(1) ORDER PROHIBITING PUBLICATION OF NAME, ADDRESS OR IDENTIFYING PARTICULARS OF THE PLAINTIFF, DEFENDANT AND EMPLOYEES OF THE DEFENDANT

(2) ORDER PREVENTING SEARCH OF THE TRIBUNAL FILE WITHOUT LEAVE OF THE CHAIRPERSON OR OF THE TRIBUNAL

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2014] NZHRRT 13**

	Reference No. HRRT 034/2011
UNDER	**THE HUMAN RIGHTS ACT 1993**
BETWEEN	**CBA**
	PLAINTIFF
AND	**LKJ LIMITED**
	DEFENDANT

AT WELLINGTON

BEFORE:
Mr RPG Haines QC, Chairperson
Ms PJ Davies, Member
Ms M Sinclair, Member

REPRESENTATION:
Mr M Freeman for Plaintiff
Mr H Waalkens QC and Ms V Knell for Defendant

DATE OF HEARING: 18, 19, 20 and 21 June 2012

DATE OF DECISION: 18 March 2014

DECISION OF TRIBUNAL

Introduction

[1] At 45 years of age and single, the plaintiff in March 2011 sought fertility treatment from the defendant company (LKJ Ltd) with the goal of achieving pregnancy. Following

medical and counselling appointments the clinical team at the defendant company decided that it would not be ethical to offer *in vitro* fertilization (IVF) as in their view the risk of harm to the plaintiff significantly outweighed the very slim chance of IVF leading to an ongoing pregnancy. In making that decision the team took into account the plaintiff's mental health.

[2] In these proceedings the plaintiff alleges that the defendant company discriminated against her by reason of her marital status (being a single woman), her age and her past history and ability to cope (her disability). The first two grounds were not pursued at the hearing and the plaintiff's case was in the final event advanced as a case based on disability. The defence to this claim is that the decision not to offer treatment was a clinical judgment and that the potential benefits of the treatment were outweighed by the risks to the plaintiff and to any child born as a result of the treatment. Further, the decision was, in terms of s 21B(1) of the Human Rights Act 1993 (HR Act) authorised or required by an enactment or otherwise by law and was therefore not unlawful.

[3] In relation to the disability claim, the defendant initially pleaded that the exception in s 52 had application (those covered by Part 2 of the HR Act must provide services to the disabled or treat those persons no less favourably in connection with the provision of those services subject to a reasonableness requirement). However, in opening submissions Mr Waalkens QC conceded that the provision had no application to the facts of the case (cf *Smith v Air New Zealand Ltd* [2011] NZCA 20, [2011] 2 NZLR 171 at [13] to [39]).

[4] The primary issues in this case are whether the plaintiff has established that she was refused services by reason of an actual disability or one which was suspected or believed to exist in terms of s 21(2)(b) of the Act and if so, whether the defendant has established on the balance of probabilities, that s 21B(1) excepts any conduct which would otherwise be unlawful.

[5] In view of the wide ranging nature of the complaints made by the plaintiff in her evidence and in her submissions, it is to be noted that the plaintiff has not brought proceedings under the Health and Disability Commissioner Act 1994 and while it will be necessary for reference to be made to the Code of Health and Disability Services Consumers' Rights (the Code of Rights), it is not the function of the Tribunal in these proceedings to adjudicate on those complaints.

An apology to the parties

[6] Before the evidence is addressed the long delay in publishing this decision is acknowledged and an apology offered to the parties. This case was not overlooked. Rather delays regrettably occurred because all members of the Tribunal are part-time appointees and despite best endeavours it is not always possible to publish decisions timeously.

Non-publication orders

[7] By consent, at the conclusion of the hearing on 21 June 2012 the Tribunal made final non-publication orders under s 107 of the HR Act prohibiting publication of the names and other details which might identify the plaintiff and defendant. This order included the names of the defendant's employees who gave evidence or who were referred to in the evidence placed before the Tribunal. In case any further non-publication orders are

sought by the parties, it will be seen that at the conclusion of this decision leave has been reserved for them to apply.

[8] The reasons for the final non-publication orders follow.

[9] The granting of name suppression is a discretionary matter for a court or tribunal: *R v Liddell* [1995] 1 NZLR 538 (CA). The starting point when considering suppression orders is the presumption of open judicial proceedings, freedom of speech (as allowed by s 14 of the New Zealand Bill of Rights Act 1990) and the right of the media to report. However, in *Liddell* it was recognised at 547 that the jurisdiction to suppress identity can properly be exercised where the damage caused by publicity would plainly outweigh any genuine public interest. The decision in *Lewis v Wilson & Horton* [2000] 3 NZLR 546 (CA) underlines that in determining whether non-publication orders should be granted, the court or tribunal must identify and weigh the interests of both the public and of the individual seeking the orders.

[10] Assisted by *C v Director of Human Rights Proceedings* CIV-2010-404-001662, 6 September 2010 at [78] to [88] we have taken into account the following factors in reaching a decision whether there should be non-publication orders:

> **[10.1]** The plaintiff has given evidence of alleged sexual abuse and of the consequences such offending has had on her. There are good reasons why her identity should not be disclosed.
>
> **[10.2]** The importance of this case lies not in the identity of the parties but in the fact that it is a unique opportunity to inform the medical profession of their responsibilities under the Human Rights Act, the Human Assisted Reproductive Technology Act 2004, the New Zealand Standard NZS8181: 2007 *Fertility Services*, the Health and Disability Services (Safety) Act 2001, the Code of Health and Disability Services Consumers' Rights and under the common law. As noted by the High Court in *C v Director of Human Rights Proceedings*, that purpose is achieved by publication of the terms of the decision itself. The identity of the plaintiff and of the defendant adds nothing to that process.
>
> **[10.3]** Suppression of the names of the defendant and of its employees in no way impacts on the public interest in knowing what happened. There is no suggestion that publication of the name of the defendant or of its employees is necessary for existing or potential clients to make future decisions about fertility treatment.
>
> **[10.4]** The four day hearing was open to the public.

[11] Having heard all the evidence we are satisfied that it is desirable to make the consent orders sought by the parties. Those orders mean, in effect, that of all the witnesses who gave evidence, only the identity of the expert witness, Professor Wayne Gillett, can be published.

Witnesses heard by the Tribunal

[12] The plaintiff was the only witness called in support of her case. The defendant called three witnesses. The first was Dr A, a registered medical practitioner in the vocational scope of Obstetrics and Gynaecology who established the defendant company and is the only dedicated full-time specialist in fertility at the clinic. The second was a counsellor, Counsellor B, who has been employed by the defendant since 1996.

The third and final witness was Professor Wayne Gillett of the Dunedin School of Medicine and who is also Clinical Director of Otago Fertility Service.

THE PLAINTIFF'S EVIDENCE – OVERVIEW

[13] It is not practicable to provide a comprehensive summary of the evidence given by the plaintiff. An overview only follows.

[14] The plaintiff's case is that in terms of s 44 of the HR Act she was unlawfully refused services by the defendant by reason of the fact its employees suspected or believed to exist the following prohibited grounds of discrimination listed in s 21(1)(h)(iii), (iv) and (v) of the HR Act, namely:

> (h) disability, which means—
> (i) …
> (iii) psychiatric illness:
> (iv) intellectual or psychological disability or impairment:
> (v) any other loss or abnormality of psychological, physiological, or anatomical structure or function:

[15] It is therefore necessary that in this part of the decision we provide an account of what, for convenience, will be referred to as the plaintiff's mental health as established by the evidence produced by her. Chronologically, that evidence relates to matters which precede the plaintiff's dealings with the defendant and will be addressed first.

The plaintiff's mental health

[16] The plaintiff, who in 2011 was 45 years of age, is single and has never had a stable long term partner. Between 2004 and 2006 she had a sexual relationship with a flatmate. It was not a committed relationship and the plaintiff alleges that when she told this person she did not want to have sex with him anymore he raped her. The plaintiff further says there was a subsequent confrontation which escalated. Feeling threatened she pulled a knife out of the knife block in the kitchen. When the Police arrived she still had the knife in her hand. On being arrested she pleaded guilty to possession of a knife, wilful ill-treatment of animals and trespass. She was required to come up for sentence if called upon within nine months.

[17] The flatmate applied for and was granted a protection order against the plaintiff. The plaintiff has been convicted for breaching that order on three occasions between 2004 and 2006. She was also convicted of failing to stop for red and blue flashing lights, resisting arrest and assaulting a police officer. Her sentence on that occasion was supervision of one year.

[18] The plaintiff has had three encounters with mental health services. All followed the events concerning the flatmate:

> **[18.1]** The first was when the plaintiff was arrested after the confrontation with the knife. At this time she was seen by CATT (Community Assessment and Treatment Team). She was asked questions relating to her mental health but she says there was no follow up.
>
> **[18.2]** When the plaintiff was charged with breaching the protection orders she was in December 2004 assessed by a psychologist as to whether she was fit to stand trial.

[18.3] In February 2007 she was assessed by a registered clinical psychologist during her sentence of supervision.

[19] Copies of the reports of the psychiatrist and of the psychologist respectively were produced in evidence. It is necessary that we refer to them, albeit briefly.

