IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

CIV-2010-485-222

BETWEEN	CATHERINE MARY HALLAGAN First Plaintiff
AND	NEW ZEALAND HEALTH PROFESSIONALS ALLIANCE INCORPORATED Second Plaintiff
AND	MEDICAL COUNCIL OF NZ Defendant

Hearing: 1-2 November 2010

Counsel: A H Waalkens QC and A L Credin for Plaintiffs
M T Scholtens QC and J P Coates for Defendant

Judgment: 2 December 2010 at 12pm

I direct the Registrar to endorse this judgment with a delivery time of 12pm on the 2nd day of December 2010.

RESERVED JUDGMENT OF MACKENZIE J

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[1] Dr Hallagan is a medical practitioner who, by virtue of professional, religious and conscience beliefs which she holds, is opposed to abortion and the taking of steps towards the obtaining of an abortion. The second plaintiff has among its members medical practitioners who share Dr Hallagan's opposition to abortion. The defendant Council is a statutory body having responsibilities in relation to the standards of practice to be observed by medical practitioners.

[2] The Council proposes to promulgate a statement entitled "Beliefs and Medical Practice" which is directed to the responsibilities and actions required of medical practitioners in certain sensitive areas of practice where the religious, cultural or ethical beliefs and values of patients and doctors may impact on matters of medical treatment and procedures. One of those sensitive areas of practice is that of abortion. The essence of the plaintiffs' concern is that, in certain respects, the proposed statement would impose obligations upon medical practitioners which may require them to act in a way which is inconsistent with their personal beliefs and values in relation to abortion. The plaintiffs contend that in a number of respects the Council's proposed statement goes beyond what the Council may lawfully require of medical practitioners. By this proceeding they seek judicial review of the exercise by the Council of its statutory powers in making the proposed statement.

[3] A fundamental aspect of the difference between the parties as to whether or not the proposed statement falls within the scope of the Council's powers is a fundamental difference as to the nature and extent of the obligations of doctors with a conscientious objection to abortion under the Contraception, Sterilisation, and Abortion Act 1977 (the CSA Act). It is therefore desirable to begin by considering that issue.

[4] Two sections of the CSA Act are of particular importance in this regard, s 32 and s 46. Section 32(1), (2) and (4) provides as follows:

> **Procedure where woman seeks abortion**
>
> (1) Every medical practitioner (in this section referred to as the woman's own doctor) 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 that female, arrange for the case to be considered and dealt with in accordance with the succeeding provisions of this section and of section 33 of this Act.
>
> (2) If, after considering the case, the woman's own doctor considers that it may be one to which any of paragraphs (a) to (d) of subsection (1), or (as the case may require) subsection (3), of section 187A of the Crimes Act 1961 applies, he shall comply with whichever of the following provisions is applicable, namely:
>
> (a) Where he does not propose to perform the abortion himself, he shall refer the case to another … medical practitioner (in this section referred to as the operating surgeon) who may be

willing to perform an abortion (in the event of it being authorised in accordance with this Act); or

(b) Where he proposes to perform the abortion himself (in the event of it being authorised in accordance with this Act), he shall—

(i) If he is himself a certifying consultant, refer the case to one other certifying consultant (who shall be a practising obstetrician or gynaecologist if the woman's own doctor is not) with a request that he, together with the woman's own doctor, determine, in accordance with section 33 of this Act, whether or not to authorise the performance of an abortion; or

(ii) If he is not himself a certifying consultant, refer the case to 2 certifying consultants (of whom at least one shall be a practising obstetrician or gynaecologist) with a request that they determine, in accordance with section 33 of this Act, whether or not to authorise the performance of an abortion.

…

(4) Where any medical practitioner is required to refer any case to any other practitioner under this section, he shall refer it in accordance with the procedure for the time being prescribed by the Supervisory Committee.

[5] Section 46(1) provides:

Conscientious objection

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

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

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

if he objects to doing so on grounds of conscience.

