OUTER HOUSE, COURT OF SESSION

[2018] CSOH 85

P61/18

OPINION OF LADY WISE

In the Petition of

SPUC PRO-LIFE SCOTLAND LIMITED

Petitioner

against

SCOTTISH MINISTERS

Respondents

for

Judicial Review of the Decision to issue the Abortion Act 1967 (Place for Treatment for the Termination of Pregnancy) (Approval) (Scotland) 2017

Petitioner: M Ross QC and Komorowski; Thorntons Law LLP
Respondents: L Dunlop QC and O'Neill (sol adv); Scottish Government Legal Directorate

15 August 2018

Introduction

[1] The petitioner is a society with an interest in promoting the belief that conception is the starting point of all new life. It is opposed to abortion and has an interest in any decision or enactment that relates to that issue. The respondents are the Scottish Ministers who have made a decision to grant an approval in terms of section 1(3) and 1(3A) of the Abortion Act 1967 ("the 1967 Act") that the petitioner seeks to reduce. In essence, the petitioner contends

that the respondents' decision to approve a pregnant woman's home as a class of place where treatment for termination of pregnancy may be carried out is unlawful. Termination of pregnancy is a subject that invokes strongly held beliefs both for and against its availability. This case concerns only the lawfulness of a particular decision made by the respondents and not the merits of the general legislative provisions permitting termination of pregnancy. In challenging a decision of the respondents to approve a woman's home as a place where termination of pregnancy can be carried out, the petitioner is not suggesting, by implication, that it should be carried out elsewhere.

The applicable law

[2] The Abortion Act 1967 provides, by section 1(1) that a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a "**registered medical practitioner**" on certain other specified conditions with which this petition is not concerned. Section 1(3) and (3A), following various amendments, are in the following terms:

> "(3) Except as provided by subsection (4) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Secretary of State for the purposes of his functions under the National Health Service Act 2006 or the National Health Service (Scotland) Act 1978 or in a hospital vested in a National Health Service trust or an NHS foundation trust or in a place approved for the purposes of this section by the Secretary of State.
>
> (3A) The power under subsection (3) of this section to approve a place includes power, in relation to treatment consisting primarily in the use of such medicines as may be specified in the approval and carried out in such manner as may be so specified, to approve a class of places."

The approval under challenge

[3] On 26 October 2017 the Scottish Ministers made the following approval in exercise of the powers conferred by section 1(3) and (3A) of the 1967 Act:

> "**The Abortion Act 1967 (Place for Treatment for the Termination of Pregnancy) (Approval) (Scotland) (2017)**
>
> …
>
> **Commencement**
>
> 1. This approval comes into force on the day after the day on which it is made.
>
> **Interpretation**
>
> 2. In this approval –
>
> "home" means the place in Scotland where a pregnant woman is ordinarily resident;
>
> "pregnancy" and "pregnant woman" are to be construed by reference to the Abortion Act 1967; and
>
> "treatment" means the taking of the medicine known as misoprostol.
>
> **Approval of class of place**
>
> 3. The home of a pregnant woman who is undergoing treatment for the purposes of termination of her pregnancy is approved as a class of place where treatment for termination of pregnancy may be carried out where that treatment is carried out in the manner specified in paragraph 4.
>
> 4. The treatment must be carried out in the following manner –
> (a) the pregnant woman has attended a clinic where she has been prescribed mifepristone and misoprostol to be taken for the purposes of termination of her pregnancy; and
> (b) the pregnant woman has taken mifepristone at that clinic and wants to carry out the treatment at home."

Submissions on behalf of the petitioner

[4] Senior counsel for the petitioner summarised the challenge made to the respondents' approval as being two fold. First, a home is not a permissible class for the purposes of the

