SUPREME COURT OF NORWAY

On 11 October 2018, the Supreme Court gave judgment in

HR-2018-1958-A (case no. 2018/199), civil case, appeal against judgment.

I.

Sauherad municipality	(Counsel Frode Lauareid)
v.	
A	
Norges Kristelige Legeforening [Norway's Christian medical association] (intervener)	(Counsel Håkon H. Bleken)

II.

A	
Norges Kristelige Legeforening [Norway's Christian medical association] (intervener)	(Counsel Håkon H. Bleken)
v.	
Sauherad municipality	(Counsel Frode Lauareid)

(1) Justice **Møse**: This case concerns termination of an employment agreement under the regular general practitioner (RGP) scheme due to refusal to insert intrauterine devices (IUDs) for reasons of conscience.

(2) A grew up in Poland and is a specialist in general medicine. She came to Norway in 2008 because her husband had found work here. In 2009, after having completed a Norwegian course and medical practice at a hospital, she applied for a position as an RGP in Sauherad municipality. During her interview, she said that she, for reasons of conscience,

would not insert IUDs. She did not get the position, allegedly because her Norwegian was poorer than that of the applicant who was employed.

(3) Later, A was given temporary employment as an RGP in the municipality, and she applied once more for a permanent position. This time she was employed, and she signed an RGP agreement on 16 May 2011. Before signing, she had been interviewed once more by the employment committee where she had repeated that she would not insert IUDs. She then started practicing at Sauherad medical centre. Whenever a patient asked to have an IUD inserted, she left that procedure to one of her colleagues without saying anything about her reservations. No complaints were made against her practice.

(4) In February 2014, the county governor of Telemark initiated supervisory proceedings, after having learned that an RGP in Sauherad municipality had reservations for reasons of conscience. He made an inquiry to the Norwegian Board of Health Supervision, which replied in a letter of 26 January 2015 that it had to be established whether the municipality's acceptance of her reservations was contrary to the municipality's duty to offer general medical services under regulatory requirements. The Board of Health Supervision's conclusion was that she could not refuse to insert IUDs, and the municipality was asked to clarify how it would ensure that the "RGP scheme/general medical service complies with regulatory requirements" in the future.

(5) The municipality summoned A to a discussion meeting on 6 March 2015 informing her that the possible breach was so serious that there was a risk of immediate termination of her employment agreement. In the letter, the municipality stated that she could not refuse to insert IUDs as a contraceptive. The municipality wanted to know whether she would adjust her practice to applicable regulations.

(6) As agreed with the municipality, A went out on leave on 1 April 2015, and has since worked at Notodden hospital aiming to specialise in psychiatry. After another discussion meeting on 31 August 2015, the municipality decided, on 3 December 2015, to terminate her individual employment agreement under the RGP scheme.

(7) A filed a writ of summons to Aust-Telemark District Court, which on 9 February 2017 concluded as follows:

> **"1. Judgment is given in favour of Sauherad municipality.**
>
> **2. The parties carry their own costs."**

(8) A appealed to Agder Court of Appeal, which on 24 November 2017 concluded as follows:

> **"1. The termination of the RGP agreement with A of 3 December 2015 is unlawful. Sauherad municipality is to reinstate A as an RGP and a municipally employed physician in a 20 percent position.**
>
> **2. Sauherad municipality is not liable for damages.**
>
> **3. The parties cover their own costs in the district court.**
>
> **4. Sauherad municipality is to pay A's costs of NOK 600 000 – sixhundredthousand – in the court of appeal of within 2 – two – weeks after the service of the judgment."**

(9) The judgment was given with one judge dissenting.

(10) Sauherad municipality has appealed against the court of appeal's ruling that the termination is unlawful. A has appealed against the issue of liability. The Supreme Court's Appeal Selection Committee granted leave to appeal to both parties, but decided that the amount of damages would not be considered for the time being, see section 30-14 subsection 3 of the Dispute Act.

(11) *Sauherad municipality* contends:

(12) No agreement existed with the municipality under which A had a right of reservation. The municipality had not relinquished its management prerogative, and the municipal council had not clarified the questions of principle involved. The delegation rules did not allow agreements on the right of reservation. The municipality had simply accepted A's practice of leaving the insertion of IUDs to others. The termination was thus objectively justified.

(13) There exists no right under the RGP scheme to refuse to insert IUDs. According to relevant statutory provisions and their preparatory works, patients have a right to receive medical services and to be on a RGP's list, and the municipality is responsible for implementing this system. The RGP's responsibility for the patients on his or her list comprises all general medical services unless otherwise specified, and the RGPs' right to distribute tasks among them does not entail any right of reservation. Discussions in the Storting support this view.

(14) The authorities' requirement that A had to insert IUDs was not contrary to Article 9 of the European Convention on Human Rights on the freedom of thought, conscience and religion. Although her reservation is an expression of a consistent belief, it is not sufficiently close to that belief and falls outside of the provision's application. According to Convention case law, each individual must accept the general regulatory requirements for his or her profession. In any case, the dismissal must be accepted under Article 9 (2). The interference with the right was legitimate, it was in accordance with law and it was proportionate. Nor has any violation been committed of Article 14 on discrimination or the previous Anti-Discrimination Act on prohibition against discrimination based on ethnicity, religion etc. (the Anti-Discrimination Act).