The psychiatric report of 6 December 2004

[20] In finding that the plaintiff was fit to stand trial the psychiatrist concluded that the plaintiff exhibited features of mild depressive disorder and noted a history "suggestive of a long standing maladaptive personality features":

> Some of the key features in her presentation included depressive symptoms, persecutory world-view, intense sense of frustration because of the injustice at the hands of the "system", defiant attitude, external attribution of blame, rigid and distorted thinking, as well as an apparent denial and minimisation of her own responsibility. This is on the background of what appears to have been long-standing difficulties in personality functioning, marked by social isolation, unsatisfying interpersonal relationships, low self esteem and employment failures.
>
> …
>
> [The plaintiff] seems to exhibit the features of mild depressive disorder, which could be understood in the context of her current circumstances. In my opinion she is not psychotic although she seems to show some distortions in her thinking, which is rigidly preoccupied with themes of injustice and persecution. I have no sufficient information regarding her long-term personality functioning, although there is a history suggestive of a long standing maladaptive personality features.

[21] After noting that the plaintiff was at risk of developing "a full-blown depressive illness", the psychiatrist observed that she might benefit from treatment which combined pharmacological and psychotherapeutic approaches. In the event of the plaintiff being sentenced to a community type sentence he recommended referral to the general mental health services or Court mandated counselling. He stated:

> Some combination of judicial and psychotherapeutic interventions has the best potential to be effective, given that she is unlikely to accept any treatment on a voluntary basis. It is going to be difficult to motivate her for therapy, however, with the prospect of judicial sanctions, she might be able to engage in treatment and modify her behaviours that led to the offending.

The psychological report of 28 February 2007

[22] The plaintiff was seen by a registered clinical psychologist from the Department of Corrections Psychological Service on five occasions between 11 December 2006 and 23 January 2007. The following observations by the psychiatrist can be noted:

[22.1] There was no evidence of gross behavioural indicators of major psychiatric disturbance.

[22.2] The plaintiff expressed both suicidal and homicidal ideation.

[22.3] She did not consider that she had an effective support network, could not rely on family members and did not feel she could confide in her probation officer.

[22.4] She reported having had recent homicidal thoughts related to both the male victim and the friend she was staying with.

[22.5] She had "a degree" of paranoia.

[22.6] There was evidence suggestive of the presence of dysthymic disorder and of a major depressive episode:

> Typically, she externalises her problems and has a propensity to be both blaming and self-justifying. By externalising her problems, she appears to further exacerbate an underlying paranoia. This is ostensibly related to both victims and people in perceived positions of power (eg the police, Justice Department, CATT and CPS). Her paranoia coupled with her low self esteem, paradoxically leaves her both rejecting of others (anger) and needing of others (guilt). At a functional level, her difficulties have resulted in depressed mood, anxiety, poor concentration and short-term memory deficits. She has low energy, a poor sleep pattern and lacks interest in attempting to pursue pleasurable things, which she sees as futile. Whilst not formally diagnosed, [the plaintiff's] self-report is suggestive of the presence of dysthymic disorder, but her recent decline and presentation appears to meet the criteria for a major depressive episode. However, considering her self-report and presentation individuals with a similar profile also meet the criteria for borderline personality disorder, with a co-morbid depressive episode.

The psychologist recommended that the plaintiff would benefit from psychological treatment via Community Mental Health services. However, no such treatment was mentioned by the plaintiff in her evidence to the Tribunal. Indeed she said she had had no involvement with any mental health service since 2006.

[23] Neither of the two medical reports were known to the defendant or to its employees until those reports were disclosed by the plaintiff in the course of the discovery process engaged in by the parties subsequent to these proceedings being filed.

The plaintiff's dealings with the fertility clinic

[24] In February 2011 the plaintiff made telephone contact with the clinic operated by the defendant. She attended an initial appointment on 24 March 2011 which included a physical examination performed by Dr A. There was difficulty in carrying out that examination and she attended a second appointment with Dr A at which the physical examination was successfully performed. Dr A concluded that from a physical viewpoint a course of treatment involving IVF and Intracytoplasmic Sperm Injection (ICSI) was a feasible option for the plaintiff. On 3 and 30 May 2011 the plaintiff attended counselling sessions with a counsellor employed by the defendant, Counsellor B. At these sessions the plaintiff discussed aspects of her past, including the incident in which she says she was raped. After the second counselling session Counsellor B raised concerns about the plaintiff receiving fertility treatment and she (the plaintiff) was given three options, namely seeking a formal psychological assessment, seeking an ethical review by ECART or having the Medical Director of the defendant's clinic review her case. The plaintiff elected the third option.

[25] By letter dated 31 May 2011 signed by Dr A, Counsellor B and by the Medical Director the defendant advised the plaintiff that it was declining to treat her. The reasons included concern that the plaintiff would be largely unsupported while going through IVF treatment and then as a single mother, concern about the ongoing effects of the alleged rape and the impact this might have on the plaintiff's ability to cope during IVF treatment, pregnancy and while parenting on her own. Furthermore there was only a very slim chance of IVF leading to an ongoing pregnancy and in the team's professional judgment the risk of harm significantly outweighed the chance of pregnancy and the team did not believe it would be ethical for the clinic to offer the plaintiff IVF treatment.

[26] In cross-examination the plaintiff's further evidence included the following:

[26.1] Asked if she agreed that the health and well-being of children born as a result of an assisted reproductive procedure should be an important consideration in all decisions about the procedure, she said she could see the point but there was CYFS (and other agencies) who could step in if need be. Later she said that giving consideration to the health and well-being of children "sounded good".

[26.2] Asked if she agreed that the health and well-being of women were to be protected in the use of the procedure, the plaintiff said she could not say yes or no as she was not a provider.

[26.3] She did not believe that her background had any relevance to the decision whether she should receive IVF service from the clinic.

[26.4] She had not had a GP since 2003 or 2004.

[26.5] She chose to be socially isolated and would rather be with a child alone ie a solo parent than with a man as he could be violent.

[27] The plaintiff's case is that the reason for refusing to treat her was due to a perceived or actual mental disability which falls within the definition of s 21(1)(h) of the HR Act.

THE EVIDENCE FOR THE DEFENDANT – OVERVIEW

Dr A – qualifications and experience

[28] Dr A is a medical practitioner registered in the vocational scope of Obstetrics and Gynaecology and is certified by the RANZCOG as a sub-specialist in reproductive medicine. He has held a Professorship at a School of Medicine in New Zealand and established the defendant company in 1992 and was its Medical Director until 2007. Presently he is the only dedicated full-time specialist in fertility at the clinic. For nine years until 2011 he was the only specialist appointee on the National Ethics Committee on Assisted Reproductive Technology (ECART) and the Hormone and Contraception Sub-Committee of Pharmac. ECART considers and determines applications for assisted reproductive procedure or human reproductive research. It also liaises with the Advisory Committee on Assisted Reproductive Technology (ACART) and other relevant ethics committees on matters relating to assisted reproductive procedures and human reproductive research.

Fertility treatment – birth rates

[29] Dr A gave evidence that age is a valid clinical indicator of the chances of becoming pregnant and achieving a live birth. IVF treatment does not overcome the effect of age due to the fact that the chance of conceiving and having a baby rapidly declines between the ages of 30 and 40 years. In a woman aged 43 years the chance of having a baby during an IVF cycle is 8%. At the age of 46 years the chance is less than 4%. Any treatment with a success rate of less than 5% is considered to be a "very poor prognosis" and in such circumstances doctors may ethically refuse to accept a patient for treatment or provide further treatment. The chance of a successful IVF procedure is less if the woman has had no previous children. The success rate for women 43 years of age with no previous children is 4%. The rate in relation to a woman aged 46 with no previous children is 2%. He said that the prospect of success for the plaintiff was in the

region of 3%. Notwithstanding this the defendant provides treatment for women 45 years and over and this accounts for approximately 1% of all cycles undertaken.

Dr A's understanding of the responsibilities engaged in the context of fertility treatment

[30] Citing the Human Assisted Reproductive Technology Act 2004 (HART Act), Dr A said that he believed important social and ethical responsibilities were engaged in the provision of fertility services. This was especially so with donor treatments and all fertility procedures are regulated in New Zealand to ensure the interests of the children, the donors and surrogates as well as the couple or single woman who want a family. In particular he emphasised the following principles which are set out in s 4 of the HART Act:

> (a) the health and well-being of children born as a result of the performance of an assisted reproductive procedure or an established procedure should be an important consideration in all decisions about that procedure:
>
> (b) the human health, safety, and dignity of present and future generations should be preserved and promoted:
>
> (c) while all persons are affected by assisted reproductive procedures and established procedures, women, more than men, are directly and significantly affected by their application, and the health and well-being of women must be protected in the use of these procedures:
>
> (d) no assisted reproductive procedure should be performed on an individual and no human reproductive research should be conducted on an individual unless the individual has made an informed choice and given informed consent:

[31] Bearing in mind these principles Dr A said that it was his view that where a fertility provider believed (based on clinical and specialist opinion) the potential benefits of a treatment were outweighed by the risks of treatment to a woman's health and well-being and/or to a child born as a result of fertility treatment, treatment may be declined or stopped.

Fertility treatment – psychological and physical stress

[32] Dr A gave evidence that not only is fertility treatment physically stressful, treatment is not only a medical matter. It is often associated with psychological stress and it is important that patients are psychologically safe to undergo treatment. The risks to the health and well-being of the woman and separately, to the child born, are in his view paramount considerations and it is vital that they are taken into account before the patient commences fertility treatment. Much time is spent ensuring these objectives are met.

[33] One mechanism utilised by the defendant to assess patient readiness and to help patients through the decision-making and preparation process for fertility treatment is specialist counselling. Counselling is also used to ensure that patients are able to understand, tolerate and comply with the demands of fertility treatment, pregnancy and parenthood. Dr A pointed out that NZS8181 *Fertility Services* requires that donors, the partners of donors and the recipients of donated material have counselling before treatment is commenced and that patients, before receiving treatment, are fully informed of the risks and benefits around using a donor. Common issues discussed during counselling include discussing expectations regarding success or failure of the

treatment, examining the patient's psychiatric history and the advantages and disadvantages of donor insemination as against adoption.