legislation and secondly the approval issued runs counter to the requirement in the legislation that abortion be carried out by a medical practitioner. It was not in dispute that the interpretation of the provisions in question did not require consideration of the Hansard Debates on the grounds permitted by *Pepper (Inspector of Taxes)* v *Hart* [1993] A.C.593. However the respondents had produced a report of the House of Commons' Science and Technology Committee entitled "Scientific Developments Relating to the Abortion Act 1967" from Session 2006 –07. While Ms Ross submitted that such a report could not provide a legitimate aid to interpretation, she referred to certain extracts simply as background and in anticipation of reliance to be placed on it by the respondents. She submitted that the Report seemed to proceed on the basis that the purpose of section 1(3A) was to allow medical abortion at home. However that view was formed, it did not proceed on a legal understanding of the 1967 Act. The report did make clear that the committee was informed that, in relation to the places where an abortion could be carried out, legal advice suggested that legislative change would be necessary to render any such change lawful. The conclusion of the report was simply to invite Members of Parliament to consider its terms when looking at any amendment to the 1967 Act or regulations required to enable the second stage of early medical abortion to be self-administered in a woman's home. As the approval now under challenge was simply a decision and not delegated legislation, there being no regulation making powers conferred by the 1967 Act, the report was not of any assistance and should be ignored.

[5] The Abortion Act 1967, passed over 50 years ago, is only seven sections long and deals with an issue of social complexity. There has been judicial criticism in relation to its lack of clarity and Ms Ross contended that a series of amendments have effected little change to it. The central provisions are contained in section 1 and the decriminalisation of

abortion only applies where the pregnancy is "terminated by a registered medical practitioner". As the Act is designed to provide protection for medical practitioners from criminal law consequences of carrying out termination of pregnancy, clarity and certainty in its provisions is particularly important, both for the medical practitioner and for the pregnant woman involved. It was accepted that the terms of section 1(3) empowered the Secretary of State (now the respondents) to approve specified places and that the addition of section 1(3A) now included within that power approving a class of place where the treatment consisted primarily in the use of medicines. The requirements of the Act included that termination of pregnancy (i) is something that can only be carried out by a medical practitioner, (ii) involves treatment, (iii) can be undertaken only in a place or class of place approved by the respondents and also (iv) in terms of subsection (4) of section 1 there are certain exceptions to the specified conditions where the life of the woman is at risk or on other situations of necessity. Importantly, prior to 1990 the government could only specify particular places. The ability to approve a class of place was introduced in 1991 by the Human Fertilisation and Embryology Act 1990. Section 4 of the 1967 Act provides for conscientious objection to participation and treatment. That exception had been the subject of the UK Supreme Court decision in *Doogan* v *Greater Glasgow and Clyde Health Board* 2015 SC (UKSC) 32. Section 5 of the Act makes clear that abortion other than in accordance with section 1 continues to be unlawful.

[6] Turning to the approval under challenge, produced at number 6/2 of process, although it contains the heading "The Abortion Act 1967 (Place for Treatment for the Termination of Pregnancy) (Approval) (Scotland) (2017)"such that it appears at first sight to be a regulation, the document indisputably simply narrated the terms of a decision taken by the respondents. The significant terms include the interpretation of "home" as the place in

Scotland where a pregnant woman is ordinarily resident and "treatment" as being the taking of the medicine known as misoprostol. Paragraph 3 of the document represents the approval itself of the home of the pregnant woman undergoing treatment as a "class of place" where termination of pregnancy may be carried out. That class of place is approved only if treatment is carried out in the manner specified in paragraph 4. The requirements of paragraph 4 are (a) that the pregnant woman has attended a clinic where she has been prescribed mifepristone and misoprostol to be taken for the purposes of termination of her pregnancy and (b) that the mifepristone has been taken at that clinic and that the woman wants to carry out the treatment at home. While the document 6/2 represents the whole of the approval under challenge, it was noteworthy that it had been sent to general practitioners together with a letter, 6/1 of process, headed "Dear Colleague" from the Chief Medical Officer for Scotland explaining what the approval is and indicating that practitioners are expected to follow clinical guidance set out by the Scottish Abortion Care Providers (SACP) Network provided as an annex to the letter. That guidance sets out a number of criteria for the assistance of medical practitioners. Two passages were of note. First, in paragraph 10 the guidance states that the patient should be advised of the standard dosing interval between mifepristone and misoprostol which is 24 – 48 hours, based on efficacy. The guidance accordingly directs that misoprostol should thus normally be administered 24 – 48 hours after mifepristone, although guidance is also provided on the possibility for longer dosing intervals. Doctors are also advised that they must record the location of the place of treatment when completing the notification of abortion form and they should tender certain advice to patients administering the misoprostol for self-administration at home. Further, the guidance states in terms that if there is no adult available to be at home with the patient then treatment as Early Medical Abortion at Home