[6] There are other relevant legislative provisions which are also important in determining the extent of the obligations of doctors under the CSA Act. Important in the scheme of s 32 is s 187A of the Crimes Act 1961 which provides for the

circumstances in which acts done with intent to procure a miscarriage will not be unlawful. Subsections (1) and (3) provide:

> **Meaning of "unlawfully"**
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> (1) For the purposes of sections 183 and 186 of this Act, any act specified in either of those sections is done unlawfully unless, in the case of a pregnancy of not more than 20 weeks' gestation, the person doing the act believes—
>
> (a) That the continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health, of the woman or girl …; or
>
> (aa) That there is a substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped; or
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> (b) That the pregnancy is the result of sexual intercourse between—
>
> (i) A parent and child; or
>
> (ii) A brother and sister, whether of the whole blood or of the half blood; or
>
> (iii) A grandparent and grandchild; or
>
> (c) That the pregnancy is the result of sexual intercourse that constitutes an offence against section 131(1) of this Act; or
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> (d) That the woman or girl is severely subnormal within the meaning of section 138(2) of this Act.
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> …
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> (3) For the purposes of sections 183 and 186 of this Act, any act specified in either of those sections is done unlawfully unless, in the case of a pregnancy of more than 20 weeks' gestation, the person doing the act believes that the miscarriage is necessary to save the life of the woman or girl or to prevent serious permanent injury to her physical or mental health.

[7] There is a further relevant provision in the Health Practitioners Competence Assurance Act 2003 (the HPCA Act). Section 174 of that Act provides:

> **Duty of health practitioners in respect of reproductive health services**
>
> (1) This section applies whenever—

> (a) a person requests a health practitioner to provide a service (including, without limitation, advice) with respect to contraception, sterilisation, or other reproductive health services; and
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> (b) the health practitioner objects on the ground of conscience to providing the service.
>
> (2) When this section applies, the health practitioner must inform the person who requests the service that he or she can obtain the service from another health practitioner or from a family planning clinic.

[8] I now briefly describe the respective cases of the plaintiffs and defendant as to the application of those provisions.

[9] The plaintiffs' submission is, in essence, that where a doctor who has a conscientious objection to abortion is consulted by a woman who wishes to have an abortion, as envisaged by s 32(1), the doctor may discuss the matter with the woman including giving consideration to whether any of the s 187A grounds may apply. If the outcome of that discussion is that the woman does not request that the doctor arrange for the case to be considered and dealt with under ss 32 and 33, then that is the end of the matter and the doctor is not required to take any further action. If the outcome is that the woman does make that request, then the doctor may, by reason of a conscientious objection, decline to arrange for the case to be considered, and must in that event inform the woman that she can obtain that service from another health practitioner or from a family planning clinic to comply with s 174(2). Alternatively, the plaintiffs submit, the doctor may consider whether any of the s 187A grounds may apply. If the doctor does not consider that any of those grounds may apply then no further action is required. Good medical practice may commend that the doctor consider informing the woman that she may consult another medical practitioner, but that is not mandated by the section. If the doctor considers that one of those grounds may apply, then at that point the right of conscientious objection is engaged. The doctor is not required to refer the patient under s 32(2), but may at that stage invoke the conscientious objection. The obligation on the doctor in that event is to inform the patient that she may obtain the service from another health practitioner or a family planning clinic, to comply with s 174(2).

[10] The essence of the defendant's submission is that, when a doctor with a conscientious objection is consulted, and a request is made to arrange for the case to be considered, the doctor is under a statutory obligation, under s 32(1), to arrange for the case to be considered and dealt with under the section. The doctor is not entitled, on grounds of conscience, to decline that request. Section 46 does not relieve the doctor of the statutory obligation under s 32(1), because arranging for the case to be considered does not amount to assisting in the performance of an abortion, so that s 46 is not engaged. The doctor may comply with the s 32(1) obligation to arrange for the case to be considered by referring the woman to another doctor who may be willing to consider the case. In doing so, the doctor must comply with proper professional standards applying to referrals. If the doctor, in the performance of the s 32(1) obligations, undertakes the consideration of the case, the doctor must, if the case is considered to be one to which s 187A may apply, comply with either s 32(2)(a) or (b). In that event, the option to refer the case to an operating surgeon under s 32(2)(a) is available to a doctor with a conscientious objection to abortion. Referring the case to an operating surgeon is not assisting in the performance of an abortion, so s 46 is not engaged. Section 174 imposes a duty, it does not confer a right of conscientious objection which overrides the mandatory provisions of s 32. Since s 46 is not engaged at either stage, namely arranging for the case to be considered under s 32(1), or referring it under s 32(2)(a), s 174 can have no application.