Dr A and the plaintiff – the first consultation

[34] The first consultation with the plaintiff lasted approximately 45 minutes and was described by Dr A as "strange and concerning" in several ways. He remarked on the plaintiff's demeanour, including her failure to make eye contact, her failure to engage with Dr A and the fact that she did not assist in their communication, in that she would not answer the majority of questions asked with more than one or two words. At the end of the consultation he was left with the impression that the plaintiff had significant personality issues which needed to be investigated before a decision was made to commence fertility treatment.

[35] When Dr A endeavoured to discuss with the plaintiff why she was seeking a donor and why she had not considered having children in previous relationships, she replied that none of her previous partners had been good-looking enough. Dr A found this explanation quite peculiar and had to explain that if donor insemination treatment was to be agreed, the selection profiles did not include a picture of the donors so that she would not be able to make a selection based on physical looks. Another aspect noted by Dr A as being unusual was that the plaintiff appeared to be of the belief that she had the right to purchase the semen and therefore the defendant was required to provide it. Dr A had to explain to her that this was not the case and that semen or sperm was not the same as a commercial product. Another issue remarked upon by Dr A was the plaintiff's reluctance to be open and frank about issues which needed to be explored regarding Dr A's responsibilities to ensure that should there be problems or difficulties during treatment, pregnancy and caring for any child, there would be a sufficient level of support available to her. He said that it was unusual for single women to attend the consultation alone as had the plaintiff.

[36] When asked directly by Dr A whether she had support, the plaintiff did not offer any information about support available to her but instead told Dr A that she did not think she needed any support, even if she had a child but stated she had the financial resources to pay for any help. As far as support during the treatment might be required, she stated that she expected the defendant to provide all the necessary support. This left Dr A with a clear impression that the plaintiff had no or no adequate support.

[37] In trying to explore her medical history Dr A was told by the plaintiff that there had been an incident some years earlier that had resulted in her subsequently not having vaginal examinations, such as smear tests. Given that vaginal and internal examinations are a necessary part of fertility treatment Dr A tried to explore this issue with the plaintiff but she refused to elaborate any further.

[38] As the plaintiff was providing only limited information about her medical history Dr A attempted to conduct an internal examination to assess whether the treatment would be physically possible. This is a routine examination to assess the reproductive tract, to ensure that any treatment is feasible and safe and that there would, should pregnancy ensue, be no predisposition to any complications. Dr A was unable to even insert a speculum into the vagina. He explained to the plaintiff that if she could not tolerate such an examination this would make donor insemination or IVF treatment physically impossible as introduction of a speculum is a necessary part of IVF treatment.

[39] Dr A also considered it significant that the plaintiff requested that no report be sent to her GP. His concern arose from the fact that the defendant considers it important to keep in contact with a patient's GP or referring doctor about the consultations and treatment received as a GP needs to be involved in the management and treatment process. He or she may know additional information about the patient's medical history and other matters that may mean that fertility treatment is contra indicated.

[40] At the end of the consultation Dr A was very concerned about the suitability of the plaintiff to undergo any treatment and about her safety during the treatment process. In his evidence he mentioned particularly his concern as to whether the plaintiff would have support during and after treatment particularly given that he was left with the strong impression that the plaintiff was not willing to accept that the chance of the treatment being successful was very low. Rather she seemed to be concerned only with the urgency of treatment because of her age. This in his opinion showed a lack of insight and willingness to cooperate with all the aspects required when undergoing such treatment.

[41] He advised the plaintiff that as with all patients wishing to undergo fertility treatment she was required to attend counselling with a specialist counsellor and that treatment could not start until this had taken place. The purpose of the counselling is not confined to the risks and benefits of the treatment but also to determine if there are other important issues, such as inadequate personality or mental or social problems which Dr A believes he is required to take into account in determining whether or not a patient should undergo fertility treatment.

[42] In his oral evidence Dr A elaborated on the safety issues for the plaintiff. He emphasised the physical nature of the treatment, the need for the patient to self-medicate both by way of oral medicine and also by way of self-injections, the taking of blood tests and vaginal scans. This can be necessary on either alternate days or sometimes daily. Intravenous sedation is also sometimes required for different steps in the process because of the pain and discomfort. The treatment regimen is a challenging one necessitating the patient to have the assistance of a support person for the physical side of the treatment. But as there is a substantial risk of psychological consequences of the treatment, including depression, anxiety, phobias and withdrawal, it is necessary for the patient to have support in these areas as well. Because the plaintiff did not appear to have any effective support and because she had unrealistic expectations and little understanding of the potential for the treatment to have serious complications the concerns held by Dr A for her safety were high.

Dr A and the plaintiff – the second consultation

[43] Dr A again consulted with the plaintiff on 15 April 2011. At that appointment he was able to perform a vaginal speculum examination and related procedures mandatory prior to all fertility treatments. He concluded that the treatment, from a physical viewpoint only, was a feasible option. He again outlined to the plaintiff what the treatment involved and again that the chance of conception was very low because of her age. This notwithstanding, the plaintiff wanted to proceed with the treatment. Because of her age and the urgency for treatment, Dr A made a plan for the treatment, were it to proceed. In normal circumstances (ie when the treatment is not urgent) Dr A would not have made a plan but reassessed the patient after the completion of counselling that supported the treatment. Dr A advised the plaintiff that the treatment could not commence until after she had met the expectations which counselling was to explore further.

[44] In setting up the treatment plan Dr A did not intend to be understood as representing that the clinical team had agreed to provide treatment. Rather it was undertaken to support the urgency which the plaintiff demanded and to save her having to return to see him again after the counselling sessions.

Dr A and the plaintiff – after the first counselling session

[45] On 3 May 2011 the plaintiff attended the first counselling session with Counsellor B. On 24 May 2011 Counsellor B met with Dr A to discuss the significant concerns held by Counsellor B in relation to the plaintiff. Counsellor B expressed to Dr A her opinion that there were major issues concerning the plaintiff's mental health as a result of ongoing effects of a past trauma. As a result of the discussion between Dr A and Counsellor B Dr A made a provisional decision that the treatment posed a significant risk to the plaintiff's health and well-being and to that of any child born as a result of the treatment (if successful). His discussions with Counsellor B confirmed his serious concerns about the plaintiff's mental health status and her apparent difficulties with relationships with others. He concluded that she was not a suitable candidate for fertility treatment.

Dr A and the plaintiff – after the second counselling session

[46] On 30 May 2011 the plaintiff attended her second counselling appointment with Counsellor B.

[47] Following consultation between Dr A, Counsellor B and the clinic's Medical Director a letter was sent to the plaintiff on 31 May 2011 advising her that it would not be ethical for the clinic to offer her IVF treatment. The letter was in the following terms:

> We are writing regarding your hope to begin IVF treatment using donor sperm.
>
> In light of concerns raised during the medical and counselling appointments, the clinical team at [the defendant company] has reviewed your situation today.
>
> As you know, we have been worried that you would be largely unsupported while going through IVF treatment and then as a single mother. We are also concerned about the ongoing effects of the distressing events in your history and the impact this might have on your ability to cope during IVF treatment, pregnancy and while parenting on your own.
>
> At times the clinic has requested a letter from a patient's GP or counsellor in support of their readiness to proceed with fertility treatment. However it is our understanding that you prefer not to have any contact with a GP or psychologist, and would not wish us to make contact with your past GP.
>
> You have been informed about the very slim chance of IVF leading to an ongoing pregnancy at your age of 45. In our professional judgement, the risk of harm significantly outweighs this and we do not believe it would be ethical for this clinic to offer you IVF treatment.
>
> It is possible that another clinic would reach a different decision and you may wish to approach an alternative fertility treatment provider.
>
> We are sorry that this decision will be very disappointing for you. We do wish you well for the future.

Counsellor B – counselling for donor insemination with IVF

[48] Counsellor B has been employed on a part time basis by the defendant since 1996. Her work at the clinic involves counselling patients attending the clinic for treatment, those wishing to assist patients by donating gametes (reproductive cells) or by offering surrogacy and people who have been conceived with the use of donated gametes. Her role is not that of gatekeeper to determine access to treatment. That is the role of the

treating doctor. However, in the course of counselling, significant risk factors may be identified that in the opinion of the counsellor may impact on the clinical decision and in those circumstances Counsellor B believes that she is under a duty to bring those factors to the attention of the treating clinician. This obligation she believes is mandated by the HART Act and by the relevant professional standards of practice. In particular, she understood that the health and well-being of women must be protected in the use of fertility procedures.

[49] The defendant has a policy of a three month "stand down" period between treatment with donor sperm being discussed with the doctor and that treatment starting. This is to allow adequate time for full consideration of this treatment option. During this period patients attend two counselling sessions, preferably spaced a minimum of a month apart. This allows people appropriate time to reflect on the issues raised during counselling. Those issues will include motivation for treatment, the context of the patient's physical, mental and social health and current situation, the treatment process and coping with this, risks and informed consent, support available and the needs of the child to be born. She said that understanding the challenges of treatment and of parenting, expectations of possible treatment outcomes (including chances of success, miscarriage and the risk of abnormality) and readiness to cope if treatment is unsuccessful, is crucial before proceeding with treatment. That is to say it is important that the client has the psychological resilience to cope with IVF treatment and its uncertainties.