should not proceed. As it could not be contended by the respondents that the letter and accompanying guidance were in any sense part of the approval, that approval had to stand alone and Ms Ross questioned whether it was clear enough in its terms. The only conditions set out in the approval were that the first stage of administering mifepristone had to be carried out at the clinic and that the pregnant woman must "want to" administer the misoprostol at home. It was submitted that effectively, the respondents, while purporting to exercise power under section 1(3A), were in effect delegating the decision on approval of a home to the medical profession. The class is so broadly defined that the individual general practitioner is effectively required to decide on a case by case basis whether a particular woman's home is in fact a suitable place.

[7] It was unclear what would happen if a doctor did not comply with the guidance. The difficulties arising from the separation of the guidance and the approval meant that if a pregnant woman had no one at home and so the doctor refused to permit her to self-administer the misoprostol at home the question as to whether the woman's home was still within the class of place approved would arise, Ms Ross submitted that the difficulty was that the starting point in the approval was too broad because the home of every woman who seeks an abortion is included. It simply could not be the case that every single home in which a woman was ordinarily resident could be suitable for this procedure. If having another adult present was important for safety that would require to be in the approval and not in separate guidance although it was accepted that the respondents could re-draft the approval to remedy that particular problem. In order to comply with the provisions of section 1, abortions have to be carried out in safe and hygienic places. Where approval is given for places that are an alternative to hospital or a clinic they have to meet those basic requirements. Applying conditions only of (a) the home being the woman's residence and

(b) her wanting to take the drug there were insufficient. The capacity of a woman to seek to take the drug at home was a necessary but not sufficient condition for her home to be a suitable place. It was the respondents' reliance on the general practitioner's judgement about whether a place is suitable that was objectionable. It was not legitimate for the respondents to delegate to the medical profession to decide which homes were suitable standing that the approval was an exercise of a statutory function. The absence of conditionality in relation to safety or hygiene rendered the approval much too wide. The respondents have sought to stretch the notion of a "class of place" in a way that the interpretation of the primary legislation cannot bear. Even if it was to be argued that the letter, approval and guidance all have to be read together that would answer only the permissible class point at best and not the second main challenge of treatment having to be by a medical practitioner.

[8] Turning to the authorities, Ms Ross submitted that the decision of the House of Lords in *Royal College of Nursing of the United Kingdom* v *Department of Health and Social Security* [1981] AC 800 provided answers to all the questions raised in these proceedings. There, the Royal College of Nursing had sought to understand the extent to which nurses required to carry out treatment for abortion. The Department of Health at the time had issued a circular relating to the administration of abortifacient drugs. The issue was whether it was unlawful to approve the administration of those drugs by nurses if directed to do so by a medical practitioner. At first instance Woolf J refused to declare the circular unlawful. That decision was reversed by the Court of Appeal. Thereafter the House of Lords allowed an appeal by the Department of Health and Social Security in a 3:2 split decision. It was anticipated that the respondents would rely on a passage from the first instance decision, reported at [1981] 1 All ER 545 where Woolf J foresaw that in the future pregnancy might be terminated merely

by the patient taking a pill. His view was that, although the process would have to be initiated by the medical practitioner who must remain responsible throughout for its overall conduct and control, any actions needed to bring a pregnancy to a conclusion could be carried out on his instructions but not necessarily in his presence (page 553). Senior counsel for the petitioner contended that the passage did not assist the respondents in this case because, even on the hypothesis postulated by Woolf J the registered medical practitioner would have to both initiate the procedure and strictly control it. It was not the contention of the petitioner that physical presence by a doctor in the same room as the pregnant woman was required but control by a medical practitioner was the issue.

