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CHALLENGING CONSCIENCE-BASED REFUSALS IN NEW ZEALAND'S ABORTION CARE: A PATIENT-CENTRED PERSPECTIVE

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Abstract

Healthcare professionals obstruct patients' access to abortion care by refusing to provide services due to their personal moral objections. This paper assesses the appropriateness of embracing conscience as a valid decision-making criterion within the healthcare sector. It asserts that such a criterion is inconsistent with the traditional evidence-based approaches that underpin healthcare decision-making. Further, this paper highlights how the arbitrary application of conscientious objection solely to reproductive services undermines the medical validity and importance of these essential healthcare provisions. Conscientious objection to abortion in New Zealand has significant practical consequences, including a reduction in available healthcare providers, service delays, and added financial and mental burdens on patients. These burdens are unjustifiable, as patients should have unimpeded access to routine healthcare. In contrast, the paper argues that the potential impacts of abolishing conscientious objection on health professionals are limited and justifiable, given their autonomous choice to enter a profession dedicated to patient care. This paper advocates for the elimination of the right to conscientious objection for reproductive services, drawing on international jurisdictions for examples to support this approach. It argues that the prohibition of conscience-based refusals is the only effective way to prioritise patients' rights to abortion care.

Keywords: *"Abortion", "Conscientious objection", "Conscience", "Reproductive health", "Healthcare", "Law and Medicine".*

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I Introduction

New Zealand health professionals can refuse to provide abortion services based on their moral opposition to the termination of a pregnancy.[1] Section 14 of the Contraception, Sterilisation and Abortion Act (CSA Act) gives health practitioners the ability to conscientiously object to providing or assisting with providing contraception, sterilisation, abortion, or information on the termination of a pregnancy.[2]

Conscientious objection aims to uphold the right to freedom of conscience, a right protected by the New Zealand Bill of Rights Act 1990 (NZBORA).[3] Health practitioners can exercise this right by refusing to provide or be involved in services related to abortion due to the conflict between providing those services and their conscience.[4] Most commonly, healthcare professionals invoke conscientious objection based on concerns regarding the sanctity of unborn life, the immorality of 'taking life', or religious beliefs.[5] The provision for conscientious objection grants practitioners the freedom to follow their personal views, overriding the obligation to adhere to objective medical standards.[6]

A health practitioner with a conscientious objection has to tell their patient at the earliest opportunity of their objection and inform them of how to access details of the closest health practitioner who would provide the service.[7] In this scenario, the objector provides an indirect referral, as they are not obligated to refer the patient to a willing provider directly.[8] The Health Practitioners Competence Assurance Act affirms the requirement of health practitioners to inform their patient of their conscientious objection.[9] The CSA Act also provides that an employer that

1 Contraception, Sterilisation, and Abortion Act 1977, s 14(1).
2 Section 14(1).
3 Section 13.
4 Law Commission *Alternative Approaches to Abortion Law* (NZLC MB4, 2018) at 196.
5 Bjørn K Myskja and Morten Magelssen "Conscientious objection to intentional killing: an argument for toleration" (2018) 19 BMC Med Ethics 82 at 83.
6 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 18.
7 Contraception, Sterilisation, and Abortion Act, s 14(2)–(3).
8 Law Commission, above n 4, at 155.
9 Health Practitioners Competence Assurance Act 2003, s 174.

provides reproductive services must accommodate conscientious objections of potential employees unless it would unreasonably disrupt their provision of health services.[10]

This paper argues that health professionals should not be able to refuse care to patients seeking abortion services. The power in s 14 of the CSA Act is inconsistent with the conventional approach to healthcare services, which prioritises patient-centred care. The ability to refuse to offer these services on the grounds of conscience also creates unjustified obstacles to the provision of health care. It undermines individuals' freedom and dignity and impedes patients' right to adequate healthcare.[11] Some advocates for the right to conscientious objection claim that eliminating conscientious objection to abortion services is impractical.[12] Drawing on insights from Sweden and Finland, this paper demonstrates that this view is incorrect. In these countries, conscientious objection to the provision of abortion has been effectively eliminated,[13] with few, if any, adverse effects on the health system.[14]

The argument proceeds as follows. Part II discusses the rationale behind conscientious objection and New Zealand's current approach. Part III explores how theoretically the right of refusal does not align with a patient-centred approach to healthcare. Part IV details the impact of the exercise of conscientious objection on patients in accessing abortion services. Part V discusses the feasibility of banning conscientious objection and shows how such an approach is desirable in New Zealand. Part VI provides a brief conclusion.

II Conscientious Objection: Rationale and Approaches

A Conscientious Objection

10 Contraception, Sterilisation, and Abortion Act, s 5(1)–(2).
11 Angela Ballantyne, Colin Gavaghan and Jeanne Snelling "Doctors' rights to conscientiously object to refer patients to abortion service providers" (2019) 132(1499) NZMJ 64 at 68.
12 Holly Fernandez Lynch *Conflicts of Conscience in Health Care: An Institutional Compromise* (Massachusetts Institute of Technology Press, Cambridge (Mass), 2008).
13 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 at 201.
14 At 205.

The CSA Act defines conscientious objection as "an objection on the ground of conscience to the provision of contraception, sterilisation, or abortion services".[15] The meaning of conscience is subject to interpretation and lacks an established legal definition.[16] Conscience represents the capacity to assess the moral characteristics of actions and discern between right and wrong.[17] Conscience can guide how an individual chooses to act as well as their perceptions regarding the morality of others' behaviour.[18] There is no universally correct conscience, given the wide variation in personal values, and beliefs, including cultural, philosophical, and religious perspectives.[19]

In healthcare, a medical practitioner's conscience reflects their personal values, distinct from their clinical or professional judgment.[20] Conscientious objection arises when established professional standards clash with personal conscience.[21] By invoking conscientious objection, practitioners gain the freedom to exclude themselves from established medical practices and instead adhere to their individual beliefs.[22]

B Rationale for Conscientious Objection

Support for conscientious objection is grounded in preserving a health professional's moral integrity and autonomy.[23] The fundamental rights to freedom of conscience and belief encompass these concepts.[24] In a democratic society, people widely recognise an individual's freedom of conscience and religion as an essential human right.[25] Protecting freedom of conscience maintains

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15 Contraception, Sterilisation, and Abortion Act, s 2.

16 Udo Schuklenk "Conscientious objection in medicine: accommodation versus professionalism and the public good" (2018) 126 Br Med Bull 47 at 49.

17 *Black's Law Dictionary* (2nd ed, 1910, online ed).

18 Schuklenk, above n 16, at 49.

19 Casey M Haining and others "Abortion Law in Australia: Conscientious Objection and Implications for Access" (2022) 48(2) Monash University Law Review 1 at 8.

20 *Hospice New Zealand v Attorney-General* [2020] NZHC 1356, [2021] 3 NZLR 71 at [197].