[11] I now turn to discuss these submissions, and to set out my conclusions as to the proper interpretation and interrelationship of the relevant provisions.

[12] Dealing first with s 32(1), there is an obligation, expressed in mandatory terms, imposed on a woman's own doctor who is consulted by a woman who wishes to have an abortion, if a request is made. The doctor must arrange for the case to be considered and dealt with under s 32 and s 33. There is no express exclusion from that statutory obligation for a doctor who has a conscientious objection to abortion. In my view, s 46 does not exempt the doctor from the s 32(1) obligation. I do not consider that arranging for the case to be considered and dealt with falls within the term "assist in the performance of an abortion". I set out my reasons for that view.

[13] Mr Waalkens QC submits that the word "assist" has a broad meaning and that in *Medical Law in New Zealand*,[1] the authors express the view that this protection includes "any preparation for the abortion". He also refers to an article by J S O'Neill, "Conscientious Objection".[2] In that article, the author notes the absence, in s 46(1)(a) of a reference to the giving of advice, in contrast to the inclusion of that within s 46(1)(b). He expresses the following view:

> … It will be noted that under the subs (1)(b) the exception covers not only physical participation but the offering or giving of advice relating to contraception. It may be argued however that subs (1)(a) must have a more restrictive interpretation in regard to abortion and even sterilisation in that it does not appear to exclude the offering or giving of advice in relation thereto. Such an interpretation would be based on the invalid presumption that the performance of the abortion or sterilisation is inevitable. A medical practitioner with conscientious objections to these operations would have no difficulty whatever in giving his advice to a patient regarding the advisability of such operations, and the section has left him free to do so if he chooses which is entirely constitutionally and professionally appropriate.

[14] Ms Scholtens QC submits that s 46(1)(a) does not extend to the giving of advice in relation to an abortion. She submits that the right under s 46(1)(a) to be excused from duties in relation to abortion is limited to those which are directly connected with the medical or surgical procedure. She refers to *Re a case stated by the Abortion Supervisory Committee*,[3] where Durie J said:

> … The consequence, the destruction and removal of the fetus, serves, in grammatical context, merely to define the nature or purpose of the medical or surgical procedure that is spoken of. In brief, an abortion, as defined in the CSA Act, is the process carried out to cause a miscarriage.

[15] On this point I accept Ms Scholtens' submissions and I do not accept Mr Waalkens' submissions. I consider that s 46(1)(a) does not extend to cover the obligation on a woman's own doctor in s 32(1) to arrange for the case to be considered and dealt with in accordance with ss 32 and 33. I consider that, on the plain meaning of the words "assist in the performance of an abortion", particularly when these words are read in their context, which includes para (b), the step of arranging for the case to be considered and dealt with under ss 32 and 33 does not fall within their scope. Mr Waalkens refers to, and seeks to distinguish, the House of

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1 PDG Skegg and Ron Paterson (eds) *Medical Law in New Zealand (*Brookers, Wellington, 2006).
2 J S O'Neill "Conscientious Objection" [1984] NZLJ 272.
3 *Re a case stated by the Abortion Supervisory Committee* [2003] 3 NZLR 87 at [35].

Lords decision in *Janaway v Salford Area Health Authority*.[4] There, a secretary/receptionist employed in a health centre refused to type a letter from a general practitioner at the centre referring a patient to a consultant with a view to a possible termination of pregnancy. She sought to rely on a statutory provision to the effect that no person should be under any duty "to participate in any treatment authorised by this Act to which he has a conscientious objection". That provision was held not to extend to the typing of a referral letter. The wording of the New Zealand statute is different and the actions in issue in this case are different, so that I do not consider that any significant assistance is to be obtained from that case.

[16] Ms Scholtens further submits that, because s 46 does not relieve a doctor from performance of the s 32(1) obligation, s 174 can have no application. It is common ground that the words "other reproductive health services" include services in relation to abortion. However, Ms Scholtens submits that s 174(1)(b) is limited in its scope to an objection on the grounds of conscience which is recognised by Parliament – that is, in the case of abortion, to the services included in s 46(1)(a). Mr Waalkens submits that s 174 applies whenever an objection on the grounds of conscience arises, and that those grounds may go beyond cases which are included within s 46.