Counsellor B – first counselling session with plaintiff

[50] The first counselling session was held on 3 May 2011. It was evident to Counsellor B that the plaintiff was still suffering psychological effects from the alleged sexual assault. The plaintiff confirmed that she had not had counselling to help her after the assault.

[51] Counsellor B explored with the plaintiff her family, their awareness of her plans, her support network, whether financial stress would be a difficulty for her and her past and current psychological and physical health. The plaintiff described being socially isolated in that she said she had few friends. Her parents were deceased. She had lost contact with two sisters. The third sister with whom she was in contact lived in another city. She did not want her GP to be contacted because after the alleged rape she had been diagnosed with depression. She believed that this diagnosis was untrue. She said she did not have any other psychological history.

[52] Compared with other women presenting for treatment in similar circumstances, the plaintiff was described by Counsellor B as having a marked lack of social support. In the opinion of Counsellor B she (the plaintiff) was still suffering psychological effects from the alleged rape. Additionally the plaintiff reported finding gynaecological procedures particularly distressing and it seemed to Counsellor B that the plaintiff might find the physical procedures involved with IVF traumatic. She had also reported a history of diagnosed depression but disputed the validity of this diagnosis. On this information Counsellor B was "significantly concerned" about the plaintiff's readiness to undergo treatment and met with Dr A to discuss the issues.

Counsellor B – second counselling session with the plaintiff

[53] On 30 May 2011 the plaintiff attended a second counselling session. In the course of this session Counsellor B conveyed to the plaintiff that there were concerns about her

readiness to proceed with the treatment. The plaintiff became "intensely angry", so much so that Counsellor B considered ending the session. The plaintiff stated that the man who had hurt her would have won and the plaintiff threatened to use the money she had saved for IVF to hire a hit man to kill him. Counsellor B advised the plaintiff that there were several avenues available to provide for a review of the concerns shared by her and Dr A, including seeking a formal psychological assessment, ethical review by ECART or having the Medical Director of the clinic review her case. The plaintiff said she did not wish to see a psychologist and that the timeframe involved in an ethical review would be too lengthy. She agreed that Counsellor B could discuss Counsellor B's concerns with the Medical Director.

[54] On 31 May 2011 Counsellor B contacted the Medical Director and discussed with him the factors Counsellor B considered might affect the plaintiff's resilience in coping with treatment and parenting on her own. Counsellor B also discussed the plaintiff's relatively recent criminal record as disclosed by the plaintiff and the fact that the protection order was still in place. She alerted the Medical Director to the threats made about hiring a hit man.

Counsellor B and the telephone call of 13 June 2011

[55] On 13 June 2011 Counsellor B telephoned the plaintiff to see how she was after receipt of the clinic's letter dated 31 May 2011 advising that the plaintiff would not be offered IVF treatment. The plaintiff was very upset and angry at the decision to decline treatment. She felt that the clinic was questioning her mental health and suggesting she would hurt her baby. She felt that taking away her last chance to have a baby left her without a point to her life and that she might have her cats put down and end her own life. When Counsellor B attempted to assess the level of intent of self-harm or harm to the man threatened by the plaintiff, the plaintiff stated that she was no longer considering hiring a hit man but had a better plan in mind. The only information she would give was to confirm that the Police would be concerned about her plans. Counsellor B discussed possible avenues for the plaintiff to seek help but the plaintiff rejected these suggestions. The call was ended by the plaintiff with the comment "watch your back". This threat unnerved Counsellor B and made her feel unsafe. It was reported to the Police.

Counsellor B – her opinion of the plaintiff

[56] Counsellor B stated that it was her opinion that there were serious concerns about the plaintiff's psychological readiness for treatment. These included her apparent difficulty in managing her anger, leading to aggressive outbursts and threats of harm towards others. Her description of her relatively recent criminal history indicated that her anger had led to acts of violence. In addition, the plaintiff had a history of diagnosed depression and she had expressed suicidal thoughts. Her unwillingness to allow contact with her GP was a cause for concern, as was the ongoing rumination, paranoid thinking, social isolation and trauma reaction to gynaecological examination associated with her history of alleged assault. In the opinion of Counsellor B the clinical decision not to proceed with treatment was appropriate. The importance of ensuring that a patient is psychologically capable and has the fortitude to undergo treatment, pregnancy and care for a child born as a result of the treatment is not a matter to be taken lightly. In her opinion these decisions must be made erring on the side of caution so as to avoid detriment to the health and well-being of the woman and also to the child.

Professor Wayne Gillett – acceptance as an expert

[57] Professor Gillett is a registered medical practitioner, Professor at the Dunedin School of Medicine and Director of Otago Fertility Service. His curriculum vitae is too extensive to be adequately summarised here but his qualifications to give expert evidence in this case were (properly) not challenged and we accept his evidence as expert evidence.

Professor Gillett – IVF treatment and the need for support

[58] Professor Gillett described assisted reproductive procedures as "complex and difficult" treatments that require "a great deal of preparation and support". It is the provider's responsibility to ensure these are in place and that the treatment is safe for the women and the potential child. In his long experience of providing donor insemination services he has seen many cases where the treatment and aftermath has generated family conflicts. Most of these were observed in the days before mandatory counselling. Nearly half of all couples having a child by donor insemination in the 1980s subsequently separated. In his opinion, this underlined why it is a requirement to undertake two counselling sessions and why clinics impose at least a three month "stand down" period. Time is needed for both the potential recipient and the provider to reflect and consider the implications of gamete donation.

[59] Providers have the obligation to seek the background for requests for donor insemination. They have the duty to establish the support systems particularly pertaining to family and relationship issues. They also have a duty to ensure that the recipient women (or couple) is, and will be, supported. In couple recipients there is the support of each other and, usually, family and friends. For most single women this is more difficult but most single women, in his experience, have the support of a friend(s) or family.

[60] The need for the presence of adequate support is, in his opinion, "absolute" and is needed at many steps: for the treatment itself, for a failed treatment, for an ongoing pregnancy and probably most importantly for the child who is born into a single woman's life along with her social and psychological environment.

[61] Professor Gillett stated that should a clinic perceive "any inkling" of absence of support at any of these stages they have a duty to seek resolution before embarking on treatment.

Professor Gillett – opinion on the decision not to treat the plaintiff

[62] On the evidence before the Tribunal Professor Gillett is of the opinion that the decision by the defendant not to treat the plaintiff owing to concerns about her mental health status, the level of support and the other obligations believed to flow from s 4 of the HART Act (requiring the consideration of the health and well-being of the woman receiving treatment and of the potential child), was the right decision and indeed one he would have made in the circumstances. In arriving at this conclusion he took into account (inter alia) the following:

> **[62.1]** In his experience women aged more than 25 seeking fertility treatment for the first time have unrealistic expectations and have other psychological or social issues that make treatment difficult.

[62.2] The plaintiff had insisted on undue haste for treatment. That haste was in contrast with the many years prior to the age of 45 when she could have sought treatment. In his experience late requests are usually accompanied by unrealistic beliefs about the treatment. Undue haste would alert him to the concern whether to accept treatment or not.

[62.3] The plaintiff's request that her GP not be involved was in the opinion of Professor Gillett "very concerning". This would have given him the sense of a risk that something had not been disclosed and in turn this could lead to a contravention of the principles of the HART Act.

[62.4] The plaintiff had poor insight on a number of issues, particularly the chances of success and hastiness of treatment.

[62.5] The evidence of Counsellor B indicated there were serious concerns about the plaintiff's psychological readiness for treatment. Professor Gillett would only have accepted the plaintiff for treatment provided she had the support of other professionals, such as a psychiatrist. In the event that another professional opinion was not acceptable to the plaintiff, Professor Gillett would insist on seeking advice, on her behalf, from ECART. If none of these avenues were acceptable then he would decline treatment.

[62.6] That a psychological opinion and ethical review by ECART were declined by the plaintiff would have made the clinic's position indefensible were it to have then offered treatment.

[62.7] Given the challenges faced by the plaintiff, the absence of any real support was of substantial concern.

[63] Professor Gillett was of the further opinion that treatment may be refused on ethical grounds for futile treatment. In his oral evidence he said that in the case of a woman aged 45 or more, should treatment be successful (which he estimated as a 2% chance), there was a 50% chance of a miscarriage and a 10% chance of the child being born with a physical or intellectual disability. Commenting on the plaintiff's position he said that he thought that she would be extremely vulnerable in her situation. If the IVF process did not go well (as was likely to happen in the plaintiff's case), there was a real risk of a deterioration in the plaintiff's mental health. Because the plaintiff had not elected the option of a psychological assessment when offered by Counsellor B, the "informed consent" process had not been completed. While mental health issues are not grounds in themselves to withhold treatment, the treating clinician would have to be satisfied that the patient's mental health allowed her to accommodate the treatment process and the potential pregnancy and its uncertain associated outcomes. He said that where cases did give rise to mental health or mental disability issues, support services are put in place to accommodate the concerns. In the plaintiff's case there were so many safety issues that they trumped her desire to have the treatment. What was missing in her case was support and communication. There was incomplete information about the criminal convictions, the support which was realistically available to the plaintiff, there was no GP support and there were concerns about her mental health. Each factor on its own might not necessarily be sufficient to lead to a decision to decline treatment. But taken together along with her election not to obtain a psychological assessment meant that neither she nor Dr A could engage meaningfully with the issues, that is in a way that allowed it to be said that the plaintiff had given her informed consent to a complex and

difficult treatment which could potentially lead to a pregnancy with highly uncertain outcomes both with regard to the mother and with regard to any potential child.