21 Michele Saporiti "For a General Legal Theory of Conscientious Objection" (2015) 28(3) Ratio Juris 416 at 417.

22 Fiala and Arthur, above n 6, at 19.

23 Law Commission, above n 4, at 156.

24 Law Commission, above n 4, at 156.

25 UN Human Rights Committee (HRC), *CCPR General Comment No. 22: Article 18 (Freedom of Thought, Conscience or Religion)* CCPR/C/21/Rev.1/Add.4 (30 July 1993) at [1].

individual autonomy and encourages the coexistence of various diverse perspectives and ethical frameworks within a country.[26]

The NZBORA affirms the right to freedom of conscience and belief in s 13. It states that every individual has the right to freedom of conscience, religion and belief, including the right to adopt and hold opinions without interference.[27] Section 13 is also closely linked with s 15, which provides individuals the right to manifest their religion or belief in "worship, observance, practice, or teaching".[28] These rights are also protected by international law, ratified under the International Covenant on Civil and Political Rights.[29]

Given the explicit provision within the CSA Act for objections based on conscientious grounds, this analysis will emphasise the broader concept of freedom of conscience rather than religious beliefs.[30] However, freedom of conscience and religion are intricately connected and often interdependent. While freedom of religion protects an individual's religious beliefs and obligations, freedom of conscience extends beyond religion to encompass moral convictions. However, the distinction is not always clear, as individuals' religious beliefs may influence their consciences.[31] It is acknowledged that a significant proportion of conscientious objectors to abortion attribute their objection to their religious beliefs.[32]

The right to freedom of conscience supports conscientious objection by allowing health practitioners to refuse participation in activities for the provision of abortion because it conflicts with their moral convictions. Many health professionals object to performing any service in relation to the procurement of an abortion on the basis it would offend their own self-dignity.[33] Given the deeply held nature of these personal beliefs, participating in or providing assistance

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26 Andrew Butler and Petra Butler *The New Zealand Bill of Rights Act: A Commentary* (2nd ed, LexisNexis, Wellington, 2015) at [14.5.4].

27 New Zealand Bill of Rights Act 1990, s 13.

28 *New Zealand Health Professionals Alliance Inc v Attorney-General (NZ)* [2021] NZHC 2510 at [62].

29 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).

30 Contraception, Sterilisation, and Abortion Act, s 14(1).

31 Nathan Chapman "Disentangling Conscience and Religion" (2013) 4 U Ill L Rev 1457 at 1461.

32 Jonathan Kelley, MDR Evans, and Bruce Headey "Moral Reasoning and Political Conflict: The Abortion Controversy." (1993) 44(4) The British Journal of Sociology 589 at 589.

33 Mark R Wicclair *Conscientious Objection in Health Care: An Ethical Analysis* (Cambridge University Press, Cambridge, 2011) at 26.

during any part of the abortion process may be perceived as violating one's moral principles.[34] Engaging in such actions can have significant psychological consequences for individuals, including feelings of guilt and shame.[35] Preserving the moral integrity of health professionals constitutes the foundation of conscientious objection.[36]

This paper does not intend to diminish the significance of individual conscience, religious convictions, or personal moral beliefs, all of which may be valued aspects of one's identity. This article accepts that individuals benefit from adhering to a personal moral code and making choices that align with their deeply held values.[37] However, in the provision of healthcare, individual conscience does not offer a suitable basis for decision-making.[38] We should expect medical professionals to exercise professional judgment in their roles, even when doing so may compromise their moral integrity.

C Approaches to Conscientious Objection

New Zealand's approach to conscientious objection aims to balance the rights of patients and practitioners. This is often regarded as the "conventional compromise", as it maintains a middle ground by permitting conscientious objection while implementing regulatory measures.[39] This approach is the prevailing model used in developed democratic societies.[40] The legitimacy of conscientious objection relies on the condition that it must not impose any unreasonable burden on the patient, including causing delays, distress, or adverse health consequences.[41] This approach is in line with international guidelines regarding the use of conscientious objection in healthcare. The United Nations Committee on Economic, Social and Cultural Rights advised countries that when health care practitioners can utilise conscientious objection clauses, governments must

34 At 26.
35 At 26.
36 Morten Magelssen "When should conscientious objection be accepted?*"* (2011) 38 J Med Ethics 18 at 19.
37 At 18.
38 Christian Fiala and Joyce H Arthur "There is no defence for 'Conscientious objection' in reproductive health care" (2017) 216 Eur J Obstet Gynecol Reprod Biol 254 at 256.
39 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 Med Ethics 1 at 2.
40 Fiala and Arthur, above n 6, at 13.
41 Keogh and others, above n 39, at 2.

regulate the use to "ensure that it does not inhibit anyone's access to sexual and reproductive health care".[42] The Committee and other authorities regard the obligation to refer to a willing provider as the "quid pro quo" for the right to refuse.[43] New Zealand's current indirect referral requirement falls short of this international expectation.

Medical guidelines also support the right of conscientious objection. The Code of Ethics set out by the New Zealand Medical Association includes the right for doctors to refuse to care for a particular patient as long as an alternative source of care is available, and they fully inform the patient of this.[44] The Medical Council of New Zealand directly reference a doctor's conscience, including that if there is a conflict of beliefs and providing treatment or advice, the doctor should inform their patient and tell them of their right to see another doctor.[45] However, it also includes that personal political, religious and moral beliefs should not affect advice or treatment, and practitioners should not exploit patient's vulnerability.[46] Medical guidelines provide recommendations for all healthcare services provisions extending beyond reproductive health. Despite this extensive scope, reproductive health is the only sector where a legal right of refusal accompanies such guidelines.

In Australia, several states have adopted a "conventional compromise" position similar to New Zealand, allowing for conscientious objection but with specific regulations.[47] In Victoria, the Abortion Law Reform Act provides the right of conscientious objection but also imposes an obligation on healthcare practitioners.[48] They are required to directly refer the person seeking an abortion to another healthcare practitioner who does not have a conscientious objection.[49] The requirement for direct referral adds an additional step beyond New Zealand's indirect referral

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42 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) at [43].

43 *New Zealand Health Professionals Alliance Inc v Attorney-General*, above n 28, at [122].

44 New Zealand Medical Association "Code of Ethics for the New Zealand Medical Profession" (2019) <cepnz.org.nz/_files/ugd/0f3f4b_f6ca9b5b10604ffdad08e01fac262eb8.pdf> at 6 (recommendation 17). It is acknowledged that the New Zealand Medical Association has since been disestablished.