[17] If Ms Scholtens' submission on this point is correct, then Parliament has imposed a mandatory requirement on a woman's own doctor to whom a request is made to arrange for the case to be considered and dealt with, with a view to an abortion. That obligation is imposed even where the doctor has an objection, on grounds of conscience, to making that arrangement. I do not attribute to Parliament an intention to impose such a requirement. It might be that some doctors with a conscientious objection to abortion would not consider it a violation of their principles to arrange for the case to be considered by making a referral, in accordance with proper medical practice, to another doctor. In that case, the doctor could perform the s 32(1) obligation, without offending his or her conscience, by arranging for the case to be considered and dealt with by another doctor. However, some doctors might regard even the step of making a formal referral as violating

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4 *Janaway v Salford Area Health Authority* [1989] 1 AC 537.

their conscience. Matters of conscience are intensely personal. The question is: has Parliament legislated in s 32(1) to require a doctor to arrange for a case to be considered by another doctor, even if taking that step offends the conscience of the doctor? Clear words would be needed to impose such a requirement. That would have been so when the CSA Act was passed. It is more obviously so today, in the light of the right to freedom of conscience enshrined in s 13 of the New Zealand Bill of Rights Act 1990, and the requirement in s 6 of that Act to prefer a meaning that is consistent with that right.

[18] Ms Scholtens submits, in this context, that the Council is working in a context that is laden with rights, but that the focus is properly on those of the patient, and the special obligations on doctors as a result of the doctor/patient relationship. She submits however that the Council is also mindful of the ethical principle that, to the extent possible, all individuals, including medical practitioners, must have their profound religious, moral and ethical beliefs afforded generous accommodation and protection. I return to this submission after first setting out my conclusions on the application of s 174 to the duties in s 32.

[19] I consider that the reference in s 174(1)(b) to an objection on grounds of conscience is not confined to a right of conscientious objection conferred by Parliament in s 46, or specifically recognised in some other way. The reference extends to any conscientious objection held by a doctor to providing some service relating to abortion, and the section does not limit or confine the extent of such a conscientious objection. For these reasons, I consider that the answer to the question posed in [17] is no. I consider that Parliament has provided, in s 174, that a doctor who has such a conscientious objection may, instead of arranging for the case to be considered, give the information required by s 174(2).

[20] Accordingly, so far as the obligation imposed by s 32(1) is concerned, I consider that a doctor with a conscientious objection to abortion has two options:

(a) If the conscience of the doctor would be infringed by arranging for the case to be considered and dealt with under ss 32 and 33, the doctor may decline the patient's request to do so. The doctor must in that

event give the information required by s 174(2). The duty to give that information is a statutory one, not one which is subject to additional professional obligations.

(b) If the conscience of the doctor would not be infringed by arranging for the case to be referred to another doctor for consideration, the doctor must take that step. The making of that referral is a matter of medical practice, to be performed in accordance with proper professional standards.

[21] The plaintiffs submit that there is a third course available under s 32(1) to the doctor with a conscientious objection to abortion, namely to undertake the consideration of the case which is required of the woman's own doctor under s 32(1). The plaintiffs submit that the doctor may do this, on the basis that:

a) If the outcome of that consideration is that the doctor considers that none of the grounds in s 187A apply, the doctor's conscience will not be engaged, and no further steps are required by the statute.

b) If the outcome is that the doctor considers that one of the grounds in s 187A may apply, the doctor may at that stage decline to act further on conscience grounds, and in so doing must give the information required by s 174(2).