(15) As for A's contentions with regard to liability, the municipality holds that even if the dismissal should be declared unlawful, there is no basis for compensation. The liability rule in the Anti-Discrimination Act is not applicable, as that would require negligence, and the municipality cannot be blamed. No liability can be imposed due to unwarranted exercise of power.

(16) Sauherad municipality has submitted this prayer for relief:

> **"1. Judgment is to be given in favour of Sauherad municipality.**
>
> **2. Sauherad municipality is to be awarded costs in all instances."**

(17) *A* contends:

(18) Before signing the individual RGP agreement between A and the municipality, the parties orally agreed that A was to have a right of reservation. This was facilitated by other physicians at the medical centre inserting IUDs when relevant. At the time of agreement,

whether or not a RGP had a right of reservation was not a question of principle; hence, it was not necessary for the municipal council to accept her reservations. The dismissal is not objectively justified, and is therefore unlawful.

(19) The legal framework of the RGP scheme does not prevent agreements on the right of reservation. The RGP scheme does not regulate this in any way, and more than 30 years of practice exists with regard to the right of reservation for reasons of conscience. No RGP carries out all procedures, and list patients are not entitled by law to have any procedure within the area of responsibilities carried out personally by his or her RGP. More than 30 percent of RGPs in Norway do not insert IUDs.

(20) The dismissal is a violation of Article 9 of the European Convention of Human Rights. From Convention case law, it is clear that the right of reservation is protected under the freedom of conscience and religion. As for the limitations set out in Article 9 (2), A accepts that the concern for health is a legitimate reason for interference. But a total prohibition against reservations for reasons of conscience is not proportionate, as the provision requires an individual assessment. She was affected disproportionately harshly by the dismissal.

(21) There is also indirect discrimination based on religion under Article 14 of the Convention, as the prohibition against reservations affects all Catholic RGPs. Thus, a minority group is excluded from the profession. Reference is also made to section 16, cf. section 4 of the Anti-Discrimination Act.

(22) As for the question of damages, the municipality is liable on several grounds – strict liability exists due to contractual breach, case law on unlawful administrative decisions, Article 13 of the Convention on the right to an effective remedy and section 25 of the Anti-Discrimination Act on employment relationships. In the alternative, there is negligence, as the municipality's ignorance of the law was inexcusable.

(23) A has submitted this prayer for relief:

> **"In the dismissal issue:**
>
> **1. The appeal is to be dismissed.**
>
> **2. A is to be awarded costs in the district court, in the court of appeal and in the Supreme Court.**
>
> **In the liability issue:**
>
> **1. Sauherad municipality is liable for the loss suffered by A as a result of the notice of termination dated 3 December 2015.**
>
> **2. A is to be awarded costs in the district court, in the court of appeal and in the Supreme Court."**

(24) *My view on the case:*

(25) I have concluded that the municipality's appeal with regard to the dismissal cannot succeed, and will first consider the question whether a binding agreement on the right of reservation for reasons of conscience was concluded in connection with A's employment in 2011.

(26) *The employment agreement in 2011*

(27) It is undisputed that the written agreement of 16 May 2011 did not contain provisions on the right of reservation. The parties entered into a standard agreement called "individual agreement on general practice under the RGP scheme". There was also no mention of the right of reservation for reasons of conscience in the municipality's offer of employment earlier the same day. The same was the case with the minutes of the selection committee's preceding meetings with the applicants for the RGP position.

(28) Thus, the question is whether an oral agreement was entered into between the selection committee and A under which A's reservations were accepted, as the court of appeal has concluded. The persons whose testimony regarding the interview has been taken in the Supreme Court – A, as well as the then municipal consultant physician and the physician representing the employees, who were both members of the selection committee – have given concurrent descriptions. A mentioned her reservation against inserting IUDs. There was agreement within the selection committee that this would not constitute a problem, since other staff at the same medical centre could carry out this procedure on the patients concerned. The selection committee had no problems with this. Those representing the municipality have testified that an agreement was indeed entered into, which the municipality also stated in connection with the administrative supervisory proceedings. Consequently, I find it clear that an oral supplementary agreement was entered into granting A a right of reservation.

(29) The municipality contends that the selection committee had no authority to enter into such an agreement, and that according to section 6 of the Local Government Act, the municipal council is the highest municipal body and that power can only be delegated to the chief executive in individual matters or in matters that do not involve questions of principle, see section 23 (4).

(30) I agree with the court of appeal that this cannot succeed. A was employed in accordance with general delegation procedures. The municipality's former head of health and social affairs, who after a reorganisation around 2009 had been titled adviser (*rådgiver*), was the chair of the selection committee. It has been stated that he had kept his competence in this area. He signed both the municipality's offer of employment, with a copy to the town manager (*rådmannen*), and the individual employment contract with A. As I will revert to shortly, there was also no basis for considering her reservation for reasons of conscience as a question of principle under section 23 (4) at the time the agreement was entered into.

(31) Against this background, I find it clear that, in May 2011, a binding agreement on employing A was entered into under which her reservations for reasons of conscience were accepted.

(32) The question thus becomes whether this agreement was invalid in any case because it, when entered into, was contrary to applicable RGP Regulations or other relevant legislation, as the municipality contends.