[9] So far as the House of Lords' stage of the case was concerned, a number of passages were relied on. The case was heard before the amendment of the Act in 1990 and the provision under discussion was section 1(3). Lord Diplock, one of the judges in the majority, made a number of important points (at page 828) in relation to the interpretation of the subsection. First, he considered it evident that parliament contemplated that treatment for termination of pregnancy would be undertaken as a "team effort" in which junior doctors, nurses, paramedical and other members of hospital staff would act on the instructions of the doctor in carrying out each of the things that formed part of the whole treatment. Ms Ross submitted that the reference to the "team" could not be suggestive of any self-administration by a patient. Secondly, Lord Diplock made clear that anyone to whom a physical act at any stage of treatment for the termination of pregnancy was delegated must be given specific instructions and that those acts could then be carried out by "nurses or other members of the hospital staff without medical qualifications". Accordingly, counsel submitted that the requirement that the treatment for termination of pregnancy must be carried out by a registered medical practitioner must be considered in deciding whether a class of place was

suitable. Lord Diplock had been clear that a doctor should always be available "to be consulted or called on for assistance from beginning to end of the treatment". Accordingly, where any act bringing about the termination of pregnancy was not carried out by a doctor him or herself, he or she must remain in charge of the treatment throughout and any delegated act had to be carried out in accordance with his or her clear directions. The respondents' approval stretched beyond breaking point the meaning of "in charge" in this context. Reference was made also to a passage of the judgment of Lord Keith of Kinkel at page 835 where a team of a doctor and nurses was clearly contemplated even where termination was by the use of abortifacient drugs. Lord Keith's reference to the "safest conditions attainable" being required for abortions was also significant. A combination of the judgment of Lord Diplock and Lord Keith led to the proposition that abortion was only lawful if carried out under conditions that were both safe and hygienic. Lord Roskill, the third judge in the majority decision reiterated (at page 838) that the taking of steps by a nurse would be fully protected provided that the entirety of the treatment for the termination of the pregnancy was at all times under the control of the doctor even if he was not present throughout the entirety of it. While physical presence was clearly not necessary, Ms Ross submitted that the type of "virtual" presence contemplated by the respondents would break the connection between the control by the doctor and the place as it was at the time of the legislation being considered by the House of Lords in the Royal College of Nursing case. The basic requirement was for a relationship between the place where the treatment was carried out and the medical practitioner. On the face of it, the terms of the approval under challenge were not sufficient, standing the lack of the relationship with the treating doctor, to fall within the class of place category that could be lawfully approved. While the petitioner's position was that acceptance of either of the two main arguments was

sufficient for the petition to succeed, there was to some extent an overlap between the two because the concept of "place" has to have some purposeful context in that the place has to be suitable for abortions to be carried out there.

[10] The *Royal College of Nursing* case was followed and approved in a decision of Supperstone J in *British Pregnancy Advisory Service* v *Secretary of State for Health* [2012] 1 WLR 580. The claimant in that case was an independent health care provider outside the NHS that wanted to provide treatment of abortifacient drugs prescribed in a clinic but taken at home. The organisation sought a declaration that the administration of drugs to the pregnant woman in this context was not "treatment for the termination of pregnancy" in terms of section 1 of the 1967 Act. The claim was dismissed on the basis that treatment was not restricted to diagnosis and treatment but included the taking of the drug and that a pregnant woman would not be permitted to take such a drug at home unless her home had been approved by the Secretary of State. Importantly, having rejected the argument that the taking of an abortifacient drug was somehow not "treatment", Supperstone J noted that if drugs or tablets for termination of pregnancy were prescribed by the registered medical practitioner and not taken by the woman, then the opportunity for treatment would have been available but would not have been taken (para 24). Accordingly, prescribing the drug is not the whole of the treatment; the act of administration of the drug is included in that definition. It was clear that the Secretary of State could not delegate the classification function in section 1(3A) to the medical profession and that only the Secretary of State (or the Scottish Ministers) could approve the place. In anticipation that, under reference to paragraph 32 of the *BPAS* case, the respondent would point out that Supperstone J referred to the home being potentially in the wide range of places that the Secretary of State could approve, counsel pointed out that the reference simply reflected the way in which BPAS

decided to run the argument. The case was not a decision on home as a class of place but related to the definition of the word "treatment". In any event, there was no proposed approval of home as a class of place at the time of the decision in that case. The high court's decision was that the legislation could not be circumvented by declarator of court.