[22] It is at this point that I part company with Mr Waalkens' submissions. I do not consider that this third course is available. The woman's own doctor has an obligation under s 32(1) to ensure that the case is considered and dealt with under ss 32 and 33. Under s 32(2), if the woman's own doctor considers that s 187A may apply, the doctor must make the referrals required by s 32(2)(a) or (b). Those referrals are an essential part of ensuring that the case is dealt with under ss 32 and 33. A doctor who has undertaken consideration of the case on the basis that, if any of the grounds in s 187A is found to apply, the doctor will at that stage decline to be involved further because of a conscientious objection, has not complied with the obligation to ensure that the case is both considered and dealt with. The obligation

on a doctor who undertakes to consider a case is a compound one having two parts: to consider the case and to deal with it in accordance with ss 32 and 33. It is not divisible. A doctor who engages medically with the case by considering it also undertakes a responsibility, both statutory and professional, to deal with it in accordance with ss 32 and 33, if the medical judgment of that doctor, after consideration, is that s 187A may apply. A doctor with a conscientious objection to abortion may avoid undertaking the obligation to consider and deal with the case, in one or other of the ways I have described at [20]. The conscientious objection must be invoked at that stage, in one or other of those ways. The statute does not contemplate that a doctor with a conscientious objection may undertake part, but not all, of the obligation to consider and deal with the case.

[23] I return to discuss the submission summarised at [18] as to the balancing of the rights of the doctor and the rights of the patient. I consider that the conclusions which I have reached, based essentially on ordinary principles of statutory interpretation, are supported by a rights-focused analysis. At the stage of the initial doctor/patient consultation envisaged by s 32, before there has been an involvement of a medical character in respect of that consultation, I consider that a focus on the rights of the doctor under ss 13 and 15 of BORA is appropriate. That focus supports the view that a right of conscientious objection at that stage is recognised and provided for in s 174. At the later stage, if the doctor has undertaken the task of considering the case, there is a medical involvement in which the focus is properly on the rights of the patient, as protected by the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. That focus supports the view that, having embarked upon that medical involvement, the doctor may not thereafter subordinate the patient's rights to the doctor's rights. On that view, the doctor's rights are appropriately recognised and protected, but the patient's rights impose a limitation on the manner and timing of the exercise of the doctor's rights.

[24] Against that background of the application of the statutory provisions, I turn to consider, in broad principle, the basis upon which the Council may regulate, as a matter of medical practice, the performance of their duties by doctors, including doctors with a conscientious objection to abortion.

[25] The statutory powers of the Council to prescribe standards of professional practice and conduct for doctors are in the HPCA Act. The Council is the authority appointed in respect of the practice of medicine under s 114(1)(a) of that Act. It is a function of the Council, under s 118, to set standards of clinical competence and ethical conduct to be observed by medical practitioners.

[26] The first point of contact between a woman and that woman's own doctor which is envisaged by s 32(1) is a consultation in which the woman makes known her wish to have an abortion. The section contemplates that the mere fact of that consultation may not immediately give rise to the obligation to arrange for the case to be considered and dealt with, since that is triggered by the making of a request which is not, on the wording of the section, an inevitable consequence of the consultation. The CSA Act is not specific as to the nature of the consultation at that initial phase, before a request is made. I consider that that initial consultation is a medical one, in respect of which the Council is able to set standards of clinical competence and ethical conduct to be observed by the doctor in that phase of the consultation. But, for the reasons I have given, a doctor who is unwilling, on grounds of conscience, to observe those standards may, at that initial phase, decline to provide that service, and give the patient the information required by s174(2). The standards set by the Council may not deprive the doctor of the ability to act in that way.

[27] If the doctor feels able to undertake that phase of the consultation, observing the standards prescribed by the Council in doing so, and the consultation reaches a point at which the request referred to in s 32(1) is made, the doctor with a conscientious objection to abortion has the options described in [20]. Under the first option, if the doctor declines to comply with the request on grounds of conscience, the duty is to give the s 174(2) information. That duty is a statutory one, not one arising as an aspect of medical practice. In my view, the Council is not able to set professional standards which restrict the ability of the doctor to invoke a conscientious objection by adopting that option, or which extend the s174(2) obligation. In general terms, when a medical practitioner is unwilling or unable, for reasons other than conscience, to advise or treat a patient, the Council may set standards to be observed by that practitioner in arranging a referral to another doctor.

However, in this specific instance, the setting of standards for referral would essentially require a doctor with a conscientious objection to arrange for the case to be considered and dealt with in accordance with ss 32 and 33. As I have held, Parliament has not imposed that obligation on a doctor who has a conscientious objection to making those arrangements. I do not consider that the Council may impose such an obligation. Parliament has specified the duty on the practitioner in that situation, in s 174(2). That must be seen as a maximum obligation, and not one which may be supplemented by the imposition of professional standards.