(33) The RGP scheme was implemented permanently in 2000 through amendments to the Municipal Health Services Act 1982. Several of its provisions, including section 1-3, gave a legal basis for providing more details in separate regulations. Particularly important were the Regular GP Regulations of 14 April 2000, establishing in section 1 that the purpose of the scheme was to increase the quality of general health services by ensuring

that every person have "access to a regular general practitioner", thus offering increased safety through easier access to general health services. Neither the Municipal Health Services Act nor the RGP Regulations of 2000, as they read when A was employed by the municipality in 2011, contained express provisions on the right of reservation for reasons of conscience.

(34) Nor did the Health Personnel Act 1999, which was also the legal basis for the RGP Regulations 2000. According to section 1 of the Act, the purpose of the Regulations is to "contribute to safety for patients and quality within the health service as well as trust in both health personnel and the health service". According to section 4, health personnel are to carry out their work in accordance with the requirements to professional responsibility and diligent care that can be expected, and to act in accordance with their professional qualifications and refer patients on to others if necessary.

(35) The municipality has also mentioned certain individual provisions in the Patient and User Rights Act 1999 and the Health and Care Services Act 2011, which replaced the Municipal Health Services Act 1982 and the Social Services Act 1991. I will revert to that, but note that neither these Acts nor the Regulations adopted thereunder contained rules on the right of reservation in 2011.

(36) On the other hand, the Termination of Pregnancy Act has contained an express provision on the right of reservation for reasons of conscience since its adoption in 1975. According to section 14, the organisation "shall take into account" health personnel who, for reasons of conscience, do not wish to *carry out or assist* in connection with abortions. And the Termination of Pregnancy Regulations 2001 establish in section 15 that health personnel who for reasons of conscience so wish "are exempt" from carrying out or assisting in abortions, but not from providing care before, during and after the procedure. These provisions demonstrate that the legislature, in a similar area of law, has found it necessary to add a specific provision regulating the right of reservation, but they do not serve as a basis for drawing conclusions in our case with regard to insertion of IUDs.

(37) In a circular letter of 20 June 1995 to Norway's county physicians and during supervisory proceedings from 2005, the Norwegian Board of Health Supervision held that physicians could refuse to refer patients for abortions etc. for reasons of conscience if the care of the patients was otherwise maintained. At the same time, the Board stressed that municipalities were obliged under the Municipal Health Services Act to provide necessary health care:

> **"In small municipalities with few physicians, the women in question may suffer an unacceptable strain if it is accepted that the physicians refuse to provide certain types of services. The municipalities should consider this in employment processes, to avoid a situation where municipal health services become inadequate. … "**

(38) The question concerning health personnel's right of reservation has also been raised in connection with assisted fertilisation offered to lesbian couples. The following was set out in a letter from the Ministry of Health and Care Services of 24 February 2009 on health personnel's right of reservation:

> **"To which extent a physician providing health services under the Municipal Health Services Act has a right to refuse to refer patients on to a specialist for consultation on assisted fertilisation, is a question for the physician at hand to address with the municipality. In the Ministry's view, there is no legal impediment for granting the**

> **physician a right of reservation if the municipality makes sure that the lesbian couple receives the same help from other staff."**

(39) Due to the objections raised, the Ministry of Health and Care Services had to reconsider. In a circular letter of 31 October 2011 – around five months after A had been employed – the Ministry stated that one had started to question health personnel's right to refuse to carry out certain procedures for reasons of conscience. This included prescribing contraceptives, providing contraceptive guidance, referral for abortion and referral of lesbian couples for consultation on assisted fertilisation. In the circular letter, the Ministry wanted to clarify the state of the law in this area:

> **"One must distinguish between physicians in the municipal health and care service and specialist health personnel. This circular letter concerns physicians in the municipal health and care service.**
>
> **General physicians and RGPs under the municipal health and care service do not currently have a statutory *right* of reservation for reasons of conscience. This concerns procedures relating to contraceptives and family planning as well as referral for assisted fertilisation or abortion.**
>
> **As for the question whether a physician for reasons of conscience should have the *possibility* to refuse to carry out certain procedures, one must distinguish between general physicians and RGPs. An RGP is a general physician enrolled in a municipal scheme in accordance with section 2 of the RGP Regulations.**
>
> **When it comes to RGPs ... there is no legal basis for the municipality to exempt the physician from providing services he or she has a statutory obligation to provide. The RGP's responsibility for patients on his or her list follows from section 7 of the RGP Regulations, stating that the 'RGP is responsible for the medical care of the persons on his or her list within the scope of the RGP scheme set out by law and in a central agreement'. This responsibility also covers 'referral for other health services if required', see the comments to the provision in the Regulations. In other words, it is the patient's need of referral that dictates the actions of the RGP. The provision does not give the RGP a right to refuse or refrain from referring the patient for any other reasons than the patient not needing it.**
>
> **Furthermore, section 7 of the RGP Regulations does not give a right to the parties, i.e. the municipality and the RGP, to deviate from this provision. Hence, it is not possible for the municipality and the RGP – through an agreement – to limit the RGP's responsibility for the patients on his or her list, including deciding that the RGP for reasons of conscience is exempt from carrying out certain procedures.**
>
> **As for a physician employed by the municipality who does not have patients on a list to attend to, he or she may on certain terms be given the possibility of reservation … The municipality may either have the procedures carried out by its own personnel or enter into an agreement with other private or public providers of medical services. Hence, physicians performing tasks on behalf of the municipality who do not have patients on a list *may* be exempt from certain procedures by the municipality. …"**

(40) The Ministry's circular letter illustrates that at the date on which A entered into her individual RGP agreement with the municipality, the state of the law was unclear, and that the municipalities had followed different practices. Evidence presented before the Supreme Court has also shown that some other municipalities in Telemark had accepted reservations against inserting UIDs, and that they had arranged it so the patient could receive the same help from a different physician, or a gynaecologist.