[11] Reference was also made to the decision in *Doogan* v *Greater Glasgow and Clyde Health Board*, *supra.* The context of that case was conscientious objection in terms of section 4. Two midwives working as labour ward coordinators who were Roman Catholics had objected to participating in treatment for the termination of pregnancy. The only interest in the case for the purposes of this petition was said to be the overall approach to interpretation. Lady Hale (at paragraph 33) had described the argument as a "pure question of statutory construction". The present case, while on a very different issue, could also be described that way. It was clear from the way in which Lady Hale identified the question in *Doogan* as being restricted to the meaning of particular words in section 4 that a consciously precise and possibly technical reading of the statute was required. The present petition did not engage the correctness or otherwise of a broader approach to interpretation.

[12] Ms Ross made five propositions in support of her first plea-in-law which challenged that a pregnant woman's home can be somewhere lawfully approved as a class of place. A sixth proposition concerns the second ground reflected in the second plea-in-law in relation to the requirement for a medical practitioner to be in charge or in control of all treatment. The first proposition was that there must be some restriction in form and in substance on location. A power to prescribe a class of place where an activity may happen necessarily implies a class which does not include all places. While the legislation as currently framed permits the Scottish Ministers to add places to those listed in section 1(3) there was no power to permit abortion to be carried out in any place whatsoever. If the power can only be

exercised in a manner that leaves some, but not all, places included, it follows that the line must be drawn in a manner that places some substantive restriction on where the activity might take place. Accordingly, approving all places in Scotland other than those that are uninhabitable would not be a lawful use of the power. Any exception must not "swallow the rule" and so an exception cannot be so broad as to cause the restriction to be little more than theoretical. Secondly, the restriction must be based on relative safety of the approved places. In this context there must be a meaningful link between the purpose of the Act in permitting abortions only in safe and hygienic conditions and the basis of identifying a class of place. The restriction must make that link. Approval of all premises with odd street numbers for example would significantly restrict where abortions could take place but would be entirely unconnected with the aim of the legislation. The bestowing of a power to approve a class of place presupposes that it is safer for abortions to take place in some places rather than others. Accordingly places within the approved class must be safer than places outwith the class. Thirdly, the restriction must be based on features that all places in the class share. As the power to approve a class is additional to the power to approve places on an individual basis, the legislation implies that there is something about those places which, as a generality, makes them more suitable than other places for abortion to take place. If each location had to be considered individually, class approval would be inappropriate. The home of the woman who wants to take misoprostol could not be regarded as more suitable than a clinic or hospital. Fourthly, the restriction must be based on the features of the place and not the user. Subsection (3A) allows approval of a class of place to be conditional upon medication of a particular kind being used in a particular manner but expresses no other conditions. Applying the maxim *expressio unius est exclusio alterius* there was no basis for implying a power to impose any other conditions than those stated. The restriction on

places was intended to further safety and so a place had to be approved solely by reference to its features. A place does not become inherently safer or less safe depending on the connection of the person receiving treatment with that place. Fifthly, a pregnant woman's home is not a permissible class. This followed from one or more of the first four propositions. An approval of all homes would not be a lawful class in terms of subsection (3A) as it would be so broad as to be meaningless. The introduction of the qualification that the place must be the ordinary residence of the woman receiving treatment did not alter that. There was no power to make approval conditional upon the relationship of the pregnant woman with the place of treatment. A test of ordinary residence at a certain place made no difference to the safety of that place. There was nothing inherent to the home of the pregnant woman who is to undergo abortion treatment that made it safer in relative terms than any other person's home. Absent any condition in the approval that there must be no cause for concern about the woman's wellbeing at her ordinary residence her home could not necessarily be taken as a safe place and so was not a permissible class for approval. To the extent that the guidelines sought to address some of the deficiencies in the approval (something the petitioner does not accept it achieves) there is nothing in the guidance about the GP ensuring that his or her advice is complied with or taken on board. This highlighted the problem of delegation to the medical profession.