EVIDENCE ASSESSMENT

[64] Dr A and Counsellor B were strong and persuasive witnesses whose evidence was given objectively and supported by notes made contemporaneously with events. The plaintiff, on the other hand, had none of these advantages. As a witness she was simultaneously unsure of herself and overconfident in her recollection of events even though she had made no notes at the time. She was clearly (and understandably) defensive about having her mental health the subject of scrutiny by the witnesses and by the Tribunal. There was more than an element of hostility to the defendant and its employees, the plaintiff at times portraying the situation as one in which she had been wrongly refused a service which the law required be provided to her on demand. She lost no opportunity to criticise the defendant for alleged shortcomings in its processes. She was also critical of Counsellor B for breaching a perceived confidentiality obligation.

[65] For these reasons we have doubts about the accuracy of the plaintiff's recall and about the objectivity of her evidence. In these circumstances we do not hesitate accepting the evidence of Dr A and of Counsellor B in preference to that of the plaintiff wherever there is a conflict in evidence.

[66] As to the evidence of Professor Gillett, we accept that he is an expert witness qualified to give the evidence that he has given. We similarly found him to be a strong and persuasive witness.

[67] It follows that we determine the case on the evidence given by the defendant's witnesses except to the extent that it is necessary to refer to the plaintiff's evidence on matters not addressed by those witnesses.

[68] We address now the legal issues.

THE LEGAL ISSUES

Overview

[69] As mentioned, the plaintiff alleges that the defendant breached s 44(1) of the HR Act which provides:

> **44 Provision of goods and services**
>
> (1) It shall be unlawful for any person who supplies goods, facilities, or services to the public or to any section of the public—
> (a) to refuse or fail on demand to provide any other person with those goods, facilities, or services; or
> (b) to treat any other person less favourably in connection with the provision of those goods, facilities, or services than would otherwise be the case,—
> by reason of any of the prohibited grounds of discrimination.

[70] The grounds of discrimination originally relied on in the statement of claim were the plaintiff's marital status (being a single woman unsupported through treatment and as a single mother), her age and finally, "her past history and ability to cope", being her disability. As the case developed the first two grounds were not pursued and the disability ground was more particularly articulated as being those grounds stipulated in s

21(1)(h)(iii), (iv) and (v) and s 21(2) of the HR Act. For convenience we shall in this part of the decision refer to these grounds as the plaintiff's mental disability:

> **21 Prohibited grounds of discrimination**
>
> (1) For the purposes of this Act, the *prohibited grounds of discrimination* are—
> (h) disability, which means—
> …
> (iii) psychiatric illness:
> (iv) intellectual or psychological disability or impairment:
> (v) any other loss or abnormality of psychological, physiological, or anatomical structure or function:
> (2) Each of the grounds specified in subsection (1) is a prohibited ground of discrimination, for the purposes of this Act, if—
> (a) it pertains to a person or to a relative or associate of a person; and
> (b) it either—
> (i) currently exists or has in the past existed; or
> (ii) is suspected or assumed or believed to exist or to have existed by the person alleged to have discriminated.

[71] The defence to this allegation is:

[71.1] The decision not to offer treatment to the plaintiff was a clinical judgment that the potential benefits of the treatment were outweighed by the risks to the plaintiff and to any child born as a result of the treatment ie the decision not to treat was not based on age, marital status or disability. Rather the defendant considered that treatment was not in the plaintiff's best interests or in the best interests of the health and well-being of any future child.

[71.2] In terms of s 21B(1) of the HR Act the decision to withhold treatment was not unlawful as the decision was authorised or required by an enactment or otherwise by law:

> **21B Relationship between this Part and other law**
>
> (1) To avoid doubt, an act or omission of any person or body is not unlawful under this Part if that act or omission is authorised or required by an enactment or otherwise by law.
> (2) Nothing in this Part affects the New Zealand Bill of Rights Act 1990.

[72] The defendant does not rely on any of the exceptions allowed by s 52 of the HR Act:

> **52 Exception in relation to disability**
>
> It shall not be a breach of section 44 for a person who supplies facilities or services—
> (a) to refuse to provide those facilities or services to any person if—
> (i) that person's disability requires those facilities or services to be provided in a special manner; and
> (ii) the person who supplies the facilities or services cannot reasonably be expected to provide them in that special manner; or
> (b) to provide those facilities or services to any person on terms that are more onerous than those on which they are made available to other persons, if—
> (i) that person's disability requires those facilities or services to be provided in a special manner; and
> (ii) the person who supplies the facilities or services cannot reasonably be expected to provide them without requiring more onerous terms.

[73] It follows that the legal issues for determination are those prescribed by s 44 and 21B(1) of the HR Act. We address s 44(1) first. Before doing so it is to be noted that it is for the defendant to establish the s 21B "defence".

Section 44(1) Human Rights Act – whether a comparator required

[74] As observed in *Smith v Air New Zealand Ltd* [2011] NZCA 20, [2011] 2 NZLR 171 at [28] citing *Air New Zealand Ltd v McAlister* [2009] NZSC 78, [2010] 1 NZLR 153, discrimination in general terms involves a person being treated differently from someone in comparable circumstances. A comparator is required at least where the section in question has a comparison inherent in the definition of discrimination. In *Air New Zealand Ltd v McAlister* at [105] McGrath J was of the view that some sections outlawing discriminatory conduct do not require a comparison. He said that in the case of such provisions an action is discriminatory merely by reason of being taken on a prohibited ground. In the same case Tipping J at [61] similarly noted that some of the prohibitions on discrimination in the employment context addressed by s 22(1) of the HR Act were absolute whereas others were comparative in that the latter category of provision stipulated that a comparison is required with the treatment afforded to other employees in comparable circumstances.

[75] Turning to s 44(1) it can be seen that the prohibition in s 44(1)(a) is absolute:

> **44 Provision of goods and services**
>
> (1) It shall be unlawful for any person who supplies … services to the public …—
> (a) to refuse … on demand to provide any other person with those … services;
> by reason of any of the prohibited grounds of discrimination.
> (b) …

[76] Establishment of the unlawful conduct does not involve any comparison between the treatment afforded to the person complaining of discrimination and that afforded to any other member of the public. The stipulation is absolute in that sense. If goods or services are supplied to the public it is unlawful to refuse to provide such goods or services to "any other person" by reason of a prohibited ground of discrimination.

[77] By contrast s 44(1)(b) introduces a comparison exercise:

> **44 Provision of goods and services**
>
> (1) It shall be unlawful for any person who supplies … services to the public …—
> (a) …
> (b) **to treat any other person less favourably** in connection with the provision of those … services **than would otherwise be the case**,—
> by reason of any of the prohibited grounds of discrimination. [Emphasis added]

[78] Conduct is unlawful if the complainant is treated less favourably "than would otherwise be the case".

[79] We address first whether a breach of s 44(1)(a) has been established before turning to s 44(1)(b).

Whether a breach of s 44(1)(a) established

[80] For the reasons explained earlier, determination whether there has been a breach of s 44(1)(a) of the HR Act does not involve a comparator. All that a complainant need show is that the supplier of the service supplied such service to the public but refused to

provide the complainant with the service by reason of a prohibited ground of discrimination. It is then for the alleged discriminator to show that his, her or its actions came within one of the permitted statutory exceptions or within s 21B of the Act.

[81] It is to be recalled that at the time they dealt with the plaintiff and at the time a decision was reached not to offer IVF treatment to the plaintiff, neither Dr A nor Counsellor B had available the psychiatric report of 6 December 2004 or the psychological report dated 28 February 2007. They did, however, suspect that the plaintiff had a psychiatric illness or psychological disability or impairment. See for example the following passages from the brief of evidence by Dr A:

> 31. … I was left with the impression that [the plaintiff] had significant personality issues that needed to be investigated further before a decision was made to commence treatment.
>
> …
>
> 64. [Counsellor B] expressed to me her opinion that there were major issues concerning her mental health (problems in respect of her personality and relationship difficulties) as a result of ongoing affects of a past trauma.
>
> …
>
> 66. … I doubted the suitability of [the plaintiff] undergoing the treatment after the first consultation I had with her. However after I discussed her case with [Counsellor B] my serious concerns about her mental health status and her apparent difficulties with relationships with others following a traumatic incident in her past were confirmed.

[82] The evidence of Counsellor B was:

> 59. In conclusion, it is my opinion that there were serious concerns about [the plaintiff's] psychological readiness for treatment.

[83] The defendant's letter dated 31 May 2011 read, in part:

> As you know, we have been worried that you would be largely unsupported while going through IVF treatment and then as a single mother. We are also concerned about the **ongoing effects of the distressing events in your history and the impact this might have on your ability to cope during IVF treatment, pregnancy and while parenting on your own**. [Emphasis added]

[84] Dr A and Counsellor B confirmed in oral evidence that the bolded phrase was a reference to the plaintiff's mental health issues.

[85] The question is whether, on this evidence, it is proper to conclude that the refusal of service by the defendant was "by reason of" a prohibited ground of discrimination.

Section 44(1) – by reason of

[86] Under s 44(1) the refusal or failure to provide goods, facilities or services or the treatment of a person less favourably in connection with the provision of those goods, facilities or services is only unlawful if such refusal, failure or less favourable treatment is "by reason of" any of the prohibited grounds of discrimination. These words indicate that there must be a causative link between the prohibited ground and the refusal, failure or treatment complained of in order for discrimination to occur under s 44(1). See by analogy *Air New Zealand Ltd v McAlister* at [111] per McGrath J.