(41) In the circular letter of October 2011, the Ministry held the responsibility for list patients under section 7 of the RGP Regulations to be the reason for the municipalities' lack of legal basis for exempting RGPs from carrying out certain procedures. However, I cannot see that the general wording on the RGP's responsibility for his or her patients gives much support for this interpretation. It may be that the comments to section 7 on referral for other health services "if required" suggest that the needs of the patients must be the dominant concern. But such a wording is not sufficient for reading a general prohibition into it. It is not necessarily so that the concern for the patients trumps the right of reservation for reasons of conscience if the patients' needs can be fulfilled otherwise, for instance by staff at the same medical centre performing the tasks. As set out in the Norwegian Board of Health Supervision's circular letter and letters in 1995 and 2005, as well as in the Ministry's letter on assisted fertilisation from 2009, an individual assessment must be made, and evidence presented in the case suggests that such a practice existed, at least in some municipalities, for a long period of time. In the case at hand, the selection committee assumed that it would not entail any disadvantages for the patients if UIDs were inserted by other staff.

(42) Based on the account I have now given on the state of the law, I cannot see that the oral agreement between the municipality and A in May 2011 regarding her right of reservation for reasons of conscience was contrary to applicable legislation at the time of the agreement. Thus, the agreement cannot be set aside on those grounds.

(43) I will now turn to the situation until the dismissal of A in December 2015.

(44) *The RGP Regulations 2012*

(45) The year after the employment – in August 2012 – the RGP Regulations 2000 were replaced by new ones with effect from 1 January 2013. The new Regulations were adopted under section 3-2 subsection 3 of the Health and Care Services Act 2011, which was a continuation of section 1-3 of the Municipal Health Services Act 1982.

(46) The new provision specified that the Regulations could cover "quality and function requirements" in private health care, which is more exact than a general legal basis for Regulations, which is to facilitate the implementation of an Act. A natural interpretation of the wording in section 3-2 is that the Ministry may regulate the conditions for becoming a RGP and for a satisfactory performance of the job, although the term "quality and function requirement" in section 3-2 seems primarily to concern chapter 4 of the Act, see Proposition to the Storting (bill) No. 91 L (2010–2011) page 250.

(47) This Proposition regarding the Health and Care Services Act contained several general phrases on the RGP's responsibilities within the application of the scheme. But although the Proposition seems to assume that section 3-2 subsection 3, like section 1-3 of the former Municipal Health Services Act, warrants a regulation of the RGP's practice, it did not elaborate on the right of right of reservation for reasons of conscience, neither in its general remarks nor in the rationale behind the expression "quality and function requirements" in section 3-2.

(48) Thus, the question is whether the new RGP Regulations regulated this issue. According to section 10, the RGP's responsibility for the list patients was to cover all general medical services. In its remarks to this provision, the Ministry of Health and Care Services held

that it concerned a specification of section 7 in the Regulations 2000 – a provision which I have already assessed – and continued:

> **"The responsibility for list patients implies that the RGP, as a starting point, is to offer all types of general medical services to his or her patients … A RGP cannot choose not to offer general medical services to his or her patients, unless the tasks are positively excluded from the responsibility under the RGP scheme. …"**

(49) These phrases are generally formulated. The same applies to the other provisions the municipality referred to in the GPR Regulations 2012, for instance in section 24 subsection 1 stating that the GPR "if required" is to refer the patients on, see my remarks on the RGP Regulations 2000, and section 11 subsection 2 that persons on a joint list are to have "a responsible physician who is in charge of records and follow-up".

(50) In the individual assessment, one must consider the fact that these provisions have not been applied in the sense that all RGPs automatically have a duty to provide all general health services. Evidence has shown that, in practice, RGPs are not expected to master any service requested. For instance, there are RGPs who are not qualified to insert UIDs; they may not have enough patients requesting the service to maintain the skill, although they in principle should have been qualified. It has never really been questioned whether they fulfil their duty as a RGP when they refer a patient on to a colleague with the necessary qualifications, unless they are asked specifically to learn or revive the skill themselves. The latter has allegedly never happened in practice.

(51) Although there is a difference between this situation and a RGP refusing to carry out the procedure for reasons of conscience, who is likely also to refuse to learn the procedure upon the municipality's request, the Ministry should have expressed itself more clearly in the Regulations if the amendments in 2012 were intended to prohibit reservations for reasons of conscience based on the notion that single procedures cannot be left to other staff, for instance because that may diminish the function of the RGP scheme. Although the wording in section 3-2 may be interpreted to allow prohibition, that was not sufficiently supported in the preparatory works and the amendments.

