Doctors’ rights to conscientiously object to refer patients to abortion service providers

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ABSTRACT

After five decades of restrictive laws, New Zealand is on the cusp of law reform that may result in abortion being treated as a health, rather than a criminal, matter. Given this possible liberalisation, a pressing issue is the way in which ‘conscientious objection’ (CO) will be accommodated within the new legislative landscape. In this context, CO constitutes a health provider refusing, on the grounds of personal conscience, to provide care that, although legal and potentially clinically appropriate, conflicts with their personal moral views. Currently, New Zealand law permits significant concessions for conscientious objectors. This paper argues that in the light of current reform, the justification for permitting CO should be revisited. It claims that even if it is conceded that some form of CO should be respected, a pragmatic compromise must be adopted so that both provider’s and women’s rights are sufficiently protected. We argue that the current legal situation in New Zealand is unbalanced, favouring the rights of providers at the expense of women’s timely access to abortion care. At a minimum, providers with a CO should be required to ensure an indirect referral to another provider who is willing to refer the woman to abortion services.

Abortion in New Zealand

Statistics indicate that around a fifth of New Zealand pregnancies are terminated and one in four women have had an abortion in their reproductive lives—more than the percentage of women who have ever used IUDs. Currently New Zealand women are among the 40% of women of childbearing age who live in countries that the World Health Organization refers to as having “highly restrictive laws”. Northern Ireland is the only other developed country with more restrictive abortion laws, while the Republic of Ireland recently liberalised its abortion law. By comparison, 61 countries, home to almost 40% of the world’s women, allow abortion upon request of the pregnant woman. A further approximately 20% of the world’s women have access to legal abortion on the grounds of social and economic circumstances.

The Minister’s Request for Advice on Law Reform: Law Commission Briefing Paper

The vast majority of abortions in New Zealand are performed on mental health grounds (97.6% in 2013) and are performed before the end of the 10th week of pregnancy. In 2017, Minister of Justice Andrew Little requested that the New Zealand Law Commission (NZLC) provide advice on what alternative legal approaches could be adopted to align abortion law with a health, rather than criminal, model. Following a public consultation, the NZLC presented a range of proposals and options for reform (see Table 1).
Significantly, the NZLC posed two options in regard to CO:

1. (1) maintaining the current law regarding conscientious objection, or
2. (2) amending it so that health practitioners who do not wish to provide health services in relation to abortion because of a conscientious objection are required, as soon as reasonably practicable, to disclose the fact of their objection and refer the woman to another health practitioner or abortion service provider able to provide the service.

Health providers as ‘gatekeepers’ model: what obligations regarding referral?

The NZLC paper presents two possible models: the first entails clinicians acting as gate keepers to the abortion process; the other involves women being able to self-refer to abortion service providers. Clearly if women may self-refer for abortion, CO becomes a less significant issue. However, it is not yet clear which recommendations the government will adopt should law reform proceed. This paper considers how, if clinicians retain their role as gate keepers to abortion services, the issue of CO should be addressed.

The NZLC emphasises that these proposals would not remove all grounds for CO in relation to abortion. Under both options, health providers would retain their right to object to perform, or participate, in the provision of abortion. NZLC states that “the Government could consider changes to ensure that CO ‘does not unduly delay women’s access to abortion services’”. We do not engage here with the question of whether health providers should be entitled to CO. In this paper we focus on the ethical question of defining the reasonable scope of CO for abortion referrals.

The current legal position regarding CO and referral

It is clear that a physician with a CO need not perform an abortion. It is equally clear that they have a duty to inform: indeed the Health Practitioners Competence Assurance Act 2003 (HPCAA) states that in the context of reproductive health services, a health practitioner who objects on the ground of conscience to providing the service must “… inform the person who requests the service that he or she can obtain the service from another health practitioner or from a family planning clinic.” In addition the Code of Consumers Rights provides that patient have extensive rights, including the right to be fully informed, and providers have corresponding duties.

The most contentious question has been around the issue of referral. The notion of ‘referral’ can relate to one of two things—referring directly to the abortion service so that the grounds for abortion can be considered by certifying consultants; or, if the clinician has a CO, referring to a colleague who is prepared to consider the matter and arrange a referral to the abortion service as indicated. The former sort of referral has been described as ‘direct referral’, the latter as ‘indirect referral’.

Table 1: Law Commission Alternative Approaches to Abortion Law: Ministerial Briefing Paper options for abortion reform.