[87] In that case the Supreme Court considered causation in the context of the almost identical phrase "by reason directly or indirectly of any of the prohibited grounds of discrimination" in s 104(1) of the Employment Relations Act 2000 which defines the circumstances in which discrimination occurs in the employment context. Elias CJ and Blanchard J at [40] said that the question was whether a relevant ground of discrimination was "a material factor" in the decision. In agreeing with use of the phrase "material factor" Tipping J at [49] and [50] said that the correct question raised by the phrase "by reason of" is whether the prohibited ground was a "material ingredient" in the making of the decision complained of. In his separate decision McGrath J at [111] said that the crucial decision is, was the prohibited ground "a reason" for the unfavourable treatment? He helpfully pointed out that this is a subjective inquiry which calls for consideration of the decision-maker's thought processes though whether the prohibited treatment was a reason for the treatment will usually be inferred from all the circumstances of the case:

> [111] It can be seen that under s 104 an employer discriminates against an employee if the employer takes action of a specified kind "*by reason directly or indirectly*" of any ground of discrimination prohibited by that Act. These words indicate that there must be a causative link between the prohibited ground and the treatment complained of for discrimination to occur under s 104. This means that it is not enough for a complainant simply to show that the unfavourable treatment would not have occurred "but for" the employee's age.
>
> The crucial question is, was the prohibited ground a reason for the unfavourable treatment? Whether the treatment was by reason of a prohibited ground, consciously or unconsciously, is a subjective inquiry which calls for consideration of the decision maker's thought processes. It need not be the sole reason, but must have been a significant one. Although the inquiry is subjective in nature, whether the prohibited treatment was a reason for the treatment will usually be inferred from all the circumstances of the case.

Section 44(1)(a) – whether causation established

[88] Adopting the "material factor" test we find that on the evidence of Dr A and Counsellor B quoted earlier there can be little doubt that the plaintiff's mental disability was a material factor or ingredient in the decision to refuse her fertility treatment. It was not the only factor, but that is not required.

[89] This finding does not of itself, however, lead to a conclusion that the defendant has acted unlawfully. Section 21B(1) of the HR Act provides that an act or omission of any person is not unlawful under Part 2 of the Act (being that part of the Act under which the plaintiff's claim is brought) if that act or omission is authorised or required by an enactment or otherwise by law. We consider this provision shortly. But first we address the second limb of s 44(1) of the HR Act.

Section 44(1)(b) – whether a comparison exercise – the statutory language

[90] The comparison exercise mandated by s 44(1)(b) has as its focus the question whether the complainant has been treated less favourably "than would otherwise be the case". In this context it is a question whether the plaintiff was treated less favourably compared with other women seeking fertility treatment. In this regard the evidence was clear and unchallenged, namely that a check is carried out in relation to each woman to ascertain whether she is both physiologically and psychologically fit for treatment and pregnancy. The treating clinician must be satisfied that the particular patient's mental health will allow her to accommodate the treatment process, the potential pregnancy and its associated uncertain outcomes. In each case a judgment is made whether the potential benefits of a treatment are outweighed by the risks of treatment to the woman's

health and well-being and to a child born as a result of the procedure. If the benefits are outweighed treatment is declined or stopped.

[91] The reasons for this were addressed both by Dr A and by Professor Gillett. It is not intended to repeat their evidence. The main points were:

> **[91.1]** Fertility treatment is often associated with physical and psychological stress. It is therefore important that patients are, among other matters, physically and psychologically safe to undergo treatment. Assisted reproductive procedures are complex and difficult and require a great deal of preparation and ongoing support. The physical nature of the treatment as earlier described requires the patient to have a requisite degree of emotional and psychological resilience as well as appropriate support.
>
> **[91.2]** Counselling is mandatory not only for the purpose of addressing the risks and benefits of the treatment but also to determine if there are other important issues such as lack of support and whether the patient is psychologically ready for treatment, a failed treatment, an ongoing pregnancy and birth of the child.
>
> **[91.3]** Dr A said that the psychological consequences of treatment were a big risk. In his experience depression was the most common consequence. He referred also to significant anxiety (requiring medication), phobias, withdrawal and changes in personality. Professor Gillett referred additionally to a case of suicide.
>
> **[91.4]** For women 45 years of age and older the risks are the highest. Dr A said that the pregnancy rate for this group was approximately 3%. Professor Gillett added that the chance of miscarriage for this group was 50% and there was a 10% chance of the child having either a physical or intellectual disability.

[92] In these circumstances we accept the evidence that all women are offered fertility treatment services by the defendant on the same terms and no category has been identified on the evidence as being treated either more or less favourably. Professor Gillett accepted that mental health or mental disability is not on its own a ground for refusing treatment. He said that there are many forms of such disability and some are of no or no particular relevance to fertility treatment. But some are. Either way, mental disability is clearly a relevant factor to be explored prior to services being provided and where appropriate, to be taken into account. In each case the question is not whether the patient has a mental disability of some kind, but whether the patient's mental health will allow her to accommodate the treatment and if successful, the pregnancy itself. In making this assessment the clinical team will need to address (inter alia) the question whether the patient has in place sufficient support and support services to ensure that the risks to her health do not outweigh the potential benefits of the treatment. This evidence is entirely in accord with Dr A's description of the assessment process at the defendant's clinic.

[93] In these circumstances we find that, in terms of s 44(1)(b) of the HR Act the plaintiff was not treated less favourably by the defendant in the provision of fertility treatment services than would otherwise be the case by reason of her suspected mental disability.

[94] In case we are mistaken we address the submissions advanced for the defendant on the comparator issue.

Identifying the comparator – same circumstances but without the feature

[95] Mr Waalkens QC submitted that the comparator issue should be resolved by adopting the purposive and untechnical approach mapped by Tipping J in *Air New Zealand Ltd v McAlister* at [51] and [52]. In particular, the most natural and appropriate comparator is likely to be a person in exactly the same circumstances as the complainant but without the feature which is said to have been the prohibited ground. In the present case this would mean that the comparator is female patients not 45 years or older, not single and not unable (for any reason) to cope with fertility treatment or pregnancy or parenting.

[96] The so-called "mirror" comparison analysis is not without its difficulties and will not always be appropriate. See *Child Poverty Action Group Inc v Attorney-General* [2013] NZCA 402, [2013] 3 NZLR 729 at [49] to [52]. The important point, as stated in *Child Poverty Action Group Inc* at [51] is to sort out those distinctions which are made on the basis of a prohibited ground. The decision-maker is looking at the reality of the situation not the abstract. It is necessary to compare apples with apples and it must be recognised that the comparator exercise is simply a tool.

[97] These reservations apart, we nevertheless accept the comparator group advanced by the defendant. Our view of the evidence is that the plaintiff was treated no differently to the comparator so understood. All women seeking fertility treatment are necessarily assessed in the same way against the same criteria.

Conclusion in relation to s 44(1)(b)

[98] Because it is our view that whichever of the two tests is applied the plaintiff was not treated less favourably than would otherwise be the case by reason of an actual, suspected or "believed to exist" disability, the plaintiff has failed to establish a case of discrimination under s 44(1)(b) of the HR Act.

[99] We now consider whether the "defence" under s 21B(1) of the HR Act has been made out in relation to s 44(1)(a). In case we are wrong in our conclusions on s 44(1)(b), we consider s 21B(1) in that context also.

SECTION 21B HUMAN RIGHTS ACT

[100] Section 21 of the HR Act relevantly provides:

> **21 Prohibited grounds of discrimination**
>
> (1) For the purposes of this Act, the *prohibited grounds of discrimination* are—
> (h) disability, which means—
> …
> (iii) psychiatric illness:
> (iv) intellectual or psychological disability or impairment:
> (v) any other loss or abnormality of psychological, physiological, or anatomical structure or function:
> (2) Each of the grounds specified in subsection (1) is a prohibited ground of discrimination, for the purposes of this Act, if—
> (a) it pertains to a person or to a relative or associate of a person; and
> (b) it either—
> (i) currently exists or has in the past existed; or
> (ii) is suspected or assumed or believed to exist or to have existed by the person alleged to have discriminated.

[101] However in clear terms s 21B stipulates limits to the reach of Part 2 of the HR Act:

21B Relationship between this Part and other law

(1) To avoid doubt, an act or omission of any person or body is not unlawful under this Part if that act or omission is authorised or required by an enactment or otherwise by law.
(2) Nothing in this Part affects the New Zealand Bill of Rights Act 1990.

[102] The defendant says that protecting the health and well-being of the woman and of the anticipated child is a duty "authorised or required by an enactment or otherwise by law".

The facts

[103] The decision to refuse treatment to the plaintiff was a clinical judgment that the potential benefits of the treatment were outweighed by the risks to the plaintiff and to any child born as a result of the treatment. This was made clear to the plaintiff in the letter dated 31 May 2011, the contents of which have been earlier set out.

[104] The defendant's decision is supported by the evidence of Professor Gillett that (inter alia):

[104.1] Assisted reproductive procedures are complex and difficult treatments that require a great deal of preparation and support.

[104.2] It is the provider's responsibility to ensure that such preparation and support are in place and that the treatment is safe for the woman and for the potential child.

[104.3] Should a clinic perceive any inkling of absence of support for the treatment itself, for a failed treatment, or for an ongoing treatment there is a duty to seek resolution before embarking on treatment.

[104.4] Given the concerns held by the defendant's clinical team about the plaintiff's mental health status and the need to consider the plaintiff's health and well-being (and that of the potential child), the decision not to treat the plaintiff was the right decision and it is a decision Professor Gillett would have made in the same circumstances.

[104.5] The fact that both a psychological assessment and an ethical review by ECART were declined by the plaintiff would have made the clinic's position indefensible had it offered treatment.