[13] In relation to the second of the two arguments, counsel submitted that self-administration following a medical practitioner's advice, where the patient is able to call upon that practitioner, does not constitute treatment by a medical practitioner. It was clear from the *British Pregnancy Advisory Service* case that treatment includes the taking of, or administration of, misoprostol. The fact that a registered medical practitioner might remain responsible for the patient's treatment was not a statutory requirement in terms of the

1967 Act. What was required was for a medical practitioner to be in charge of all treatment and an ability to call on or consult a doctor from a distance was not sufficient for that. Sending a woman home with specific instructions on how to take misoprostol was a virtual, distant type of control and one not envisaged by the legislation. The approval under challenge differs from the approval given in the circular in the *Royal College of Nursing* case in three respects. First, the treatment to be administered by the nurses in that case was on the instructions or orders of a doctor whereas the current approval contemplates advice only from the doctor and so no control by him or her. Secondly, the pregnant woman is neither a member of clinical staff nor an employee of any clinic and so the treatment relationship of doctor and patient was very different from the doctor and nurse relationship being discussed by the House of Lords. There is no system implicit in the respondents' approval to monitor what happens when the woman is at home. Accordingly, the requirement for the hierarchical system of workers under the control of a doctor breaks down on the change of environment provided for in the approval. While of course the modern understanding of "participation" differs from the traditional doctor-patient relationship, that was irrelevant as it could never be said that the patient was somehow part of the team. She remained someone being treated as distinct from those providing the treatment. Thirdly, the respondent was likely to contend that the medical practitioner would remain responsible during the taking of misoprostol and would be available to be called upon at all stages of the treatment. While others, qualified or not, can be called upon to carry out parts of the treatment as defined in the legislation, the woman herself cannot fall within the definition of someone to whom the doctor delegates. While treatment may have a wide meaning and while the petitioner did not suggest that physical presence of a doctor at all stages was required, it stretched the language of the legislation too far to suggest that a doctor was in

charge or control simply by his providing a telephone number to the pregnant woman. This could be illustrated by considering the 24 hour window within which misoprostol can be taken. On the basis that it is accepted that taking the pill is treatment and the patient self-administers in the middle of the night, that amounts to the administration of it. Absent an emergency situation, what does it mean to say that she can call on her treating medical practitioner? It is likely that she would wait until the morning, unlike a situation where she is present in a clinic or at hospital when the drug is administered.

[14] In summary, the logical consequence of the proposed approval is that the word "place" encompasses anywhere at all. In any event, treatment by a registered medical practitioner as required by the primary legislation loses any meaning if a telephone call from home is good enough to fall within that definition. If either of these two arguments were accepted an order for reduction of the approval should be granted.

Submissions for the respondents

[15] Ms Dunlop QC pointed out at the outset that the petition was directed only to the second part of a process of treatment for termination of pregnancy. The treatment under discussion had to be distinguished from the medical induction process being discussed in the Royal College of Nursing case. The petitioner contends that the second part of the two stage process cannot be effected by a woman in her own home, something that, by granting the approval, the respondents clearly do not accept. The respondents' position is that the approval is *intra vires* and so the order sought by the petitioner should be refused.

[16] Senior Counsel for the respondents emphasised the scheme of the legislation and the limited circumstances in which termination of pregnancy will not be a criminal offence. So far as sections 1(3) and 2 of the 1968 Act are concerned, the Secretary of State's functions

thereunder were transferred, so far as exercisable in or as regards Scotland, to the Scottish Ministers by virtue of the Scotland Act 1998 (Transfer of Functions to the Scottish Ministers etc) Order 1999. Further, abortion law generally now falls within the devolved powers of the Scottish Parliament and Scottish Government as a result of the Scotland Act 2016. The arguments in the present case were concerned only with the Scottish Ministers' power to approve a class of place in terms of section 1(3A). Ms Dunlop confirmed that there is no real factual dispute between the parties the resolution of which is required for disposal of the petition. The use of mifepristone, a progesterone blocking drug, followed 24 – 48 hours later by the administration of misoprostol, a prostaglandin, to initiate expulsion of the pregnancy has been a recognised method of termination for some years. This was clear from the House of Commons' Science and Technology Committee report, referred to by senior counsel for the petitioner. It was noteworthy that, at paragraph 113 of that report there is a reference to the need for Regulations, indicating that there was never thought to be a need for primary legislation to be enacted on this issue.