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<td>• Repealing the current grounds for abortion contained in the Crimes Act 1961.</td>
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<td>• Removing the requirement for abortions to be authorised by two specially appointed doctors, called ‘certifying consultants’.</td>
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<td>• Allowing women to access abortion services directly, or alternatively to be referred by any health practitioner they choose to consult (GP, nurse, midwife, counsellor), rather than having to get a referral from a doctor as required under the current law.</td>
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<td>• Removing the current restrictions governing who may perform an abortion, and where abortions must be performed. Instead, the provision of abortion services would be regulated by appropriate health bodies, just like any other healthcare procedure.</td>
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<td>• Disestablishing the Abortion Supervisory Committee.</td>
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<td>• Assigning responsibility to the Ministry of Health for collecting statistics on abortion and overseeing the distribution of funding and abortion services.</td>
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The High Court has made it clear that both direct and indirect referrals are subject to the right of CO in New Zealand. In 2010, the New Zealand Medical Council sought to clarify that practitioners with a CO to providing direct referral for abortion services must arrange for the woman’s case to be considered by another practitioner willing to consider and deal with the matter. This became the subject of a legal challenge by anti-abortion group, New Zealand Health Professionals Alliance (NZHPA). The High Court substantially upheld NZHPA’s case, holding that, under the HPCAA, the practitioner’s statutory duties extend only to informing the woman that she could be treated elsewhere, but did not extend, and importantly, could not be extended by the Medical Council, to referring the woman to another practitioner who can arrange the referral to an abortion service.

Consequently, a practitioner’s duties in New Zealand are minimal. They need only inform the woman of the option of seeking out another provider, but are not required to put her in touch with an alternative provider, facilitate her transfer or even provide contact details. The NZLC clearly provides the option for changing the status quo in regards to CO and referrals, however the New Zealand Medical Association (NZMA) opposes any change to the current scope of CO.

Response to the NZLC

The response from the medical and allied health professions to the Law Commission’s proposals has been mixed. The New Zealand College of Midwives, the Australian and New Zealand College of Psychiatrists and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists all considered that “conscientious objectors should either refer a woman in a timely manner to another practitioner who provides the services she seeks, or provide the woman with sufficient information about practitioners who provide the services to enable her to access those services”. In contrast, the NZMA’s submission to the Law Commission states that it “strongly supports the retention of the existing provisions” of CO. No further justification for this is offered in the submission. However, in a recent New Zealand Herald article, chairwoman Kate Baddock appeared to endorse the argument that: “For the same reason that patients have a right not to be coerced into receiving treatment, doctors and nurses have a right not to be coerced into providing it”. This argument, which we call the “Argument from Symmetry”, is flawed. It fails to account for significant differences between the respective positions of patient and provider. First, it fails to account for the role-specific professional obligations of doctors. Second, it seems to misunderstand some of the core tenets of medical ethics and professionalism, such as patient autonomy and non-maleficence. As such, it cannot provide grounds for CO in general, or for the strong version that New Zealand law presently protects.

Professional autonomy: the argument from symmetry

To be clear, we are not disputing that there is a role for professional autonomy for health providers. Rather, we are arguing that the nature and scope of professional autonomy cannot be derived from, nor seen as directly analogous to, the nature and scope of patient autonomy. Medical ethics and medical law accord significant weight to the autonomous choices of adult patients. In terms of treatment refusals, a competent patient’s autonomy is all but absolute. They can refuse treatment even when it is medically necessary to preserve their life or health. Furthermore, at least in theory, the patient is under no obligation to offer any justification for such a decision. It does not follow that providers have an analogous right to refuse to provide treatment or advice without justification. Rather, a doctor seeking to withhold a medically indicated and requested procedure will be required to justify their decision. (In much the same way, the fact that a defendant in a criminal trial has the right to silence does not mean that the judge can decline to offer reasons for his or her decision). Perhaps most obviously, a patient’s right to refuse all medical interventions could not sensibly find its mirror in a physician’s right to refuse to perform all medical procedures; such a refusal, we might think, would amount to refusing to be a doctor at all.
There are also critical differences in power, freedom and vulnerability between the patient and the doctor that the Argument from Symmetry obscures. The patient is in need of clinical care (and may well also be suffering morning sickness or other pregnancy related health issues); whereas the GP is well and working in a professional capacity. Arguably, access to medical services will have significantly greater consequences for the patient's life course than providing a referral will have on the doctor's life course. The patient cannot choose not to be pregnant, but we might think that, in undertaking a professional role, the doctor has voluntarily undertaken certain responsibilities. For these reasons, the professional responsibilities of doctors are not analogous to the moral rights of patients. The fact that patients cannot be coerced into accepting treatment is irrelevant to the question of whether doctors should be coerced/required to offer referrals (or provide other services).