(52) I will now turn to considering the development of law after the new RGP Regulations had been implemented in January 2013.

(53) *The Ministry's two consultation papers and the role of the Storting*

(54) In a letter of 21 January 2014, the Ministry of Health and Care Services proposed amendments to the Health and Care Services Act and the Patient and User Rights Act, as well as to the RGP Regulations 2012. The background was the cooperation agreement between the political parties *Høyre*, *Fremskrittspartiet* and *Kristelig Folkeparti*.

(55) In the consultation paper enclosed to the letter, the Ministry proposed to add a new subsection 3 to section 3-2 of the Health and Care Services Act that gave a legal basis for making Regulations on RGPs' possibility to refuse to refer and treat patients in the event of serious conflicts of conscience relating to life and death, i.e. abortion and assisted suicide. The comments stated that the right of conscience did not include prescribing or insertion of UIDs or referral for assisted fertilisation.

(56) The consultation paper stressed the municipalities' responsibility to organise the RGP scheme. Each municipality must ensure the supply of general medical services and a

sufficient number of physicians participating in the RGP scheme. It was thus up to the municipalities to assess, based on local conditions, whether they would enter into an agreement with a RGP on the right to refuse to refer a patient for abortion. The RGPs would not have had a right to refuse, but a possibility.

(57) There was a strong resistance against the proposals in the consultation paper. On 27 June 2014, the Ministry therefore issued a new consultation paper with a proposal to amend the Regulations 2012 and the Termination of Pregnancy Regulations 2001. It was proposed that RGPs were no longer to be required to sign the abortion request form, or to attach a written referral. Furthermore, the Ministry proposed an addition to section 11 of the RGP Regulations on the RGP's responsibility the patients on his or her list:

> **"The RGPs may distribute responsibilities and tasks among them to compensate for vacant positions or special agreements, or for holiday or other absence out of consideration for the quality of the health care."**

(58) From the remarks, it appeared that the system with joint lists, which raised the issue of distribution of tasks in particular, did not mean that RGPs were to distribute tasks among them for other practical reasons than those mentioned in the Regulations, nor for political or economic reasons or reasons of conscience when it came to inserting UIDs, prescribing contraceptives or referring patients for assisted fertilisation.

(59) The Ministry also proposed to add to section 16 of the RGP Regulations that the RGP is to perform his or her duties in accordance with "statutory requirements". According to comments to this provision, this entailed that the RGP "[could] not refuse, for reasons of conscience, to carry out procedures covered by the responsibility for the patients on his or her list, such as inserting UIDs, prescribing contraceptives or refer patients for assisted fertilisation".

(60) The background for the proposals was summarised as follows:

> **"The basic idea behind the RGP scheme is that all Norwegians have a right to a RGP responsible for offering his or her patient overall general medical services over time. The RGP should master all general medical procedures, such as inserting UIDs and following up and treatment of common diseases such as diabetes 2 or COPD. The patient must be able to expect that his or her RGP can carry out all general medical services in a professionally responsible and caring manner.**
>
> **Some may find that the system with joint lists can result in reservations for reasons of conscience, that a wish to make reservations can be solved in practice by giving the patient an appointment with another RGP from the joint list while at the same time fully maintaining the rights of the patient.**
>
> **However, the RGP scheme is meant as a scheme under which the patient turns to one permanent physician who is to follow up all general medical services over time. The system was established to improve the quality of the services offered to the individual patient by more continuity in the physician-patient relationship and a broader spectrum of services. Although a patient on a joint list must expect to see various physicians, the patient may have a need to see the physician she knows best, especially when it comes to intimate matters such as contraceptives guidance and insertion of UID. These are also central tasks for RGPs which the patient must be able to trust that the RGP attends to."**

(61) The Ministry also found that refusing to refer patients for assisted fertilisation, inserting UIDs and prescribing contraceptives would entail a reduced access to the first-line service and weaken the right to reproductive health. Also, the RGPs might wish to refuse to carry

out other procedures, which could make it more difficult to maintain a RGP scheme if one should start allowing reservations for reasons of conscience.

(62) The proposed changes to sections 11 and 16 of the RGP Regulations were adopted by Royal Decree on 5 December 2014 and entered into force on 1 January 2015. The Minister's motivation to the Decree was much shorter than the consultation paper, but based on the same principal views.

(63) In connection with the Ministry's two consultation papers, one should also consider the role of the Storting in this process. Following the reactions to the Ministry's first consultation paper of January 2014 and before the second consultation round late June in the same year, three members of the Storting proposed, on 18 March 2014, measures for efficient enforcement of the prohibition against reservations for physicians, see Document 8:37 S (2013–2014). One of the reasons was the Ministry's first consultation paper. The proposers thought it was essential to secure efficient enforcement of the prohibition against reservations, to provide equal medical services to the citizens. Thus, they proposed that the Ministry commission the Norwegian Board of Health Supervision to clarify physicians' right of reservation, specify towards supervisory authorities that any non-compliance in that regard would be sanctioned, and to propose necessary legislative amendments to facilitate the enforcement of the prohibition against reservations.