45 Medical Council of New Zealand "Good Medical Practice" (November 2021) <www.mcnz.org.nz> at 20.

46 At 20.

47 Keogh and others, above n 39, at 3.

48 Abortion Law Reform Act 2008 (Vic), s 8(1).

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

approach by directly connecting the patient with a healthcare provider who is willing to provide the requested services. This practice increases the likelihood of a streamlined transfer of care, reduces patients' vulnerability while accessing the healthcare system, and enhances overall efficiency in the process.[50] Despite this, a study found that there had been widespread negative experiences with health practitioners relying on their right of conscientious objection.[51] These instances arose due to providers falsely claiming a conscientious objection to abstain from providing abortion services, as well as health practitioners failing to fulfil their duty by not referring patients.[52]

In New Zealand, the process for healthcare professionals to claim a conscientious objection is relatively straightforward. Aside from their obligation to inform patients where they can access alternative services, healthcare professionals are only required to convey their objection to the patient.[53] The efficacy of this approach predominantly hinges upon the good faith of practitioners to only invoke conscientious objection when actioning a patient's request would genuinely conflict with their moral principles. However, as observed in Victoria, this has not been the practice, with health professionals opting out for a myriad of reasons.[54] Healthcare workers might choose to refrain from offering abortion services due to apprehensions about potential social stigma, financial repercussions, or damage to their reputation.[55]

The misuse of conscientious objection by health professionals in this manner not only undermines the conventional compromise approach but also significantly impacts the accessibility of healthcare services.[56] However, as conscience cannot be objectively verified or proven, regulating the exercise of conscientious objection becomes exceedingly difficult.[57] Some academics have proposed additional regulations for this middle-ground approach, advocating for the

50 Law Commission, above n 4, at 162.
51 Keogh and others, above n 39, at 7.
52 At 7.
53 Contraception, Sterilisation, and Abortion Act, s 14(4).
54 Keogh and others, above n 39, at 7.
55 At 8.
56 At 7.
57 Udo Schuklenk and Ricardo Smalling “Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies” (2017) 43 J Med Ethics 234 at 236.

implementation of a reasonability test when evaluating claims of conscience.[58] However, assessing the validity of held beliefs is likely arbitrary, given they may rest on deeply personal justifications.[59] Further, allocating administrative support and resources to assess healthcare workers' claims might redirect valuable assets away from more critical and urgent priorities within the healthcare sector.

This balancing act attempts to satisfy all affected parties but inadequately addresses the needs of patients seeking abortion services.[60] While the moral integrity of health professionals is important, these individual opinions should not overshadow the societal goal of providing essential healthcare services. When examining the situation in Victoria, Australia, it also becomes evident that this middle-ground approach can be vulnerable to misuse, offering an avenue for individuals without conscientious convictions to avoid participating in abortion care.[61]

III Conscientious Objection and Professional Responsibilities

A medical practitioner's objection to providing legally accessible treatment is incompatible with their role in healthcare.[62] Health professionals owe a duty of care to patients to act in their best interests and exercise clinical judgment.[63] A refusal to carry out legally recognised medical services undermines the principles of patient-centred care.[64]

58 Doug McConnell "Conscientious Objection in Health Care: Pinning down the Reasonability View" (2021) 46 The Journal of Medicine and Philosophy 37 at 38.
59 Julian Savulescu and Udo Schuklenk "Doctors Have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception" (2017) 31(3) Bioethics 162 at 167.
60 Keogh and others, above n 39, at 2.
61 At 7.
62 Wicclair, above n 33, at 43.
63 Schuklenk, above n 16, at 51.
64 Fiala and Arthur, above n 6, at 13.

A Right to Healthcare

Accessibility to abortion services is a human right.[65] It is widely recognised as an essential component of reproductive health services that safeguards women's rights.[66] Autonomy over one's own body is of fundamental importance and engages a range of crucial rights, including the right to privacy, healthcare, bodily integrity, and self-determination.[67]

New Zealand has not expressly provided for the right to healthcare in domestic legislation. However, New Zealand has committed to safeguarding the right to healthcare by ratifying international human rights treaties. The right to health is expressly stated in the International Covenant on Economic, Social, and Cultural Rights, which recognises the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[68] This also encompasses abortion services, as acknowledged by the World Health Organization, which recognises comprehensive abortion care as a vital part of essential healthcare.[69]

Reproductive rights, including legal and accessible abortion services, are a fundamental component of the human right to healthcare.[70] The decriminalisation of abortion in New Zealand also signifies a commitment to empowering women and pregnant individuals to make their own reproductive choices. New Zealand's ratification of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) further underscores the importance of reproductive rights.[71] The CEDAW mandates that states guarantee equal access to healthcare services, including family planning, and upholds women's rights to make their own reproductive

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65 United Nations 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), art 16(e) [CEDAW].

66 This article acknowledges the diversity of individuals who can become pregnant, recognizing that not all of them identify as women. To be inclusive, this article has used gender neutral terms such as “patient” whenever feasible. Nevertheless, it is important to emphasise that the issue of abortion predominantly affects women, thereby making it a significant matter for women's rights.

67 Law Commission, above n 4, at 52–56.

68 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.

69 World Health Organisation “Maintaining essential health services: operational guidance for the COVID-19 context” (1 June 2020) <www.who.int/> at 29.

70 CEDAW, above n 65.

71 CEDAW, above n 65.

choices freely.[72] Limitations and obstacles in accessing abortion care impede patients' right to healthcare.

B Distinction between Health Services

New Zealand legally recognises abortion services as a part of healthcare.[73] The passing of the Abortion Legislation Act 2020 (the ALA), which amended provisions in the CSA Act, significantly altered the position of abortion in Aotearoa. The ALA decriminalised abortion and brought the legal framework for the provision of abortion services in line with other health services.[74] By doing so, abortion is recognised as a health issue under the law, removing any previous criminal associations.[75] The ALA aimed to eliminate obstacles that previously impeded access to abortion services, including requirements such as statutory tests and limitations on self-referral.[76] However, the Act's provision for accommodating conscientious objection remained largely unchanged, allowing this barrier to persist.[77] Section 17 of the ALA modified the Health and Disability Commissioner Act, acknowledging that abortion services are now encompassed within health services.[78]

However, despite this recognition, there is a sharp contrast in how reproductive services are provided compared to other health services. Most health services operate within the general health regulatory framework rather than possessing their own separate legislation.[79] The Pae Ora (Healthy Futures) Act establishes the legislative framework for public healthcare provision in New Zealand.[80] The health sector is designed to protect and promote people's health and well-being.[81]

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72 Art 12(1) and 16(1)(e).
73 Health and Disability Commissioner Act 1994, s 2(1)(b)(ii).
74 Jeanne Snelling "Beyond Criminalisation: Abortion Law Reform in Aotearoa New Zealand" (2022) 30(2) Med Law Rev 216 at 216.
75 At 216.
76 Law Commission, above n 4, at 13.
77 Contraction, Sterilisation, and Abortion Act 1977, s 46.
78 Health and Disability Commissioner Act, s 2(1)(b)(ii).
79 Law Commission, above n 4, at 11.
80 Pae Ora (Healthy Futures) Act 2022.
81 Pae Ora (Healthy Futures) Act, s 7(1)(e).

Reproductive services are the sole category among standard health services impacted by a statutory right to conscientiously object.[82] The majority of abortions are routine and uncomplicated medical procedures comparable to other treatments an individual might undergo.[83] Therefore, the foundation for this distinction lies in the political and moral attitudes towards abortion rather than any basis differentiating the treatment medically.[84]

In most other areas of healthcare, a doctor cannot refuse to help a patient access a service that is legal, efficient, and beneficial to the care of a patient on the basis that it conflicts with their values.[85] Less realistic examples of conscientious objection in the context of healthcare can be used to show that there is no fundamental difference to justify the accommodation of conscientious objection specifically for abortion. A hypothetical situation where a health professional refuses to administer antibiotics because of their moral belief that bacteria have sanctity of life, which needs to be protected, cannot be distinguished from an objection to abortion.[86] Both scenarios involve a health professional's personal beliefs conflicting with the provision of essential healthcare; however, it is likely agreed upon that the former objection should not be accommodated by society. This example highlights that when the connotations of abortion are removed, imposing personal moral views in place of standard healthcare cannot be accepted. [87]

During the enactment of the ALA, authorities evaluated the legality of abortion in New Zealand.[88] As a result, upon the implementation of the Act, healthcare professionals should duly recognise and respect the legal status of abortion services. The legalisation of abortion affirmed its societal benefits, making it inconsistent to grant legal validity to those who dispute its value.[89]

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82 Fiala and others, above n 13, at 201. The End of Life Choice Act 2019 also includes a statutory provision for conscientious objection with regard to assisted dying services. However, conscientious objection to assisted suicide does not raise comparable concerns as those in the reproductive health sphere due to the limited prevalence of the practice.

