Comment on judgment MacKenzie J, 2 December 2010

This judgment must be read in conjunction with the revised guidelines from the Medical Council of New Zealand (MCNZ) *Beliefs and medical practice* dated October 2010. The revised guidelines are substantially different from the draft guidelines dated March 2009 as a result of submissions from a number of interested parties including a group of anti-abortion doctors who banded together under the name of New Zealand Health Professionals Alliance Inc (NZHPA) in November 2009 expressly to challenge the MCNZ's guidelines. ALRANZ also made a submission but only the NZHPA was accorded negotiating status with the MCNZ. When the NZHPA and the MCNZ failed to reach an agreement the NZHPA initiated court proceedings. The case was heard in the Wellington High Court on 1-2 November 2011 and the reserved judgment of MacKenzie J was delivered on 2 December 2010.

There was no argument about the right to exercise a conscientious objection to abortion as this is clearly provided for in s46(1) of the Contraception Sterilisation & Abortion Act (CS&A).

Where the two sides differed was in the extent to which a doctor was obliged to go in referring the woman on for treatment. The NZHPA argued that any involvement in an abortion referral was abhorrent. Because of the confusing wording in the CS&A Act they could point to legitimate reasons not to be involved e.g. s32 of the CS&A Act which says that referral is only required if the woman requests it and only if the doctor considers the woman has legal grounds for abortion. They could also point to the imprecise wording of s174 of the Health Practitioners Competence Assurance Act (HPCA) that allows for the exercise of conscientious objection for "other reproductive health services" but does not specify abortion. Thankfully the judge closed both of these loopholes.

On the other hand the MCNZ placed greater emphasis on good medical practice and the importance of not allowing personal views to prejudice the care of patients. In the revised guidelines at para 17 MCNZ advises that "If you feel your beliefs might affect the advice or treatment you provide, or if you choose not to provide a service because of a conscientious objection, you must explain this to patients and advise them of their right to see another doctor. You must ensure that the patient has sufficient information to exercise that right" as provided by clause 20 of another MCNZ document G*ood medical practice.*

In the revised guidelines at para 27 the MCNZ highlights s32 of the CS&A Act which stipulates that <u>every doctor</u> should arrange for the case to be considered if requested to do so according to the procedures set down, but later on at para 32 the guidelines allow an exception if the doctor has a conscientious objection to abortion. In that case the doctor must arrange for the case to be considered by another medical practitioner and importantly one that will provide abortion services.

However there is no section of the CS&A Act or the HPCA Act that stipulates a legal obligation to explain to the patient that the doctor has a conscientious objection and no section that specifically covers the details of the procedure for referral when the doctor has a conscientious objection. This is covered in the MCNZ guidelines more under the category of professional standards or best medical practice. In paras 14-18 the guidelines recommend that the doctor explain that they have a conscientious objection, and the doctor should provide the patient with the names and contact details in the area of another who can provide abortion services. Furthermore the doctor must take all reasonable steps to ensure that arrangements are made, without delay, for another doctor to take over her care. None of this is strictly required by law.

MacKenzie J places greatest emphasis on s174 of the HPCA Act which sets out the statutory duty of the doctor with a conscientious objection to abortion which is simply to inform the patient that she

can obtain the service from another health practitioner or from a family planning clinic. Limited though it is this is the maximumrequirement and some anti-abortion doctors find even this a step too far. Other anti-abortion doctors may feel more comfortable making a referral.

Supporting some of the arguments of the antis, but rejecting others, the judge has recommended that the MCNZ amend paras 27, 29 and 32 as in his opinion there is no legal requirement to actively make a referral if the doctor's conscience won't allow it. A doctor with a conscientious objection should rely on s147 HPCA Act which does not carry the obligation to (a) explain his or her objection or (b) to actively refer, only to advise the woman to obtain the service from another doctor or family planning clinic.

The three paragraphs to be amended by the MCNZ in accordance with the judgment of MacKenzie J are:

Para 27 states "Section 32 of the CS&A Act 1977 sets out the procedure to be followed where a woman seeks an abortion. Section 32(1) provides that every medical practitioner who is consulted by, or in respect of, a female who wishes to have an abortion shall, if requested to do so by or on behalf of the female, arrange for the case to be considered and dealt with in accordance with the requirements of s32 and s33 of the Act."