(64) The proposal was discussed by the Standing Committee on Health and Care Services on 10 June 2014, see Recommendation to the Storting 276 (2013–2014). In the meantime, the Ministry announced that it would issue the second consultation paper in June. The Committee had several factions. It recommended that the proposal be attached to the protocol, which was done after the debate in the Storting on 17 June 2014, see Parliamentary Journal (2013–2014) pages 3483–3487.

(65) The debate in the Storting clearly reflected a need of clarification of practice. The Ministry of Health and Care Services, Bent Høie, stated:

> **"The Government will, as we all know, in the course of June issue a consultation paper with a proposal to remove the referral from the RGP when women request a termination of pregnancy. This solution maintains both the rights of the women requesting an abortion and those of physicians who for reasons of conscience have difficulties referring for abortion.**
>
> **The consultation paper will also specify applicable law under which it is impossible for RGPs to refuse to insert UIDs, prescribe contraceptives or refer patients for assisted fertilisation.**
>
> **Furthermore, the consultation paper will clarify the municipalities' responsibility to ensure that RGPs do not have reservations in conflict with the rules. The right of the supervisory authorities to enforce the rules, and the fact that joint lists do not warrant such reservations either, will be clarified.**
>
> **…**
>
> **These are measures reforming a practice that has not worked satisfactorily for many years, and which will secure quick and available health care for women in important areas. In my view, this also fulfils the proposers' wish for a more explicit specification of the need to enforce the law."**

(66) Similar statements were made by several Committee members in the Recommendation and by members of the Storting. There was a general, strong support of the withdrawal of the first consultation letter, and of the need to change the practice of allowing reservations by drafting new Regulations.

(67) In my view, these amendments to the RGP Regulations 2012 lead to a significant clarification of the state of the law. Admittedly, the wording in section 11 was limited to the RGP's responsibility with regard to his or her list patients, where the distribution of tasks was particularly relevant. But it follows from the Regulations, read in context, that they cover all RGPs, and that the considerations the Regulations are to take apply in general for the RGP scheme. And even if the amended wording in section 16 of the Regulations could have been clearer in itself, both the general and special motives establish that a RGP cannot refuse to insert UIDs for reasons of conscience. In addition, the views of the majority of the Storting in June 2014 – between the first and second consultation paper – clearly indicated what the further process should be. It was clearly the Storting's prerequisite that the Ministry amend the Regulations in line with the solution chosen. Consequently, I conclude that it was sufficiently clear how the RGP Regulations 2012 were to be read following the amendments in December 2014, which entered into force on 1 January 2015.

(68) I have previously mentioned that section 3-2 of the Health and Care Services Act, which since 2011 has been the legal basis for the RGP Regulations, is so generally worded that it also allows a regulation of the question of reservations for reasons of conscience, but that the preparatory works – and the Regulations 2012 – did not support any implementation of a prohibition. It may be argued that a right of reservation touches upon issues of such principle that they belong in the Storting and can therefore not be regulated based on a provision stating that regulations can be adopted for implementation purposes. In this case, the Storting has expressed its view on the matter and left it to the Ministry to issue the rules by way of regulations.

(69) *The dismissal*

(70) The framework agreement on general medical practice in the municipalities' RGP scheme (ASA 4310), entered into between the Norwegian Association of Local and Regional Authorities and the Norwegian Medical Association, contains rules in clause 16 on termination of individual agreements on RGP practice. Any termination by the municipality must be objectively justified.

(71) As mentioned, the municipality terminated A's RGP agreement by a letter of 3 December 2015. The decision reads:

> **"The agreement on general medical practice under the RGP scheme between Sauherad municipality and A is terminated in accordance with ASA 4310, item 16. The termination also includes the agreement on municipal part-time position warranted in the individual agreement on general medical practice under the RGP scheme. The termination is effective from 3 December 2015.**
>
> **The termination is due to your refusal to insert UIDs on patients requesting this treatment. Sauherad municipality believes the procedure is comprised by the duties under the RGP agreement and that any refusal to carry it out is a breach of agreement, see the Health and Care Services Act with Regulations. The breach is considered to be so serious that it qualifies for dismissal."**

(72) The reason for the dismissal – her refusal to insert UIDs – is based on the assumption that it was in conflict with her duties under the individual RGP agreement. This is not suited to describe the case at hand. I have previously concluded that A, in addition to the written RGP agreement, entered into an oral agreement under which her reservation for reasons of conscience was accepted, and that this agreement was binding on the municipality.

(73) To the extent the agreement also refers to the Health and Care Services Act with Regulations, I have already found that neither applicable legislation nor the RGP Regulations prohibited reservations for reasons of conscience when A was employed in 2011, and that the amendments in 2012 did not change that. On the other hand, section 30 subsection 4 of the Regulations of 2012 established that a RGP and the municipality could not enter into any agreement in conflict with the Regulations. According to the comments in 2012 to section 30 subsection 4, agreements between the municipality and a RGP in conflict with a new Act or revised Regulations would be unlawful. The statement seems however to be based on the assumption that agreements on the right reservation could also not be entered into prior to the Regulations of 2012. As already demonstrated, this assumption was not correct. Hence, one cannot interpret section 30 subsection 4 to mean that it applies to an RGP who had a right of reservation under a valid agreement, like A.