83 Law Commission, above n 4, at 32.

84 Fiala and Arthur, above n 38, at 255.

85 Fiala and others, above n 13, at 201.

86 Alberto Giubilini "Objection to Conscience: An Argument Against Conscience Exemptions in Healthcare" (2017) 31 Bioethics 400 at 403.

87 At 407.

88 Abortion Legislation Bill 2019 (164-3) (select committee report) at 33.

89 Fiala and others, above n 13, at 204; and Savulescu and Schuklenk, above n 59, at 167.

Additionally, conscientious objection reinforces the unwanted stigma of abortion as a morally 'wrong' practice, a purely subjective belief that should not underpin the basis for abortion law.[90]

The argument against the provision of conscientious objection has a strong foundation in the fact that no other healthcare procedure receives comparable treatment.

C Tension between Personal Conscience and Healthcare

Tension arises as the provision for conscientious objection allows health practitioners to assert their personal views and beliefs, overriding the obligation to adhere to objective medical standards. Conscientious objection to abortion often stems from personal moral and religious beliefs that lack support from established medical and legal standards.[91] This inherent subjectivity and the absence of verifiability creates a conflict between the acceptability of conscientious objection and the principles of evidence-based medicine.[92] Evidence-based medicine relies on scientific research and clinical expertise to guide medical practices and prioritise patient well-being.[93] Accepting conscience-based claims in health care is expressly inconsistent with this foundation.[94]

Ensuring access to healthcare relies fundamentally on the willingness of health practitioners to provide services to patients.[95] If healthcare professionals have the necessary training and skills to deliver a legally recognised healthcare service, they have no valid rationale to abstain from providing it. The refusal to provide abortion services represents an abandonment of the professional obligation to provide the requested and necessary treatment.[96] A fundamental tenet of the medical profession is the commitment to act in the patient's best interests.[97] This should not be discarded when a healthcare provider's conscience does not align with the optimal care of the patient.

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90 Fiala and Arthur, above n 38, at 255.
91 At 254.
92 At 255.
93 Steven Tenny and Matthew Varacallo *Evidence Based Medicine* (StatPearls Publishing, Florida, 2022).
94 Schuklenk, above n 16, at 51.
95 Law Commission, above n 4, at 157.
96 Savulescu and Schuklenk, above n 59, at 167.
97 Fiala and Arthur, above n 6, at 17.

Healthcare professionals owe a professional duty to provide health services within their scope.[98] This duty is also reflected in the health practitioner's professional and legal obligation to provide medical assistance in an emergency, regardless of any claims of conscientious objection.[99] The exclusion of conscientious objection in emergencies provides an argument against its allowance altogether. As medical professionals are obligated to prioritise the immediate health and safety of patients in urgent situations, it raises questions about the validity of failing to prioritise this standard of care in non-emergency contexts.

The distinctive attributes of the medical profession intensify this professional duty. The medical profession's defining feature is its monopoly over the delivery of healthcare services.[100] Society depends on health professionals to deliver necessary medical care in line with accepted medical practices.[101] Healthcare professionals hold significant power and authority as the exclusive providers of essential services.[102] The medical profession intentionally imposes restrictions through rigorous training and skill requirements to maximise the public good.[103] This rests on the expectation that healthcare professionals will use their skills to serve individuals' healthcare needs and promote the community's overall well-being.[104] When a healthcare professional declines to offer an otherwise available health service, they compromise the broader provision of healthcare. The practice of conscientious objection not only breaches the professional duty to provide accepted healthcare but also infringes upon individuals' right to receive essential medical services.

Conscientious objection undermines the importance of abortion as a healthcare issue and compromises the duty of care that healthcare professionals owe to their patients.[105] Allowing personal beliefs to interfere with the provision of comprehensive and equitable care undermines the position of abortion as a legally validated and medically approved practice.[106] It is imperative

98 Haining and others, above n 19, at 7.
99 Contraception, Sterilisation, and Abortion Act, s 14(4).
100 Schuklenk and Smalling, above n 57, at 236.
101 At 236.
102 T A Cavanaugh “Professional Conscientious Objection in Medicine with Attention to Referral” (2011) 9 Ave Maria Law Review 189 at 196.
103 Schuklenk, above n 16, at 53.
104 Fiala and Arthur, above n 6, at 15.
105 Savulescu and Schuklenk, above n 59, at 167.
106 Haining and others, above n 19, at 2.

to prioritise evidence-based practices and ensure that individuals seeking abortion receive the necessary care.

IV Impacts of Conscientious Objection

The importance of abortion in healthcare cannot be overstated. However, the exercise of conscientious objection significantly undermines the provision of abortion care.[107] The negative impacts of allowing conscientious objection include delays in accessing care, financial and economic costs on patients, unjust stigmatisation of abortion services, and increased burdens on non-objecting health providers. After considering the societal value of access to abortion, this section elaborates on each of these points.

The CSA Act encompasses a range of reproductive-based services, including contraception and sterilisation. However, this paper will primarily focus on the provision of abortion services and information or advice concerning the termination of pregnancy. Among these services, abortion is regarded as the most contentious within this category, thus offering a suitable basis for analysing conscientious objection within New Zealand.[108]

A Significance of Accessibility to Abortion Services

While this paper does not undertake an exhaustive examination of the profound importance of access to abortion, it is advantageous to provide an outline of how abortion impacts society. Abortion services safeguard bodily autonomy, support women's livelihoods, and enable individuals to make informed decisions about their reproductive health.[109] Approximately one in four women in New Zealand will have an abortion in their lifetime, therefore making the regulation of abortion law central to the protection of women's rights.[110]

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107 Law Commission, above n 4, at 157.

108 Christopher Kaczor *The Ethics of Abortion: Women's Rights, Human Life, and the Question of Justice* (3rd ed, Taylor & Francis Group, New York, 2022) at 243.

109 *R v Morgentaler* [1988] 1 SCR 30 at 166, 171 and 173.

110 Catriona Melville "Abortion care in Australasia: A matter of health, not politics or religion" (2022) 62 Aust N Z J Obstet Gynaecol 187 at 187.