[104.6] Given that the prospect of a successful pregnancy following donor insemination or IVF is extremely poor for women aged 45 years and over and that there is a 50% chance of a miscarriage and a 10% chance of the child being born with a physical or intellectual impairment and further given the plaintiff's longstanding maladaptive personality features, the plaintiff was extremely vulnerable. Without a psychiatric or psychological assessment it would not have been possible to determine whether the fertility treatment would be safe. In addition the informed consent process was also incomplete.

[104.7] In the plaintiff's case there were so many safety concerns that they trumped her desire to have the treatment. Her decline of the option to see a psychologist meant that neither she nor the clinical team could engage with the issues in a way that allowed it to be said that she had given her informed consent.

[104.8] Even if the plaintiff was in a position to give her informed consent the medical practitioner still had the responsibility to decide if there was to be admission to the procedure.

[105] It follows from this evidence (which we accept) that it has been established that the clinical judgment made by the defendant's employees (that the potential benefits of the treatment were outweighed by the risks to the plaintiff and to any child born as a result of the treatment) was the appropriate and correct judgment.

[106] The next issue is whether protecting the health and well-being of the woman and of the anticipated child can be said to be "authorised or required by an enactment or otherwise by law". The same question must be asked in relation to the need for a patient to give informed consent.

Authorised or required by an enactment

[107] The Human Assisted Reproductive Technology Act 2004 received much attention in both the evidence and in the submissions by the parties. This was because s 4 of the HART Act sets out seven principles by which all persons exercising powers or performing functions under that Act must be guided:

> **4 Principles**
>
> All persons exercising powers or performing functions under this Act must be guided by each of the following principles that is relevant to the particular power or function:
> (a) the health and well-being of children born as a result of the performance of an assisted reproductive procedure or an established procedure should be an important consideration in all decisions about that procedure:
> (b) the human health, safety, and dignity of present and future generations should be preserved and promoted:
> (c) while all persons are affected by assisted reproductive procedures and established procedures, women, more than men, are directly and significantly affected by their application, and the health and well-being of women must be protected in the use of these procedures:
> (d) no assisted reproductive procedure should be performed on an individual and no human reproductive research should be conducted on an individual unless the individual has made an informed choice and given informed consent:
> (e) donor offspring should be made aware of their genetic origins and be able to access information about those origins:
> (f) the needs, values, and beliefs of Māori should be considered and treated with respect:
> (g) the different ethical, spiritual, and cultural perspectives in society should be considered and treated with respect.

[108] Dr A and Professor Gillett made reference to these principles in discussing and analysing the decision not to offer fertility treatment to the plaintiff.

[109] For the plaintiff it was submitted that neither the defendant nor any member of the clinical team was, in making that decision, "exercising powers or performing functions" under the HART Act and for that reason the principles in s 4 of that Act were irrelevant.

[110] In our view the plaintiff's challenge is based on the false premise that the so-called guiding principles in the HART Act can only be taken into account if the decision-maker is exercising a power or performing a function under the HART Act. The correct position is that the guiding principles are relevant to decisions of the kind made by Dr A and his clinical team not because of the HART Act in and of itself, but because of the Health and Disability Services (Safety) Act 2001 (HDSS Act) and NZS8181 *Fertility Services*. The HART Act principles are reflected in these two instruments.

[111] The HART Act is helpfully discussed and analysed by Nicola Peart in "Alternative Means of Reproduction" in Skegg and Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) at 415. For present purposes the primary point to note is that the HART Act does not substantively regulate assisted reproductive procedures, aside from prohibiting some activities. Its main purpose is to establish a procedural framework to develop and implement policy by means of two committees: The Advisory Committee on Assisted Reproductive Procedures and Human Reproductive Research, known as the Advisory Committee on Assisted Reproductive Technology (ACART) and the Ethics Committee on Assisted Reproductive Technology (ECART). See Peart at op cit [15.2].

[112] While the HART Act does not establish a licensing regime for providers of fertility services, s 80 deems fertility services to be included in the definition of "specified health or disability services" in s 4(1) of the HDSS Act.

[113] The purpose of the HDSS Act is, as its title suggests, the promotion of the safe provision of health and disability services and the establishment of standards for providing health and disability services to the public safely:

> **3 Purpose**
>
> The purpose of this Act is to—
> (a) promote the safe provision of health and disability services to the public; and
> (b) enable the establishment of consistent and reasonable standards for providing health and disability services to the public safely; and
> (c) encourage providers of health and disability services to take responsibility for providing those services to the public safely; and
> (d) encourage providers of health and disability services to the public to improve continuously the quality of those services.

[114] Section 9 of the HDSS Act stipulates that any person providing healthcare services of any kind (which, by definition, includes fertility services):

> **[114.1]** Must be certified by the Director-General (ie the chief executive of the Ministry of Health); and
>
> **[114.2]** Must meet all relevant standards:
>
> > **9 Providers of health care services to meet service standards**
> >
> > A person providing health care services of any kind must do so—
> > (a) while certified by the Director-General to provide health care services of that kind; and
> > (b) while meeting all relevant service standards; and
> > (c) …
> > (d) …
> > (e) …

[115] The phrase "service standards" is defined in s 4 of the HDSS Act as standards approved by the Minister of Health under s 13 of the Act which provides:

> **13 Minister may approve service standards**
>
> The Minister may, by written notice describing by name the standards concerned, approve standards for providing health or disability services of any kind.

[116] On 24 March 2010 the Minister of Health gave notice that NZS8181 *Fertility Services* had been approved under s 13. See the Health and Disability Services (Safety) Standards Notice 2010 (SI2010/84) which came into force on 1 October 2010.

[117] By virtue of s 9 of the HDSS Act the defendant is required to meet the standards set by NZS8181 *Fertility Services*. If, under that standard the defendant, in supplying fertility services, is required to take into account a patient's mental health or mental disability, the HDSS Act and the NZS8181 *Fertility Services* will meet the requirement of s 21B(1) of the HR Act that the act or omission be authorised or required "by an enactment or otherwise by law".

NZS8181: *Fertility Services*

[118] While the "guiding principles" in s 4 of the HART Act are referred to in the Background pages of NZS8181 *Fertility Services*, those principles are not as such formally incorporated into the Standard. Nevertheless their purpose and effect are explicitly articulated by numerous provisions of the Standard, which is hardly surprising given the purposes of the HDSS Act and the fact that NZS8181 *Fertility Services* defines quality and safety requirements in the context of the provision of fertility services.

[119] The protection of the health and well-being of women is more particularly protected by the following "outcome" and "guidance" requirements of NZS8181 *Fertility Services*. There is both explicit and implicit reference to the HART Act:

[119.1] Part 1 – Consumer Rights

Page 17

Outcome: *Consumers receive safe and reasonable services in a manner that is respectful of their rights, minimises harm and acknowledges their cultural and individual values and beliefs*.

[119.2] Part 1 – Consumer Rights

Page 24

1.7 Informed consent

Outcome: *Consumer consent is obtained in line with the requirements of the Code of Health and Disability Services Consumers' Rights and the principles of the Human Assisted Reproductive Technology Act.*

[119.3] Part 2 – Organisational Management

Page 29

Outcome: *Consumers receive services that are managed in a safe, efficient and effective manner and that comply with legislation*.

Guidance: *Relevant legislation*
Services shall comply with the New Zealand Human Assisted Reproductive Technology (HART) Act, and other relevant legislation and ethical guidelines.

[119.4] Part 2 – Organisation Management

Page 31

2.2 Quality and Risk Management Systems

Guidance: …

Sound clinical judgement shall be applied in balancing safety and risk in relation to a consumer's own goals.

[119.5] Part 2 – Organisation Management

Page 36

2.7 Design and Implementation of Services Using New Assisted Reproductive Technology

Outcome: New assisted reproductive techniques are well-designed to maximise the safety and well-being of consumers and their children.

[119.6] Part 3 – Continuum of Service Delivery

Page 43

3.1 Entry to Services

3.1.2 The organisation ensures consultation and diagnosis determines existing and potential risks for each consumer in order to facilitate appropriate and timely entry into the service.

[119.7] Part 3 – Continuum of Service Delivery

Page 48

3.6 Safety of ART Treatment

Outcome: The well-being of consumers and their children is improved by limiting the risks of ART treatment.

[120] Turning now to the protection of the health and well-being of offspring born as a result of fertility services, it is to be noted that NZS8181 *Fertility Services* addresses their interests in almost the same language as s 4(a) of the HART Act:

[120.1] Part 1 – Consumer Rights

Page 25

1.8 Health and Well-being of Offspring as a Result of Reproductive Technologies

Outcome: The health and well-being of offspring born as a result of fertility services shall be an important consideration in all decisions about the services.

1.8.1 The organisation ensures the service provider demonstrates during the development and delivery of fertility services that the health and well-being of children have been considered.

1.8.2 The organisation ensures it contributes information about the outcomes of treatments, including the health and well-being of children, to ANZARD, and any other agencies appointed by the Ministry of Health.

[121] In addition there is a general obligation (see for example NZS8181 *Fertility Services* at 1.1 and 1.7) to ensure that patients receive services in accordance with the Code of Health and Disability Services Consumers' Rights which are appended to NZS8181 *Fertility Services*. Because we address that Code of Rights separately, we refer here only to the relevance of Right 4, being the right to services of an appropriate standard and to Right 7, being the right to make an informed choice and to give informed consent.

[122] Given the explicit terms of NZS8181 *Fertility Services* there can be no doubt that in the provision of fertility services the provider must necessarily take into account and protect the health and well-being of women and of children born as a result of those services. It matters little whether the service provider articulates this obligation by reference to "the HART Act principles" rather than "the NZS8181 *Fertility Services* principles". There is no material difference.