(74) The municipality's dismissal of A was thus not objectively justified. The dismissal must be set aside as unlawful.

(75) *The European Convention on Human Rights*

(76) A has succeeded in her contention that the dismissal of her was unlawful. Hence, it is unnecessary to consider whether the dismissal was also contrary to the European Convention on Human Rights, in particular Article 9 on the freedom of thought, conscience and religion. But due to the parties' contentions and the fact that this aspect of the case has been given much attention, I will all the same say something on the application of the Convention when a RGP for reasons of conscience refuses to insert UIDs. Article 9 reads:

> **"1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.**
>
> **2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others."**

(77) The European Court of Human Rights has given several judgments under this provision, including judgment 15 January 2013 *Eweida and others v. United Kingdom.* The case involved four applicants who in various ways experienced conflict between their religious conviction and their employment. The Court found that Article 9 had been violated in the case of the first applicant.

(78) For a conviction to be covered by the provision, two requirements must be met according to Convention case law. There must be a certain level of cogency, seriousness, cohesion and importance, as well as a sufficiently close and direct nexus between the act and the underlying belief, see *Eweida* paragraphs 81 and 82.

(79) During the revision of the RGP Regulations in 2014, the Ministry of Health and Care Services assumed in its second consultation paper of June 2014 that denying an RGP a right of conscience with regard to inserting IUDs would be an interference in the RGP's rights under Article 9 of the Convention. I agree.

(80) When Article 9 thus is applicable, the question is whether the three conditions in Article 9 (2) are met. It is clear that a prohibition against an RGP's refusal to insert IUDs has a *legitimate purpose*. As mentioned in the quote from the Ministry's second consultation paper in June 2014, the basic idea behind the RGP scheme is that every individual has a right to comprehensive general medical services over time. Limitations to a physician's right to refuse to insert IUDs thus serve both the concern for "health" and "for the rights and freedom of others".

(81) The second condition – *that limitations are prescribed by law* – means that the interference must have a basis in domestic legislation, and that the rules must be accessible and foreseeable. Currently, it is clear that this requirement under the Convention has been fulfilled.

(82) Thus, the third condition under Article 9 (2) is decisive – that the interference is *necessary in a democratic society*. According to Convention case law, an assessment of proportionality is required here. Convention states are given a certain margin of appreciation, but the intervention must be justified and proportionate, in view of the purposes to be fulfilled, see *Eweida* paragraph 84. This will depend on an individual assessment, while the general balancing of the opposite considerations that have given rise to the rule applied will be given great weight also in the assessment of whether there is a violation of the Convention. But special circumstances in each case may entail that interference that generally may seem justified must be considered a violation nevertheless.

(83) In its assessment of the amendment of the Regulations in 2014 and the application of Article 9, the Ministry of Health and Care Services held the following in the second consultation paper from June 2014:

> **"Some may say that the patient will have her rights protected … because she may have the UID inserted by another physician sharing list with the physician who refuses. Some may also say that some physicians have made such arrangements for years in agreement with the municipality without it creating any problems …**
>
> **On the other hand, the RGP scheme is meant to be a system where the patient is to have the possibility of dealing with one physician who will follow up all general medical services over time."**

(84) Against this background, the Ministry found that a right of reservation exercised in connection with certain tasks, including the insertion of UIDs, would weaken the scheme and reduce the services. The Ministry continued:

> **"Refusal by way of referring the woman to another GP for reasons of conscience may affect the trust between the RGP and the patient. It can also not be ruled out that a referral may affect the women's psychological wellbeing and that she will later be reluctant to tell her RGP about conditions that she believes may be caused by the UID or the contraceptive. This in itself may have the effect that the patient does not get necessary health care.**

> **Reservations may in other words be contrary to the requirement of professional responsibility and diligent care under section 4 subsection 1 of the Health Personnel Act. Reservations may damage the access to the first-line service and diminish women's right to reproductive health."**

(85) These are undoubtedly legitimate and weighty considerations. If the consequence of a RGP's refusal to insert UIDs is that the women affected will not receive this treatment or they are faced with an unreasonable strain, it will be difficult to reach any other result than that the considerations stressed by the Ministry must be decisive.

(86) Although it can be argued that the Ministry's assessment of the application of the Convention was rather general, I find it clear, and in accordance with Convention case law, that the courts in this area must be reluctant to review the balancing of legitimate considerations made by political authorities. The states' margin of appreciation will be wider if a balance is struck against the rights of others, such as patients' health and safety, see for instance *Eweida* paragraphs 99, 106 and 109.

(87) When the women concerned are secured adequate health care, here in the form of insertion of UIDs, the balancing becomes more complex. In *Eweida*, the Court of Human Rights has summarised the central meaning of Article 9 as such:

> **"79. The Court recalls that, as enshrined in Article 9, freedom of thought, conscience and religion is one of the foundations of a 'democratic society' within the meaning of the Convention. In its religious dimension it is one of the most vital elements that go to make up the identity of believers and their conception of life, but it is also a precious asset for atheists, agnostics, sceptics and the unconcerned. The pluralism indissociable from a democratic society, which has been dearly won over the centuries, depends on it (see Kokkinakis v. Greece, 25 May 1993, § 31, Series A no. 260-A)."**

(88) The balancing connected to the right of reservation must be struck against this background.