Pregnant women should maintain complete control over making decisions about their bodies and exercising their choice regarding if and when to have children. Improving access to abortion plays a crucial role in supporting women's livelihoods, which is fundamental in pursuing the goal of gender equality.[111] Empowering women with the freedom to choose allows them to make decisions that align with their personal goals.[112] Enabling safe abortions allows women to pursue education, enhance their careers, and fully participate in the workforce.[113] It helps to reduce barriers that have previously hindered women's economic independence by not limiting their role to bearing children.[114]

B Consequences of Conscientious Objection

The exercise of conscientious objection provisions in healthcare can result in detrimental consequences such as delays in obtaining essential care, geographical barriers that limit access, and the imposition of judgment on individuals seeking abortion services.[115]

A study conducted 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 participants expressed objections to providing abortion services based on conscientious or religious beliefs.[116] It can be suggested that individuals who choose to enter fields related to reproductive health may have a lower likelihood of objecting to providing abortion services due to the nature of their chosen profession.[117] Consequently, a higher proportion of general health practitioners would likely object to performing abortion services. Additionally, while evidence of the number of conscientious

111 Tanni Mukhopadhyay "Women's reproductive rights are human rights" (11 July 2017) Human Development Reports <www.hdr.undp.org>.
112 Fiala and Arthur, above n 6, at 16.
113 Mukhopadhyay, above n 111.
114 Mukhopadhyay, above n 111.
115 Ballantyne, Gavaghan and Snelling, above n 11, at 68.
116 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.
117 Anastasia Theodosiou and Oliver R Mitchell "Abortion legislation: exploring perspectives of general practitioners and obstetrics and gynaecology clinicians" (2015) 30 Reproductive BioMedicine Online 197 at 200.

objectors among general practitioners is limited, informal observations have found the practice to be "quite common".[118] This presence of conscientious objectors could result in challenges for women in finding willing and supportive healthcare providers, thereby creating potential barriers to access within New Zealand.[119]

While individuals in New Zealand now have the option of self-referral, many are likely to rely on local healthcare providers or their general practitioners as their initial point of contact for health concerns. In such cases, an objecting health practitioner would prevent an individual from receiving appropriate medical care at first instance and require them to take further steps to access a non-objecting health provider. The exercise of conscientious objection can force patients to delay their abortion, as they have to organise alternative arrangements.[120] Delay specifically reduces the likelihood of being able to access an early medical abortion (EMA), as this method can only be carried out within the first ten weeks of gestation.[121] Consequently, even minor delays could eliminate the option of utilising this method, potentially requiring a pregnant individual to undergo a surgical abortion.[122] EMAs involve ingesting medication that induces a miscarriage, allowing pregnant individuals to undergo the procedure in the comfort of their homes.[123] This alternative can be more appealing than a surgical abortion, offering a heightened sense of naturalness and privacy.[124] Early abortions are safer and less complicated, which helps to minimise the potential physical and psychological harm for individuals seeking termination of a pregnancy.[125] Any delays or obstacles in getting reasonable legal access to abortion services can result in riskier or more invasive procedures being carried out.[126] This is a particular issue in New Zealand, where abortions are accessed significantly later than in other jurisdictions, as explored later in the article.[127]

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118 Law Commission, above n 4, at 111 n 66.
119 Ballantyne, Gavaghan and Snelling, above n 11, at 68.
120 Ballantyne, Gavaghan and Snelling, above n 11, at 68.
121 Ministry of Health "Abortion Services Aotearoa New Zealand: Annual Report 2022" (28 October 2022) <www.health.govt.nz> at 19; and Law Commission, above n 4, at 33.
122 Abortion Services in New Zealand "Abortion Procedures" <www.abortion.org.nz>.
123 National Women's Health "Medical Termination" Te Whatu Ora <www.nationalwomenshealth.adhb.govt.nz>.
124 National Women's Health, above n 123.
125 Martha Silva, Rob McNeill and Toni Ashton "Factors affecting delays in first trimester pregnancy termination services in New Zealand" (2011) 35(2) Aust NZ J Public Health 140 at 140.
126 Law Commission, above n 4, at 32.
127 Ballantyne, Gavaghan and Snelling, above n 11, at 69.

Objecting health providers especially pose an issue for those in rural or isolated regions of New Zealand, where alternative services like Family Planning may not be accessible, requiring them to undertake significant travel to obtain abortion care.[128] This may also lead to a financial cost to patients, possibly paying for multiple appointments alongside the cost of travel. In contrast, healthcare professionals can still claim payment for the appointment where they refused to perform essential public services based on personal grounds.[129]

In Italy, conscientious objection remains largely unregulated, shedding light on the implications on access to abortion services.[130] Abortion is a legal right in Italy; however, the widespread practice of conscientious objection makes it extremely hard for pregnant persons to access it.[131] According to 2020 statistics, approximately 65% of Italian gynaecologists identify as conscientious objectors, escalating to nearly 85% in certain regions.[132] In contrast to New Zealand, where any qualified health practitioner is authorised to provide abortions, Italy restricts the provision of abortions exclusively to gynaecologists and obstetricians.[133] Given this restriction and the substantial number of objectors, individuals seeking abortions in Italy face barriers to accessing safe and prompt services. Many must travel to other areas of Italy or internationally to carry out the procedure.[134] The European Committee of Social Rights held that Italy's widespread and largely unregulated use of conscientious objection impeded access to abortion services, thereby violating the right to health as outlined in the European Social Charter.[135] Despite being significantly higher than the prevalence of conscientious objection in New Zealand, it clearly illustrates the substantial impact of conscientious objection on abortion access, even in cases where abortion is a legally protected right.

128 At 68; and Law Commission, above n 4, at 158.
129 Ballantyne, Gavaghan and Snelling, above n 11, at 68.
130 Francesca Minerva "Conscientious objection in Italy" (2015) 41 J Med Ethics 170 at 170.
131 Tommaso Autorino, Francesco Mattioli and Letizia Mencarini "The impact of gynaecologists' conscientious objection on abortion access" (2020) 87 Social Science Research 1 at 14.
132 At 1.
133 Minerva, above n 130, at 170.
134 At 171.
135 At 171.

Conscientious objection also significantly compromises the dignity of individuals seeking abortion services by subjecting them to unwarranted judgment.[136] The moral stigma and societal opinions already associated with abortion can impose a considerable mental burden on a patient contemplating having an abortion.[137] Facing a rejection based on conscientious objection could significantly aggravate these mental impacts.[138] A pregnant individual could perceive the act of conscientious objection as a moral criticism of their choice. Given the vulnerability of many in the position of considering or seeking an abortion, such a perception could strongly impact their self-esteem.[139] Further, conscientious objection perpetuates the stigma surrounding abortion as a morally objectionable act, which is rooted in subjective beliefs and should not serve as the foundation for abortion legislation.[140]

The exercise of conscientious objection places an unfair burden on non-objecting health professionals. Those willing to perform abortion services face an increased workload due to assuming the responsibilities of objecting health workers.[141] A study found that non-objecting health workers often encountered stigma and judgement from their colleagues for their stance.[142] In comparison, objectors faced no consequences for their failure to fulfil professional obligations or for burdening other health professionals.[143] This issue worsens when health professionals claim a conscientious objection to evade their professional duties, even without genuine conscientious or moral objections to providing abortion services.[144]

Conscientious objection can hinder access to certain healthcare services and impose financial and timely burdens on individuals. In New Zealand's patient-centred public health system, the disadvantages associated with the exercise of conscientious objection disproportionately affect vulnerable pregnant individuals rather than the objecting healthcare providers.[145] This highlights

136 Ballantyne, Gavaghan and Snelling, above n 11, at 68.
137 Law Commission, above n 4, at 213.
138 Fiala and Arthur, above n 6, at 15.
139 At 15.
140 Fiala and Arthur, above n 38, at 255.
141 Fiona de Londras and others "The Impact of 'conscientious objection' on abortion-related outcomes: A synthesis of legal and health evidence" (2023) 129 Health Policy 1 at 8.
142 At 9.
143 At 9.
144 Keogh and others, above n 39, at 7.
145 Ballantyne, Gavaghan and Snelling, above n 11, at 68.

the inequity and impact of conscientious objection on patients, emphasising the limitations of accommodating such objections.