[28] If the doctor with a conscientious objection to abortion feels able, in conscience, to arrange for the case to be considered and dealt with by another doctor (option (b) in [20]), then the making of those arrangements is an aspect of medical practice, and the Council may properly set standards of clinical competence and ethical conduct to be observed by the doctor in making those arrangements. If compliance with those standards would offend the conscience of the doctor, the doctor should adopt the first option in [20].

[29] The composite stage of considering the case and (if any of the s 187A grounds may apply) making the referrals required under s 32(2) involves matters of medical practice. The Council may properly set standards for those matters. Those standards may include the procedures to be adopted if the doctor is of the opinion that none of the s 187A grounds applies. The CSA Act is not specific as to what is to occur in that eventuality. The Council may properly set standards which address that aspect. Those standards need not allow for the possibility of a conscientious objection to following those standards. That is so because, as I have held, the proper course for a doctor who has a conscientious objection to carrying to its conclusion the statutory process of considering and if appropriate referring the case is to decline to embark upon that process.

[30] It may be the case that a doctor with a conscientious objection to abortion would not find it a violation of conscience to carry the s 32 process through to the stage of considering the case and, if any of the s 187A grounds may apply, referring the case to another medical practitioner under s 32(2)(a), and thereafter having no further involvement. That is entirely a matter for the individual conscience of the

doctor. A doctor who is in that position may feel able to undertake the whole task of considering and dealing with the case in this way. If that is the case, then the doctor will have undertaken a service which is a matter of medical practice, and must comply with all standards properly set by the Council for all doctors in undertaking that service. That will include compliance with standards which address the case where none of the s 187A grounds are considered to apply, as well as those which address the steps to be taken as a matter of professional practice in making the s 32(2)(a) referral.

[31] I now turn to consider the terms of the Council's proposed statement, and the plaintiffs' challenges to it, in the light of that analysis of the statutory scheme. The principal challenge is to paragraph 32 of the proposed statement. That reads:

> 32. Your obligations under paragraph 28 of this statement mean that if you have a conscience objection to abortion and you are consulted by or on behalf of a pregnant woman 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 Contraception, Sterilisation and Abortion Act 1977.

[32] It is common ground that the reference to paragraph 28 should be to paragraph 27. That reads:

> 27. Section 32 of the Contraception, Sterilisation and Abortion 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 Sections 32 and Sections 33 of the Act.

[33] Counsel for the plaintiffs submit that paragraph 32 misstates the law and misleads the medical profession as to the doctor's legal obligation.

[34] Based on the foregoing discussion and my conclusions there expressed, I consider that paragraphs 32 and 27 do overstate the duty of a doctor with a conscientious objection, by failing to give adequate recognition to the ability of that doctor to decline to provide the service requested, by exercising the first option

described in [20] of this judgment. They require amendment to recognise that ability.

[35] The plaintiffs also object to a number of other paragraphs in the proposed statement. If paragraphs 27 and 32 were amended to make clear the doctor's ability to decline to become medically involved as described in [20] of this judgment, most of those paragraphs would be unexceptional. The one exception is paragraph 29, which refers to s 174. That purports to impose obligations which go beyond the duty imposed by s 174(2). I consider that that paragraph also requires amendment to reflect this judgment.

[36] It is not for this Court to dictate to the Council the terms of its statement. That is the statutory function of the Council. In preparing the proposed statement, the Council has undertaken a wide consultation process, and it might wish to consult further on any alterations. For these reasons, I consider that the appropriate course, under s 4(5) of the Judicature Amendment Act 1972, is, instead of granting any other relief, to direct the Council to reconsider its proposed statement, and in so doing to take into account the terms of this judgment. Beyond that, I do not consider it appropriate to give any further directions as to that reconsideration.

[37] There will accordingly be an order directing the Council to reconsider its proposed statement entitled 'Beliefs and Medical Practice', and, in that reconsideration, to take into account the terms of this judgment.

[38] Costs are reserved. The parties may submit memoranda if they are unable to agree.

"A D MacKenzie J"

Solicitors: Fisher Lamberg, Auckland for Plaintiffs
A H Waalkens QC, Barrister, Auckland
Buddle Findlay, Wellington for Defendant
M T Scholtens QC, Barrister, Wellington