reproductive health, is it unconscionable to object?" (2018) 20(2) O&G Magazine 34 at 34.

> abortion, or to *perform, direct, authorise or supervise* an abortion for that woman, and the practitioner has a conscientious objection to abortion, the practitioner must –
>
> (a) inform the woman that the practitioner has a conscientious objection to abortion; and
>
> (b) refer the woman to another registered health practitioner in the same regulated health profession *who the practitioner knows does not have a conscientious objection* to abortion.
>
> (Emphasis added.)

This provision imposes an express requirement on objecting practitioners to refer their patient directly to another practitioner whom they know does not object. Such a requirement reduces the impact of conscientious objection on access to healthcare, because it avoids the possibility of a patient having to experience subsequent objections or being unable to navigate the health system on their own. Victoria's scope for conscientious objection is also more specific than New Zealand's, because only practitioners who are advising on, performing, directing, authorising or supervising an abortion can object.

5 Portugal

Rates of conscientious objection in Portugal are not well documented. Despite this, abortion is considered to be accessible because of Portugal's stringent regulation of conscientious objection. First, only practitioners who are directly involved in the provision of abortion care can object. Practitioners must provide their hospital's director with a written statement on their reasons for objecting. They are also required to refer patients to a non–objecting provider of the requested service. Lastly, at least one non–objecting doctor must be available in all gynaecological departments.[161]

6 Sweden

Sweden, like Iceland and Finland, has no provision for conscientious objection in healthcare.[162] Institutions and employers can allow exemptions to their

161 International Women's Health Coalition, above n 95, at 23.

162 At 23. See also Christian Fiala and others "Yes we can! Successful examples of disallowing 'conscientious objection' in reproductive health care" (2016) 21 Eur J Contracept Reprod Health Care 201.

employees,[163] but it is not a right protected by law.[164] Abortion services are treated as professional obligations and compulsory training is provided to practitioners. Students who oppose performing abortions are often discouraged from specialising in the fields of obstetrics, gynaecology and midwifery. Hospitals can refuse to hire practitioners who object to providing abortions.[165]

In the case of *Federation of Catholic Families in Europe (FAFCE) v Sweden*, the Federation of Catholic Families in Europe challenged Sweden's legal position on conscientious objection to the European Committee on Social Rights.[166] The Committee held that neither the right to health nor the right to freedom from discrimination under the European Social Charter entitled health practitioners to conscientiously object to providing abortion services.

Sweden has also featured in two cases before the European Court of Human Rights. In *Grimmark v Sweden*, and *Steen v Sweden*, the applicant nurses both argued that not allowing conscientious objections was a breach of the right to freedom of conscience and that refusal to hire them on the grounds that they objected to providing abortions was discriminatory. The European Court of Human Rights held, on the first issue, that the law requires abortions to be carried out as soon as possible. To that end, providing high quality healthcare for patients seeking abortions constitutes a legitimate and objectively justifiable goal to limit the right to freedom of conscience.[167] On the second issue, the Court held the employment criteria were both appropriate and necessary to fulfil the legitimate purpose of providing abortion services swiftly.[168] The Court found that refusal to hire conscientious objectors did not constitute unlawful discrimination against Christians, because allowing these objections could impinge upon the right to access abortion.

D Conclusion

In *New Zealand Health Professionals Alliance Inc,* the High Court held that the current CSA Act does not engage ss 13 and 15 of the NZBORA and, if it does, any limit on those rights would be justified.[169] This section has firstly argued

163 International Women's Health Coalition, above n 95, at 17.
164 At 23.
165 At 23.
166 *Federation of Catholic Families in Europe (FAFCE) v Sweden* European Committee of Social Rights, Complaint No 99/2013, 17 March 2015.
167 *Steen v Sweden*, above n 60, at [20]; and *Grimmark v Sweden*, above n 60, at [25].
168 *Steen v Sweden*, above n 60, at [21]; and *Grimmark v Sweden*, above n 60, at [26].
169 *New Zealand Health Professionals Alliance Inc*, above n 59, at [111]–[124].

that further regulation of conscientious objection in the CSA Act would satisfy the *Hansen* test for reasonable limits on the right to freedom of conscience, noting that a gap in sufficient empirical data exists which currently limits the undertaking of a proportionality analysis. Secondly, upon examination of the above guidance on conscientious objection and overseas legislative frameworks, it is evident that New Zealand requires more robust regulation of conscientious objection in healthcare in order to better balance the various rights at stake. This analysis has been used to form the basis for this article's proposed reforms, set out below.

VI PROPOSALS

A Registration of objecting practitioners

As in Italy and Portugal, New Zealand should impose a requirement on practitioners to register their status as an objector in advance. This would protect patients from having to experience avoidable difficulties, such as delays or stigma, that they may face when encountering an objecting practitioner.[170] This would also promote transparency and eliminate the element of surprise for the patient.

Section 18 of the CSA Act already requires the Director–General of Health to compile and maintain a list of abortion service providers. It is recommended that the CSA Act introduce a requirement on objecting practitioners to register their status as an objector on this list, in order to prevent patients seeking abortion services from them. Although doing so may raise concerns around the privacy of practitioners, the list is managed by the Ministry of Health and is only accessible on request.[171] This may provide a sufficient balance between the privacy of practitioners and access to healthcare. However, a less effective alternative (which avoids privacy concerns) may be to require objecting practitioners to remove their name and contact details from the list of abortion service providers. This alternative is less favourable because it does not provide patients with positive disclosure of objecting practitioners.