V Abolishing Conscientious Objection

In addition to the theoretical considerations, a comprehensive assessment of the potential implications of prohibiting conscientious objection within New Zealand's healthcare system is crucial. Advocates of conscientious objection maintain that adverse consequences would arise from denying the right to refusal, suggesting that the delivery of healthcare services would be negatively impacted.[146] However, the strength of this argument diminishes upon analysis of countries that do not have a right of conscientious objection. Analysing health systems that have effectively eliminated conscientious objection reveals the practical feasibility and benefits of implementing such bans.

A Successful Cases of Eliminating Conscientious Objection.

Sweden and Finland offer examples of democratic societies that have effectively restricted or disallowed conscientious objection.[147]

Sweden is one of the few countries that do not provide a legal right for healthcare professionals to refuse to perform a legal, medical service on the grounds of conscientious objection.[148] Swedish abortion law has been characterised as some of the world's most progressive and permissive legislation.[149] The country legalised abortion in 1975, with subsequent amendments in 1996 allowing self-referral for abortion services until the 18th week of pregnancy.[150]

146 Lynch, above n 12, at 85.
147 Fiala and others, above n 13, at 201.
148 At 202.
149 Marge Berer "Abortion Law and Policy Around the World" (2017) 19(1) Health Hum Rights 13 at 21.
150 Fiala and others, above n 13, at 201.

Abortion care is an integral and compulsory component of medical training and a professional expectation for individuals pursuing careers in midwifery, obstetrics, and gynaecology.[151] Unlike New Zealand, hospitals are able to decline employment to healthcare workers who hold objections to providing abortion services.[152] The European Committee of Social Rights and the European Court of Human Rights (ECHR) have upheld this ability numerous times.[153] In *Grimmark v Sweden,* an objecting nurse contended that the Swedish authorities had infringed upon her freedom of conscience and religion by preventing her from working as a midwife. She further argued that refusing to hire her on this basis amounted to discrimination.[154] The ECHR held that interference with the manifestation of her religion was justified in the pursuit of safeguarding women's health and ensuring the provision of abortion services.[155] The Court determined that employers possess the right to select employees based on their ability to fulfil the responsibilities associated with midwifery, including handling abortion cases. The exercise of this right by health centres to screen out potential employees with objections does not amount to discrimination against individuals due to their religious beliefs.[156]

The barriers to accessing abortion services in Sweden are minimal, as hospitals are mandated to perform abortions without delay, and there are no geographical limitations on access.[157] This commitment to providing timely and unrestricted abortion care underscores Sweden's progressive stance on reproductive healthcare, ensuring that individuals have equitable and convenient access to the services they need.

While Finland has stricter statutory regulations regarding access to abortion, it also adopts a more progressive stance on conscientious objection than New Zealand.[158] Accessing abortion services involves an application process in which patients must provide a justification for the abortion and

151 Keogh and others, above n 39, at 2.
152 Fiala and others, above n 13, at 202.
153 At 202; and *Grimmark v Sweden* ECHR 43726/17, 11 February 2020; and *Steen v Sweden* ECHR 62309/17, 11 February 2020.
154 *Grimmark v Sweden*, above n 153, at [17]–[19].
155 At [25]–[26].
156 At [26] and [43].
157 Fiala and others, above n 13, at 202.
158 At 202.

obtain approval from multiple doctors.[159] Despite this, individuals accessing these services receive comprehensive care, and their decision to terminate their pregnancy is widely accepted and respected. [160] One contributing factor to this is the absence of conscientious objection. In public healthcare, doctors are prohibited from refusing to consider an abortion application, and all healthcare professionals employed in public gynaecological clinics are obligated to participate in abortion care.[161]

The benefits of adopting a progressive approach to abortion and conscientious objection are evident in the timing of access to abortion services, where a lower gestational age signifies fewer barriers and contributes to safer and more effective treatment for pregnant persons.[162] In Sweden, approximately 93% of abortions occur within the first eight weeks, and medical abortions account for 90% of abortions.[163] In contrast, New Zealand records a lower proportion of medical abortions, accounting for only 44% of abortion procedures in 2021,[164] and less than half of abortions occurred before eight weeks gestation.[165]

B Challenging the Practical Justifications for Conscientious Objection

Supporters of conscientious objection not only emphasise the internal importance of upholding practitioners' conscience but also present practical reasons in its favour.[166] However, there is a lack of any supporting evidence for the actualisation of these arguments.

One concern of disallowing conscientious objection is the limitation of diversity in the health profession.[167] This restriction affects both the range of individuals working in the field and the variety of moral opinions they bring to the practice.[168] Some advocates for conscientious objection

159 At 203.
160 At 203.
161 At 203.
162 Law Commission, above n 4, at 33.
163 Fiala and others, above n 13, at 202.
164 Ministry of Health, above n 121, at 22.
165 Ministry of Health "Abortion Services Aotearoa New Zealand: Annual Report 2021" (15 October 2021) <www.health.govt.nz> at 9.
166 Schuklenk, above n 16, at 50.
167 Lynch, above n 12, at 85.
168 Lynch, above n 12.

assert that the presence of diverse ethical and moral views in healthcare will diminish, limiting critical professional discourse.[169] However, disallowing conscientious objection would not separate morality and clinical judgment entirely. Healthcare professionals would likely continue to uphold their beliefs regarding the morality of abortion services, even when they cannot adhere to those beliefs.[170] The relationship between morality and healthcare is an essential consideration in debate about medical practices. However, this discourse is more vital in policy-making stages where advancements are being considered rather than in situations where established medical practices exist and need to be implemented.[171]

There are also arguments that people may leave the profession altogether if 'forced' to participate in abortion services, and losing qualified health professionals who may excel in other areas negatively impacts the provision of health services.[172] However, this demonstrates a degree of oversimplification in its approach to the prohibition of conscientious objection and does not align with the observed responses.[173] In many areas of medicine, participating in abortion services would not be expected, and a practitioner's skills could be utilised.[174] Professionals in fields like general practice, nursing, midwifery, and obstetricians/gynaecologists (OB/GYNs) are all likely to encounter aspects of abortion care at some stage in their careers.[175] This contrasts with other specialisations like dermatology or plastic surgery, where this issue is unlikely to arise.[176] Therefore, there should be no accommodation for health professionals who voluntarily entered their respective fields but then wish to be exempt from fulfilling the expected duties of that profession.[177] Professionals with strong objections to performing abortions should be advised not to choose pathways that could bring about conflicts of conscience.[178] In Sweden, professionals who object to participating in abortion care cannot become OB/GYNs or midwives.[179] This is assisted by discouraging medical and nursing students from entering those specialities if they are