Even proponents of respecting physician autonomy stop some way short of arguing for a strong autonomy right, analogous to the autonomy of an adult patient. Hence Shimon Glick and Alan Jotkowitz call for a “nuanced” and “balanced” approach, recognising that always giving CO priority over patient requests “would result in anarchy and in deprivation of services to many patients”.17 We argue, then, that support for CO cannot plausibly be derived from a putative equivalence between the autonomy rights of patients and doctors, as the NZMA has suggested. Other grounds for recognition of a right to CO have, however, been advanced.

A more plausible basis of CO: moral integrity or vocational calling

One such basis for respecting CO derives from the medical practitioner’s moral integrity. Marc Wicclair explains moral integrity element in this way:

“To claim that [the physician's] moral integrity is at stake implies that: (1) she has core ethical values (eg, principles, virtues and/or paradigm-based maxims). (2) These core ethical values are part of her understanding of who she is. That is, they are integral to her self conception or identity. (3) It would be incompatible with those core ethical values to participate in [the requested treatment].”18

On Wicclair’s account, moral integrity is synonymous with one’s personal identity, hence mere distaste or disapproval of a particular procedure will not provide an adequate basis for a valid CO. Wicclair also claims that “an appeal to conscience has significant moral weight only if the core ethical values on which it is based correspond to one or more core values in medicine.”18

Christopher Cowley bases his support for CO on a similar idea, although he prefers the language of “calling” over “moral integrity”;

“Once we take seriously the idea of a calling, then we come closer to understanding the motivation of the conscientious objector; they deserve accommodation not out of respect for their integrity, but rather out of respect for their conception of medicine.”19

Like Wicclair, Cowley requires that the objection be rooted in “an understanding grounded in the role of doctor as healer”.19 If this is right, it would set an important limitation on the exercise of CO, requiring the practitioner to locate his/her position within a broader context of shared ethical values. Whether opposition to abortion would meet this standard is, presumably, arguable, but it is not a line of enquiry we pursue further here.

Freedom of conscience

A second plausible basis for CO can be found in the broad right to freedom of conscience. The New Zealand Bill of Rights Act states that “Everyone has the right to freedom of thought, conscience, religion and belief, including the right to adopt and to hold opinions without interference”.20

As the NZLC noted, these rights may, however, be “subject to reasonable limits” acceptable in a free and democratic society.7 The right to freedom of conscience does not automatically extend to the right to act on those beliefs (we are not, for example, permitted to refuse to pay tax because we object to military spending, or because we object to funding certain health services). Further, the broad right to conscience is not equivalent to the much more circumscribed right to CO. Health providers have scope to act on conscience in many ways that do not invoke CO. They choose the area in which they practice /specialise and which patient populations to serve; they make important
contributions to academic and public debates about health policy and medical ethics; and they participate in associations aimed at political reform (eg, Doctors4Refugees, Voice for Life, Euthanasia-free New Zealand). None of these expressions of conscience invoke the right of CO.

The remainder of this article is concerned with the question of reasonable limits on the right to freedom of conscience.

Reasonable limits

Provision for CO at all has come in for renewed criticism in recent years. For critics like Julian Savulescu and Udo Schuklenk, providers exempting themselves from provision of healthcare is simply incompatible with the ethical demands of the medical profession. Significantly, the NZLC's proposals do not suggest dispensing with CO altogether, nor do any of the submissions from the medical professional bodies. Moreover, recent initiatives around physician aid-in-dying make specific provision for CO.

It seems unlikely, therefore, that there is much appetite for removal of CO in New Zealand medicine in the foreseeable future. Thus the real debate is around the limits of CO, and how to balance competing interests. For most moderate commentators, this takes the form of a search for a 'reasonable compromise' or 'conventional compromise' position, which typically requires a trade-off between the doctor's right to conscience, and other considerations. Advocating for the conventional compromise, Dan Brock states:

“... a physician/pharmacist who has a serious moral objection to providing a service/product to a patient/customer is not required to do so only if the following three conditions are satisfied:

1. The physician/pharmacist informs the patient/customer about the service/product if it is medically relevant to their medical condition;
2. The physician/pharmacist refers the patient/customer to another professional willing and able to provide the service/product;
3. The referral does not impose an unreasonable burden on the patient/customer.”