Additionally, requiring practitioners to register their objections would also provide the Ministry of Health with essential data on the prevalence of conscientious objection to abortion in New Zealand. This information would be both necessary and valuable in allowing the Ministry of Health to monitor

170 Newman, above n 121, at 33 and 40–41.

171 Section 18(3).

and, if required, rectify any obstructive impact of conscientious objection on access to healthcare.

B The scope of conscientious objection should be narrowed

As is the case in Victoria, the United Kingdom and Portugal, the scope for conscientious objection should be narrowed in New Zealand. The current scope for all health practitioners "providing or assisting with providing" abortion services is vague and does not clearly specify how involved the objecting practitioner must be in order to object. It is recommended that this provision be narrowed to avoid ambiguity, obstruction of access to healthcare and the risk of future litigation. This recommendation could be implemented by changing the provision to apply only to practitioners who are "directly involved" in providing abortion services (including a definition of this term in legislation) or, in the alternative, practitioners who are "advising on, performing, directing, authorising or supervising" an abortion (as in Victoria, Australia).

C A requirement to provide effective referrals should be instated

As in Victoria, Canada and Portugal, and as recommended by FIGO, the WHO and the United Nations treaty monitoring bodies, New Zealand should instate a requirement on objecting practitioners to provide referrals that are both direct and effective. An effective referral is one considered to be made in good faith to a non-objecting, available and accessible health practitioner.[172]

The responsibility to ensure that a patient is able to access the service objected to should fall on the objecting practitioner, rather than on the patient.[173] This approach has been widely accepted as integral to minimising the intrusion of conscientious objection on access to healthcare and minimising consequent harm to persons seeking an abortion. It is recommended that the Canadian definition of an effective referral (as set out above) be adopted in the CSA Act.

Alternatively, practitioners could be required to refer to another health practitioner whom they reasonably believe does not object to providing the requested service,[174] or to a health practitioner whom the objecting practitioner

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172 This is the definition adopted by the College of Physicians and Surgeons of Ontario: *Christian Medical and Dental Society of Canada*, above n 78, at [2].

173 Newman, above n 121, at 42–43.

174 At 46.

knows does not object to providing the requested service (as in Victoria, Australia).[175]

This recommendation raises concerns around whether requiring practitioners to provide direct referrals still constitutes a breach of their right to freedom of conscience. It has been argued that practitioners who provide indirect referrals are less causally responsible for the provision of abortion services than practitioners who provide direct referrals. Theoretically, however, a heightened degree of causal responsibility does not necessarily mean an increase in moral responsibility. It may well be the case that both direct and indirect referrals have the same moral impact.[176]

In any case, Ellis J in *New Zealand Health Professionals Alliance Inc* held that the duty to provide indirect referrals under s 14 of the CSA Act does not engage the practitioners' rights to freedom of conscience (or religion) or manifestation of their beliefs.[177] Though direct referrals were not in issue in the case, Her Honour went on to say that an obligation to provide a *direct* referral is rightly regarded as the quid pro quo of the right to conscientiously object at all.[178] In the case of *Christian Medical and Dental Society of Canada*, the Ontario Court of Appeal held that a requirement to provide direct referrals to non–objecting practitioners satisfied the *Oakes* test and was therefore a reasonable limit that is demonstrably justified in a free and democratic society.[179]

VII CONCLUSION

The moral and ethical dilemma posed by conscientious objection in healthcare is not new, nor is it black and white. This area of law presents a challenging conflict between the rights of patients to access legal healthcare and the rights of practitioners to object to performing services which are incompatible with their beliefs. The fairest balance between rights lies in retaining conscientious objection, but only where it is appropriately regulated so that it does not infringe upon the right to healthcare to the degree and extent that it can currently.

This article has revisited the legal debate on conscientious objection in healthcare in order to contextually examine New Zealand's recent abortion

175 Abortion Law Reform Act (Vic), s 8(1)(b).

176 Steve Clarke "Conscientious objection in healthcare, referral and the military analogy" (2017) 43 J Med Ethics 218 at 221.

177 *New Zealand Health Professionals Alliance Inc v Attorney-General*, above n 59, at [88] and [115].

178 At [180].

179 *Christian Medical and Dental Society of Canada*, above n 78, at [187].

law reform in light of the amendments made by the ALA. It has found that inadequately regulated conscientious objection can lead to obstruction of access to healthcare, creating delays and barriers to access which are likely disproportionally greater for women and pregnant persons in rural and lower socio-economic contexts. It also strips women and pregnant persons of their dignity and independence and creates an institutionally discriminatory health system. On close examination of the specific regulations on conscientious objection in New Zealand, it is evident that a stronger regulatory framework is required to protect against such intrusions on the right to healthcare.

Guided by the *Hansen* test, various professional bodies and overseas jurisdictions, this article has offered a range of proposals to better regulate conscientious objection in New Zealand. Specifically, this article has argued that the CSA Act should be amended to require practitioners to register their objections, to narrow the scope of practitioners who can object, and to impose a duty of direct, rather than indirect, referrals.

Overall, the key question is whether the recent reform of abortion law in New Zealand has struck the correct balance between the rights of patients to access healthcare and the rights of practitioners to freedom of conscience. This article has advocated that the current balance does not appropriately protect the right to healthcare in New Zealand and has proposed reforms to provide a fairer balance between the two fundamental human rights.