169 Lynch, above n 12.
170 *New Zealand Health Professionals Alliance Inc v Attorney-General,* above n 28, at [87].
171 Schuklenk, above n 16, at 53.
172 Wicclair, above n 33, at 30.
173 Savulescu and Schuklenk, above n 59, at 163.
174 Fiala and others, above n 13, at 202.
175 Fiala and Arthur, above n 38, at 257.
176 Schuklenk and Smalling, above n 57, at 239.
177 At 238.
178 At 239.
179 Fiala and others, above n 13, at 202.

unwilling to partake.[180] In *Grimmark v Sweden*, a nurse's refusal to participate in abortion services did not result in her being excluded from working within the entire Swedish healthcare system.[181] However, she was not accepted for women's healthcare positions,[182] such as midwifery, where abortion is considered an essential aspect of the profession.[183]

The Swedish standpoint reassures objectors that they are never obligated to act against their conscience, although they may have to accept the consequences of their choice.[184] A health professional who cannot bring themselves to engage in abortion services can avoid it simply by seeking alternative employment.[185] Exclusion from specific health sectors should be a consequence for the objecting health professional to bear. The monopolistic nature of the health sector also justifies any screening out of professionals who are not willing to provide services within their role.[186] Given the critical nature of proper medical care, the medical profession must comprise professionals who adhere to generally accepted medical practices, including those related to abortion. Entering a profession is a voluntary choice, and as such, individuals who cannot fulfil the required duties and responsibilities of their profession, such as providing abortion services, should be replaced with those who will.[187] This aligns with occupations beyond the healthcare sector, where a reluctance to fulfil necessary job responsibilities would make you an unsuitable candidate.[188] This approach guarantees the ongoing provision of essential and ethical healthcare services.

Alternatively, healthcare professionals might stay within those areas and participate despite their moral reservations. This raises the concern that patients may receive substandard care from unwilling health practitioners providing reproductive services.[189] This scenario could arise because healthcare professionals reluctantly fulfil their duty to assist a patient while holding reservations

180 At 202.
181 *Grimmark v Sweden*, above n 153, *at* [26].
182 At [4] and [5].
183 Fiala and others, above n 13, at 202.
184 Christian Munthe "Conscientious refusal in healthcare: the Swedish solution" (2016) 43 J Med Ethics 257 at 258.
185 At 258.
186 Schuklenk, above n 16, at 52.
187 Schuklenk and Smalling, above n 57, at 238.
188 At 238.
189 Savulescu and Schuklenk, above n 59, at 163.

or showing a lack of support for the procedure. However, evidence supporting this proposition is scarce.[190] Health professionals have an obligation to treat their patients with care and respect, free from personal bias.[191] Although unlikely, breaches of these professional standards should be subject to appropriate disciplinary actions to maintain patient trust and professional integrity.[192]

C Balancing Rights

The legal framework surrounding conscientious objection is shaped by the attempt to balance the right to healthcare and the right to freedom of conscience.[193] Objecting healthcare professionals would argue that eliminating the right to refusal constitutes a violation of their conscience, as protected by NZBORA.[194]

Whether the current indirect referral required of health professionals legally engages the rights relating to conscience was considered by the High Court in the recent case of *New Zealand Health Professionals Alliance Incorporated v Attorney-General.*[195] The plaintiffs in the case were a body of health professionals who objected to the current obligation of indirectly referring patients, asserting that it conflicted with their fundamental rights.[196] Ellis J concluded that s 14 of the CSA Act did not engage ss 13 and 15 of the NZBORA, providing the right to freedom of conscience and the manifestation of this belief in practice.[197] Section 13 was not engaged as it protects internal thought processes that are unaffected by an obligation to act.[198] The purpose of the indirect referral requirement in s 14 of the CSA Act is not to impact their subjective beliefs but to ensure action despite their deeply held convictions.[199] In bringing this case, the plaintiffs prove that such a requirement does not influence their internally held opinions, as they aim to uphold those beliefs.[200] This reasoning can be employed to assess whether removing the right of refusal would

190 At 163.
191 Medical Council of New Zealand, above n 45, at 1 and 20.
192 Savulescu and Schuklenk, above n 59, at 163.
193 *New Zealand Health Professionals Alliance Inc v Attorney-General,* above n 28, at [190].
194 At [57].
195 *New Zealand Health Professionals Alliance Inc v Attorney-General,* above n 28.
196 At [61].
197 At [86].
198 At [111] and [88].
199 At [87].
200 At [87].

breach s 13. Similarly, an obligation to engage in abortion services or provide abortion-related information would not impede a health professional's freedom to maintain their internal beliefs.

Section 15 was also held not to be engaged as the provision of information required by s 14 of the CSA Act did not constitute practice and observance of one's beliefs.[201] The scope of 'practice' does not encompass every act or omission motivated by religion or conscientious opinion.[202] The ECHR in *Pichon and Sajous v France* maintained that a refusal by conscientiously objecting pharmacists to supply contraceptives did not constitute a qualifying "manifestation" of religious belief.[203] This was held as the sale of contraception was a legal duty, and the pharmacist could manifest their beliefs outside of their professional sphere.[204] This reasoning might also be applied to conscientious objecting health professionals declining to offer abortion services. Health professionals would be obligated to engage with abortion care only when acting in their professional capacity and are similarly not limited in expressing their beliefs privately. It should be acceptable to enforce such limitations in the workplace when the expression of these beliefs is inconsistent with established professional standards. However, withholding contraception may be less connected to the belief that abortion is morally unacceptable than the direct provision of those services. Hence, the decision to refuse participation in abortion services could be a manifestation of that belief, therefore engaging s 15 of NZBORA.

1 Justified limitations on the rights to freedom of conscience and belief.

Rights and freedoms contained in the NZBORA may be subject only to "such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society".[205] In *New Zealand Health Professionals Alliance Inc v Attorney-General*, Ellis J held that the right to freedom of conscience, enshrined in s 13, is an absolute internal right that cannot be limited

201 At [111].
202 At [113].
203 *Pichon and Sajous v France* [2001] ECHR 898.
204 *Pichon and Sajous v France*, above n 178.
205 New Zealand Bill of Rights Act, s 5.

because no external act can alter an individual's personally held beliefs.[206] In comparison, the right of every person to manifest their beliefs may be justifiably limited.[207]

This article argues that excluding conscientious objection in the context of reproductive healthcare could be justified in limiting the right to manifest one's conscience. Ensuring the right to reproductive healthcare, including access to abortion services, is paramount and warrants limitations on a health professional's manifestation of belief.

The New Zealand Supreme Court in *R v Hansen* adopted the Canadian *Oakes* test to analyse what constitutes a reasonable and justified limit on a right under s 5 of NZBORA.[208] Ellis J set out the approach to be taken as below:[209]

> "[177] Limits on rights fall to be considered under s 5 in accordance with the Oakes test. In order for such a limit to be justified:
>
> (a) the objective of the impugned provision must be of sufficient importance to warrant overriding a constitutionally protected right or freedom, meaning it must relate to concerns that are pressing and substantial in a free and democratic society; and
>
> (b) the means chosen to achieve the objective must pass a proportionality test, meaning that they must:
>
> (i) be "rationally connected" to the objective and not be arbitrary, unfair or based on irrational considerations.
>
> (ii) impair the right or freedom in question as "little as possible"; and
>
> (iii) be such that their limitation of rights and freedoms are proportional to the objective."