(89) Besides Article 9 of the Convention, it is interesting with regard to the right of reservation to consider the basic provision on women's right to health care, included in Article 12 of the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The first part of the Article reads:

> **"States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."**

(90) In my view, what I have quoted from the Ministry's grounds for the amendment corresponds well with the considerations justifying the basic provision on women's right to health care included in Article 12 of CEDAW. However, this does not imply that a right of reservation for RGPs will constitute a breach of CEDAW. This is clearly expressed in Comment 24 from 1999 (Women and Health) by the Committee on the Elimination of Discrimination against Women. It is stressed early in the Comment that "access to health care, including reproductive health, is a basic right". Section 11 of the Comment reads:

> **"It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers."**

(91) The fact that CEDAW does not preclude that a right of reservation according to the circumstances has been accepted does not mean that the views presented by the Ministry are without independent substance, but this must be balanced against the freedom of thought, conscience and religion in a slightly different manner.

(92) The different results in the four applications included in *Eweida* illustrate the complexity of the considerations to be made. It will be the courts' task to decide on the concrete balancing of the opposite interests in any future cases.

(93) *The question of liability*

(94) A has claimed damages for economic loss as a result of the termination. According to the ruling of the Supreme Court's Appeals Selection Committee of 13 March 2018, the Supreme Court is not to consider the question of damages for the time being.

(95) The court of appeal found that no such special considerations existed to establish strict liability on the part of the authorities due to non-statutory exercise of power. Since the municipality could not be deemed to have acted negligently, judgment was given in its favour. Before the Supreme Court, A has asserted several bases of liability.

(96) As a starting point, I take it that the claim for damages is based on the view that an unfair termination of an individual RGP agreement has been carried out, which places the situation under contract law. The condition for dismissal – that it must be objectively justified – is the same as in section 15-7 of the Working Environment Act, where a part of the protection against unfair dismissal is compensation if the dismissal is in contravention of the provisions of the Act, see section 15-12.

(97) In a contractual relationship, strict liability is normally imposed in the event of mistake of law, see e.g. Supreme Court judgment HR-2016-1235-A (*Røldal-Suldal*) paragraph 49. In the case at hand, the municipality's dismissal is not objectively justified as it is based on an incorrect understanding of the rules on the RGP scheme. Hence, there are weighty reasons for imposing strict liability.

(98) It is true that the RGP scheme also contains elements of exercise of public power. In its judgment Rt-2010-291 (*Vangen*), concerning a claim for damages under the Planning and Building Act, the Supreme Court held that no general rule applies with regard to strict liability for non-statutory exercise of authority, and that such liability is only imposed in certain areas where special considerations must be made, see paragraphs 33-35. Strict liability was the result in e.g. Rt-2005-416, where the Lawyers Licensing Committee had turned down an application despite the fact that the situation justifying the revocation had ceased. The Supreme Court emphasised that the case involved a non-statutory exercise of power that deprived the lawyer of the chance to practice, and where the rejection was worded in a sanction-like manner, see paragraph 65.

(99) The judgment has certain similarities with the case at hand. It is true that A was offered a new position, but she lost her job as an RGP, and the notice of termination was worded in a sanction-like manner. Combined with the main view that the municipality's dismissal took place in a contractual relationship where the individual party carries the risk of any mistake of law, I have no objections against establishing strict liability in this particular case.

(100) A has succeeded and is entitled under section 20-2 of the Dispute Act to have her costs covered. The municipality has had objections to the size of the amount. I find that the respondent's cost claim for work performed in connection with the municipality's appeal regarding the validity of the termination should be somewhat reduced. The same applies to the costs concerning the claim for damages before the Supreme Court.

(101) Due to the Supreme Court's decision to postpone the measure of damages, the claim for damages will not be finally settled at this stage, but the outcome of the claim will have no effect on the costs for the parts of the case already completed; hence, there is sufficient basis for determining the costs now, see section 20-8 subsection 3 of the Dispute Act and Schei and others: *Kommentar til tvisteloven* (Commentary to the Dispute Act*)*, 2013, Volume I pages 744–745. Thus, the Supreme Court may determine the costs both in the question of lawfulness and in the question of damages before all instances.

(102) I have concluded that the total necessary costs in all three instances may be set at NOK 2 500 000 including expenditures.

(103) I vote for the following

J U D G M E N T :

1. Sauherad municipality's appeal is dismissed.

2. Sauherad municipality is liable for the loss suffered by A as a result of the termination of her employment dated 3 December 2015. The court of appeal's judgment, item 2 of its conclusion, is set aside, and the case is referred to the court of appeal for consideration of the issue of damages.

3. Sauherad municipality is to pay costs in the district court, the court of appeal and the Supreme Court to A of NOK 2 500 000 – twomillionfivehundredthousand – within 2 – two weeks – of the service of the judgment.

(104) Justice **Bull:** I agree with the justice delivering the leading opinion in all material respects and with his conclusion.

(105) Justice **Berglund:** Likewise.

(106) Justice **Bergsjø:** Likewise.

(107) Justice **Endresen:** Likewise.

(108) Following the voting, the Supreme Court gave this

J U D G M E N T :

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