[123] On the evidence we have heard it is inescapable that any relevant actual or suspected psychiatric illness, intellectual or psychological disability or impairment or any other loss or abnormality of psychological function is a mandatory relevant consideration for those providing fertility services. It is not, however, a mandatory "disqualification". As Professor Gillett said, everything depends on the circumstances of the particular case and on the level of support available to the patient. Among the obligations on a medical practitioner is the duty to protect the health and well-being of the patient (including those with and those without a disability) and in the context of fertility treatment to give recognition to the principle that the health and well-being of the child to be born is an important consideration. A person with disability is treated no differently to other patients. As stated by Counsellor B in her evidence, it is important to ensure that all patients are psychologically capable and have the fortitude to undergo fertility treatment, pregnancy and the care of a child born as a result of the treatment.

[124] We conclude that by virtue of the HDSS Act and NZS8181 *Fertility Services*, the provider of a fertility service is authorised or required by an enactment to take into account both the mental health and any mental disability of a patient. Section 21B(1) of the HR Act is therefore engaged. We see nothing in the Convention on the Rights of Persons with Disabilities 2006 (particularly Article 25 – Health) inconsistent with this analysis.

The Code of Consumers' Rights

[125] We address now the relevance of the Code of Health and Disability Services Consumers' Rights to s 21B(1) of the HR Act.

[126] The Code of Rights confers a number of legal rights on all consumers of health and disability services in New Zealand and places corresponding obligations on providers of those services. The provisions of the Code of Rights relevant to the present case follow:

> **1 Consumers have rights and providers have duties**
>
> (1) Every consumer has the rights in this Code.
> (2) Every provider is subject to the duties in this Code.
> (3) Every provider must take action to—
> (a) inform consumers of their rights; and
> (b) enable consumers to exercise their rights.
>
> **2 Rights of consumers and duties of providers**
> The rights of consumers and the duties of providers under this Code are as follows:
> …
>
> ***Right 4***
> *Right to services of an appropriate standard*
> (1) Every consumer has the right to have services provided with reasonable care and skill.
> (2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
> (3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.
…

Right 6
Right to be fully informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including—
- (a) an explanation of his or her condition; and
- (b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
- (c) advice of the estimated time within which the services will be provided; and
- (d) notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and
- (e) any other information required by legal, professional, ethical, and other relevant standards; and
- (f) the results of tests; and
- (g) the results of procedures.

(2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.
(3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about—
- (a) the identity and qualifications of the provider; and
- (b) the recommendation of the provider; and
- (c) how to obtain an opinion from another provider; and
- (d) the results of research.

(4) Every consumer has the right to receive, on request, a written summary of information provided.

Right 7
Right to make an informed choice and give informed consent
(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.
(2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.
…
(7) Every consumer has the right to refuse services and to withdraw consent to services.
…

[127] Under Right 4(4) services are to be provided "in a manner that minimises the potential harm to, and optimises the quality of life of" the consumer. The phrase "optimise the quality of life" is defined as "to take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances". This principle of harm minimisation is one aspect of the general duty on healthcare providers to exercise reasonable care and skill.

[128] In view of the expert evidence given by Professor Gillett we are of the opinion that the exercise of reasonable care and skill by Dr A and by the clinical team required them to take account of the plaintiff's suspected mental disability. They were also required to obtain informed consent to the treatment.

[129] For the plaintiff it was submitted that the duty to exercise reasonable care and skill and to protect the health and well-being of women had to be exercised in conformity with human rights principles and in particular the non-discrimination principle. This submission, however, misses the point of s 21B(1) of the HR Act. An act or omission is

not unlawful under Part 2 of the HR Act if the act or omission is authorised or required by an enactment or otherwise by law. It also misses the point that in the context of fertility services any relevant actual or suspected psychiatric illness, intellectual or psychological disability or impairment or any other loss or abnormality of psychological function is a mandatory relevant consideration for the service provider.

[130] We conclude that by virtue of the Health and Disability Commissioner Act 1994 and the Code of Rights, the provider of a fertility service is authorised or required by an enactment to take into account both the mental health and any mental disability of a patient. Once again, s 21B(1) of the HR Act is engaged. It follows that neither Dr A nor any member of the clinical team unlawfully discriminated against the plaintiff by taking into account her mental disability.

Otherwise by law – the common law

[131] The legal duty on healthcare providers to perform their professional duties to the standard of reasonable care and skill is also a common law duty. See Joanna Manning "The Required Standard of Care for Treatment" in Skegg and Paterson (eds) *Medical Law in New Zealand* at [3.1] and [3.2.2]. That common law duty is not displaced by the Code of Rights and can be relied on by the defendant. Properly it was conceded by the plaintiff that s 21B(1) applies to the common law.

[132] At common law a medical practitioner must treat the patient in accordance with his or her own best clinical judgment and even a court cannot require the medical practitioner to adopt a course of treatment which in the bona fide clinical judgment of the practitioner is contra-indicated and not in the best interests of the patient. See *J (A minor)* [1992] 3 WLR 507 (EWCA) at 516 cited with approval in *Shortland v Northland Health Ltd* HC Auckland M75/97, 20 September 1997. In that case Salmon J at 13 said:

> There is no suggestion that the respondent's medical staff are acting in bad faith. That being the case, they must be allowed to act in accordance with their clinical judgment. It is totally inappropriate for the Court to attempt to direct a doctor as to what treatment should be given to a patient.

This judgment was upheld in *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 (CA) where the paramountcy of the clinical judgment of the medical practitioner was again emphasised.

[133] The plaintiff did not have a right to demand fertility services when Dr A and his team for good reason had reached the bona fide clinical judgment that such treatment was not in her best interests. In arriving at this judgment it was necessary that they take into account the plaintiff's mental disability.

[134] We conclude that by virtue of the common law Dr A and the clinical team were required to take into account the plaintiff's mental disability and the absence of compensatory support mechanisms. Had they failed to do so they would not have performed their professional duties to the standard of reasonable care and skill. Once again s 21B(1) of the HR Act is engaged.

Conclusion

[135] In view of our conclusions in relation to the HDSS Act, NZS8181 *Fertility Services*, the Health and Disability Commissioner Act, the Code of Rights and the common law, it follows that there was no breach of the s 44(1)(a) and the s 44(1)(b) prohibitions on discrimination.

SUMMARY OF FINDINGS

[136] The plaintiff's primary case is that in terms of s 44(1)(a) of the HR Act the defendant acted unlawfully by refusing to provide fertility services by reason of a prohibited ground of discrimination, namely her mental disability. Her case is also that in terms of s 44(1)(b) the defendant acted unlawfully by treating her less favourably than would otherwise be the case by reason of her mental disability.

[137] We accept that the evidence establishes that in relation to s 44(1)(a) and s 44(1)(b) the plaintiff's mental disability was indeed a material factor in the decision to refuse fertility treatment to the plaintiff. However, the defendant did not thereby act unlawfully. A summary of our reasons follows.

Section 44(1)(a) of the Human Rights Act 1993

[138] First, as to s 44(1)(a) of the HR Act we have found that:

> **[138.1]** The defendant refused to provide fertility services to the plaintiff by reason of (inter alia) her mental disability.
>
> **[138.2]** In terms of s 21B(1) of the HR Act the taking into account of the plaintiff's mental disability was authorised or required:
>
> > **[138.2.1]** By an "enactment", being the HDSS Act 2001 and NZS8181 *Fertility Services* as well as the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights, Rights 4, 6 and 7; or
> >
> > **[138.2.2]** "Otherwise by law" ie the common law duty on the clinical team to perform their professional duties to the standard of reasonable care and skill.

[139] It follows that in respect of s 44(1)(a) the defendant did not act unlawfully under Part 2 of the Human Rights Act.

Section 44(1)(b) of the Human Rights Act 1993

[140] Second, as to s 44(1)(b) of the HRA Act we have found:

> **[140.1]** The plaintiff was not treated less favourably than would otherwise be the case.
>
> **[140.2]** However, should this finding be wrong, the defendant has in terms of s 21B(1) of the HR Act established that the act of omission complained of was authorised or required by an enactment or otherwise by law. The reasons for this finding are the same as those which apply to s 44(1)(a).

CONCLUSION

[141] It follows that the plaintiff has failed to establish that the defendant acted unlawfully under Part 2 of the Human Rights Act and her case is dismissed.

COSTS

[142] The defendant company does not seek costs. In any event, because the plaintiff is in receipt of legal aid s 45 of the Legal Services Act 2011 applies. It follows that there will be no order as to costs.

FORMAL ORDERS

[143] For the foregoing reasons the decision of the Tribunal is that:

[143.1] The proceedings brought by the plaintiff are dismissed.

[143.2] There is to be no order for costs.

NON-PUBLICATION ORDERS

[144] As to the final non-publication orders it is confirmed that:

[144.1] A final order is made prohibiting publication of the names, addresses and any other details which might lead to the identification of the plaintiff or of the defendant company or of the employees of the defendant company who gave evidence to the Tribunal or who were referred to in the evidence placed before the Tribunal.

[144.2] There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

[144.3] If any other non-publication orders are to be sought application must be made within fourteen days of this decision. If no such application is made the Secretary is to release this decision for general publication. Until then publication to the parties only is permitted.

[144.4] In case it should prove necessary, we leave it to the Chairperson of the Tribunal to vary any timetable steps.

.....	.....	.....
Mr RPG Haines QC	**Ms PJ Davies**	**Ms M Sinclair**
Chairperson	**Member**	**Member**