Accessibility of abortion services is significantly important in a free and democratic society. The public interest in providing safe and accessible abortion care, considering its impacts on bodily autonomy and women's rights, justifies the restrictions on the manifestation of conscience.[210] This

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206 *New Zealand Health Professionals Alliance Inc v Attorney-General,* above n 28, at [65].
207 At [65].
208 *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 at [103]–[104] per Tipping J, citing *R v Oakes* [1986] 1 SCR 103.
209 *New Zealand Health Professionals Alliance Inc v Attorney-General,* above n 28, at [177].
210 Fiala and Arthur, above n 6, at 20.

approach prioritises the needs of patients accessing healthcare rather than the subjective beliefs of healthcare providers.

Removing the right of refusal is proportional to the objective of ensuring accessibility to abortion services. Requiring health professionals to deliver abortion services can be directly linked to the overarching goal of enhancing the availability of abortion care.[211] It is neither arbitrary nor unjust to expect that health professionals will actively participate in the fundamental duties of their profession.[212] In comparison, permitting conscientious objection introduces arbitrary and unfair elements to the provision of abortion services. Conscientious objection undermines the rule of equality under the law by prioritising the subjective beliefs of objecting health professionals and allowing them to impose burdens on others. Additionally, conscientious objection lacks consistency in its application across various health services, with a particular and outdated focus on reproductive health services.[213] Removing the legal right to conscientious objection would reinstate a fair and just position.

The obligation to participate in these services imposes a minimal infringement on the expression of personal beliefs, given that it is not concerned with disseminating those beliefs through teaching or worship.[214] Instead, it solely relates to professional practice that could potentially intersect with the exercise of this right. Beyond their medical responsibilities, a health professional's ability to manifest their beliefs remains unimpaired.[215]

The Swedish and Finnish systems provide an exemplary approach to balancing rights concerning conscientious objection, prioritising patient's rights.[216] Courts and tribunals in Sweden have consistently ruled that the right of women to access reproductive healthcare takes precedence over the right of healthcare professionals to refuse care based on personal beliefs.[217] This demonstrates that the inclusion of the right to conscientious objection is not an inherent requirement and can be

211 Fiala and others, above n 13, at 205.
212 Christian Munthe and Morten Ebbe Juul Nielsen "The Legal Ethical Backbone of Conscientious Refusal" (2016) 26(1) Cambridge Quarterly of Healthcare Ethics 59 at 65.
213 At 63.
214 *New Zealand Health Professionals Alliance Inc v Attorney-General,* above n 28, at [111].
215 *Pichon and Sajous v France,* above n 178.
216 Fiala and others, above n 13.
217 At 202.

re-evaluated in democratic societies with widespread acceptance of the importance of robust reproductive healthcare.

D Reform

This paper advocates for removing the right to conscientiously object to abortion services set out in New Zealand's CSA Act. New Zealand should place the utmost priority on upholding medical standards and ensuring the provision of high-quality patient care. As demonstrated by Sweden and Finland, this approach is practical and optimal. In these countries, barriers to access are nearly non-existent, and healthcare professionals have not suffered unfair disadvantages.[218] A zero-tolerance policy eliminates the potential for misuse or uncertainty in healthcare practice. Healthcare professionals are fully aware of what is expected of them when they enter their field, enabling them to make informed career decisions.[219] Additionally, under this approach, conscientious objection does not allow healthcare professionals to evade their responsibilities for other reasons.

However, New Zealand cannot exclusively achieve the reform of conscientious objection through legal amendments. While legal changes remain significant, they must be accompanied by the evolution of societal perspectives and clinical practices.[220] Conscientious objection in reproductive healthcare is associated with broader societal influences, including the impact of religion in a country, patriarchal ideals, and conservative viewpoints regarding the morality of abortion.[221] The success of some Nordic countries in effectively managing conscientious objection can be attributed not only to their strong legal frameworks but also to the widespread acceptance of women's rights, gender equality, and evidence-based decision-making.[222] This is supported by the finding that conscientious objection is less common in countries where the law and public opinion normalise and accept abortion and value women's autonomy.[223]

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218 At 205.
219 At 204.
220 Keogh and others, above n 39, at 2.
221 Fiala and Arthur, above n 38, at 255 and 257.
222 Fiala and others, above n 13, at 204.
223 Wendy Chavkin, Liddy Leitmana and Kate Polin "Conscientious objection and refusal to provide reproductive healthcare: a White Paper examining prevalence, health consequences, and policy responses" (2013) 123 Int J Gynaecol Obstet 41 at 51.

Therefore, New Zealand may face challenges in successfully implementing legal changes due to its comparatively less progressive approach to reproductive health. This is evident in the delayed reform in the area; abortion was only recently decriminalised in 2020, with the Bill passing the House of Representatives with less than 60% support.[224] Additionally, there remains substantial support for the inclusion of conscientious objections by the New Zealand Law Commission and various medical associations. [225]

Despite this potential limitation, it should not deter the pursuit of reform. Legal changes can serve as a catalyst in the broader process of destigmatising and normalising abortion services within society. Through legal change, there is an opportunity to influence societal attitudes towards greater acceptance, thereby promoting the widespread provision of abortion services.

VI Conclusion

Conscientious objection to abortion is a contentious aspect of legal frameworks, engaging many rights, varying opinions, and societal attitudes. The current middle-ground approach attempts to balance this by weighing the rights of health practitioners against the rights of patients to access abortion services.[226] However, the notion that laws concerning conscientious objection need to satisfy all affected parties is flawed. In the provision of healthcare, society should prioritise patients' rights to access care. This should take precedence over conscience-based claims of refusal.

The current practice of conscientious objection affords health professionals extensive freedom to abandon their fundamental responsibilities. Permitting healthcare workers to make decisions based on their subjective beliefs undermines the commitment to provide care according to medical health standards. Moreover, conscience-based refusals impose unfair burdens on individuals seeking access to essential health services. The resulting delays in care, unwarranted judgment, and

224 (18 March 2020) 745 NZPD 17197.
225 Ballantyne, Gavaghan and Snelling, above n 11, at 66.
226 *New Zealand Health Professionals Alliance Inc v Attorney-General*, above n 28, at [190].

financial repercussions are unjustifiable burdens to place on vulnerable individuals who have a right to access abortion care.

Eliminating the legal right and practice of conscientious objection is the only effective way to adequately uphold patients' rights. Contrary to some scholarly opinions, banning conscience-based refusals does not impose unjustifiable impacts on health practitioners, neither in terms of limiting their freedom of conscience nor occupational burdens they may face.[227] There should be no tolerance for conscience-based refusals to safeguard patients' rights and well-being and establish a genuinely patient-centred and equitable healthcare system. While implementing reform can be challenging, legislative changes hold the promise of creating a more inclusive and accepting environment for abortion services.

227 Fiala and others, above n 13, at 202.

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