Para 29 states "In complying with s174 of the HPCA Act 2003 and s32 of the CS&A Act 1977, you must act in a timely manner and in accordance with the guidance outlined in paras 14-23 of this document."

Para 32 states "Your obligations under para 27 [incorrectly stated as s28 in the guidelines]of this statement mean that if you have a conscience [sic] objection to abortion and you are consulted by or on behalf of a pregnant women who wishes to have an abortion, you must, if requested to do so by or on behalf of that woman, arrange for the woman's case to be considered by another medical practitioner who is able to consider whether an abortion may lawfully be performed and take the appropriate steps required by the CS&A 1977."

What this case demonstrates is the need for greater clarity in the law. Up until now anti-abortionists have used a number of tactics based on their interpretation of the law e.g. the woman might not request an abortion, the doctor after considering the case might say that there are no legal grounds and therefore not be required to do anything, or that s174 HPCA does not actually use the word abortion. The judge has ruled all of these out of order.

As the judgment stands an anti-abortion doctor does not need to do anything more than comply with s147 HPCA and tell the woman to go elsewhere. The judge states at the conclusion of his judgment "In preparing the proposed statement the Council has undertaken a wide consultation process, and it might wish to consult further on any alterations." We would beg to differ on the extent of the consultation so far by the MCNZ and trust that they will heed this advice. ALRANZ contends that the MCNZ must widely distribute the amended guidelines so that all interested parties will have an opportunity to provide input. Merely circulating to medical practitioners is not sufficient.

Initially the MCNZ lodged an appeal and although we can only guess on what grounds, it is possible that they might have wished to argue that when balancing the doctor's rights and the patient's rights good medical practice dictates more than merely observing s174 of the HPCA Act.

What no-one has suggested is that the law go back to Parliament for clarification. Much confusion arises from the issue being dealt with in three separate sections: s32 and s46 of the CS&A Act and s147 of the HPCA Act.

From the Patient's Perspective

In abortion care, timing is crucial. The earlier an abortion is performed, the safer it is. In New Zealand, abortion approval procedures are already cumbersome meaning (according to a 2001 Ministry of Justice memo) a woman might have to see up to five doctors before a decision is made to approve an abortion. Under the changes mandated by the MacKenzie ruling, that number could go up even further, making the wait – already averaging more than three weeks – even longer. Is this what it means to put patients first?

New Zealand already lags in timely abortion care. In its 2009 report, for example, the Abortion Supervisory Committee expressed concern that many women were unable to access abortion before 9 weeks gestation. Meanwhile, latest statistics, released 28 October 2011, showed only 56% of abortions were performed before 10 weeks in New Zealand, compared with 73% in the UK (2008) and 78.5% in the U.S. (2006). Those overseas figures are from a recently released paper in the New Zealand Medical Journal ("Improving termination of pregnancy services in New Zealand," by Martha Silva, Toni Ashton, Rob McNeill), which points out that delays and complicated referral pathways "can add stress to an already emotionally difficult situation, and this in turn can have an impact on emotional outcomes."

An earlier study, in 2009 by the same authors, which clocked the waiting time between first contact with a doctor and an abortion at an average of 25 days, found that most women seeking abortions felt the time they had to wait was too long. (Silva M, McNeill R, Ashton T. Ladies in Waiting: the timeliness of first trimester pregnancy termination services in New Zealand. Reproductive Health. 2010;7:19.)

From a patient's perspective, it is a frightening thought that under the MacKenzie ruling, if you want an abortion, your doctor has the right to simply show you the door, that you in turn must then seek out another health-care provider, make another appointment, wait for that appointment date, and only then – you hope – find a doctor who is willing to take any action to address your health and medical needs.

In big bold letters on Page 2 of the MCNZ's publication "Good Medical Practice: A Guide for Doctors" (2008), the MCNZ makes this claim: "Patients are entitled to good doctors. Good doctors make the care of patients their first concern." What some anti-abortionists want, what the High Court has delivered, and what the MCNZ is allowing to stand is the opposite of that: doctors who make the care of their own ideological beliefs their first concern, not their patients.

ALRANZ 20 November 2011