Even Cowley, when defending the right to CO against critics, accepts that indirect referral may be a moral duty:

“Refusing to inform a patient in such a context would not only be illegal, it could also be akin to sulking and preciousness. This is one place to draw the line, and where the conscientious objector has to accept the reality of a genuine moral pluralism, as well as her status as a minority in a reasonably democratic society.”

Even scholars defending the right of CO, then, would not support the New Zealand situation, where providers can refuse to transfer the care of the patient to another provider who will process the referral.

Why we should be worried about (unrestricted/broad) CO and delays in access to abortion care

We disagree with Baddock that the current CO provisions for referrals in New Zealand are reasonable and working well. Current CO provisions regarding termination referral in New Zealand impose an unreasonable burden on women. It is highly plausible that refusal to provide indirect referral can cause significant patient harms: potential inability to find another provider, delay in access to care, increased financial cost (time off work, cost of additional consultation, travel), stigma, embarrassment or loss of trust in the ‘non-judgmental’ role of providers, which may have significant implications for some patient groups that already have a tenuous relationship with the health system and the medical profession. Remarkably, when a GP refuses to even consider referral, they remain entitled to claim the cost of the consultation (prenatal care is government-funded). While the patient is left with the emotional, financial and time burden of finding another provider, the doctor can be paid for refusing on personal grounds to perform this core public service. In a health system that is supposed to be ‘patient-centred’ the current weighting of doctor and patient interests seems distorted.

Refusals to refer undeniably create some delay. The length of delay will vary; but we argue that in the context of abortion services in New Zealand, we should be concerned about all delays. Compared to other developed countries (UK, Australia,
US), abortion services in New Zealand are accessed significantly later in the first trimester. New Zealand women wait an average of 25 days between the first visit with a referring doctor and the date of their procedure.24

Timely access to abortion services is critical to women’s psychological and physical health, with earlier abortions safer.24, 25 For example, women who intend to terminate using medication (as opposed to surgical abortion) need to access services within the first 63 days of pregnancy. In general, long waiting times for elective surgery increases anxiety and have a negative impact on quality of life and psychosocial measures.26 Barriers to abortion, including delays, have disproportionate impact for rural women, minorities and less advantaged women.27 Thus the World Health Organization recommends that “Regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed”.28

Research shows that most of the existing delay in accessing abortions in New Zealand is at the referral stage.29 Even those GPs willing to refer sometimes require multiple consultations before they refer a woman to an abortion provider.28 It remains unclear what is causing this delay. Specifically, there is no available evidence to show that the delays in referral are the result of refusing to refer to another referrer, as opposed to simply refusing to refer to the abortion provider (while facilitating referral to another GP). This lack of specific data is not surprising; it is not known how many health providers have a CO, and conducting research with women requesting abortion is notoriously difficult given the stigma associated with abortion. We do know that New Zealand has surprising delays in the referral process relative to comparable countries and that New Zealand law currently allows for a very wide interpretation of the scope of CO. We should be especially concerned about the potential role of CO in delaying accessing to abortion referrals in New Zealand.

Conclusion

The State is responsible for ensuring the provision of core health services.28 Arguably, CO provisions need to be considered at a system level—balancing the harm to potential objectors of compelling action contrary to their conscience, against the harm to patients of delaying or barring access to care.

The NZLC’s modest proposal would recognise the right to CO, and would safeguard the right of objectors to be employed in roles even where they have no intention of providing all the services that role would usually require, even where those roles are in remote areas with few other doctors. These are significant concessions to those holding a minority view.

The current legal situation in New Zealand is unbalanced, favouring the rights of providers at the expense of women’s timely access to abortion care. We endorse the position of the New Zealand College of Midwives, the Australian and New Zealand College of Psychiatrists, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists that providers should directly refer to abortion services, or facilitate transfer to another provider who can do the referral. Allowing providers to object to direct referrals, when one of their core professional obligations is to navigate patients through the health system, is one thing. But providers objecting to making indirect referrals, and thereby failing to ensure the safe transfer the patient to the care of a colleague, amounts to abandoning the patient. This takes CO too far.
Competing interests:
Nil.

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VIEWPOINT