[17] On the first ground of review relating to "place", a distinction had to be drawn between the limited ability to approve specific places in terms of section 1(3) and the terms of section 1(3A), introduced by the Human Fertilisation and Embryology Act 1990, when pharmaceutical abortion was contemplated and so required an amendment to the Act. In 1967 abortion had been decriminalised in certain circumstances and brought into the public sector to address the problem of the risk to women of the previously covert activity required to terminate pregnancy. A recent judicial pronouncement in relation to the introduction of a policy to address the mischief of "back-street" abortion can be found in a passage by Lady Hale in the case of *Doogan* v *Greater Glasgow Health Board, (supra)* at paragraph 27. It was acceptable to look at contemporaneous material in this context. Counsel referred to the

report of Standing Committee F on the Medical Termination of Pregnancy Bill as it then was (No 7/3 of process). The discussion there illustrated that the original plan had been to restrict the places at which termination of pregnancy could be carried out to hospitals or registered nursing homes. The possibility of carrying out terminations at a nursing home was then removed. A discussion about that referred to a "suitable place for the carrying out of these operations". Accordingly, the concern in 1967 around place seemed to be suitability. While safety might be part of suitability, suitability could not be said to be restricted to safety. The approval of places had, as part of its rationale, the need to regulate the private sector. In contrast, the 1990 amendment was not designed to remedy any mischief. It related to the imminent arrival of pharmaceutical abortions. The discussion was in relation to the drug RU486, now known as mifepristone. There was a desire to approve a process of termination using tablets. In the *British Pregnancy Advisory Service* case (supra) it was argued that "treatment" in the Act did not involve the taking of the tablets but the respondents accept that the claimant's argument in that case was wrong. The purpose of the 1990 amendment was to set up a system to cope with medical abortion by administration of tablets including the conferring of an ability to approve a class of place as distinct from specific places.

[18] The respondents' position was that, *prima facie*, a category of "the homes of women undergoing abortion" was capable of being included as a class of place. There had been a recognition by Supperstone J in the *British Pregnancy Advisory Service case* (at paragraph 32) that a wider range of place "including potentially the home" might be envisaged. While that was not sufficient to resolve matters in this court, it was noteworthy that it did not appear to strike Supperstone J as outwith the lawfulness of the provision that the home might be a permissible class of place. The subsection under discussion was general in its expression

and a straightforward interpretation did not, in Ms Dunlop's submission, restrict the class of place that might be approved.

[19] The issue of safety was one that was woven through the petitioner's submissions and there appeared to be a hint in those that approval of a woman's home was somehow not safe. If the condition was better expressed as "suitability" with safety being a part of that, it could not be said that a woman's home was somehow less safe for the taking of a tablet. One could also take into account other factors in relation to the suitability of place such as where someone is when the tablet takes effect. Privacy and comfort had to be relevant in this context. When those were taken into account it could not be said that a woman's home would be necessarily less suitable for administration of the second part of the treatment than some other place.

[20] The petitioner's propositions on place were answered in detail. On the first proposition, namely that there must be some places where the activity cannot take place, it was important to note that the legislation did not restrict the activity of termination of pregnancy to certain places. Accordingly there was no restriction of location for its own sake. The whole context was not one of a legitimate activity restricted by parliament (such as the sale of noxious substances) as abortion was almost entirely unlawful prior to the passing of the 1967 Act. The focus of a restriction on place was initially to bring operations in from the underground to places where it could permissibly be performed. These included hospitals and clinics but as science progressed and the ability to approve a "class of place" was introduced parliament conferred an unfettered power to designate a class of place. There was no restriction using words such as "or any other similar place" to suggest that any features of a hospital or clinic were required. The normal strictures of administrative law must apply to the approval. This meant that the class of place so

approved must be both reasonable and rational but there was nothing to support a contention that the provision to grant approval was itself restrictive. Further, the incremental extensions granted first by the legislation and now by the respondents followed the developments of science and the changes in medical procedure. It could not be said that in the long term place would be restricted at all.

[21] On the petitioner's second proposition that restriction must be based on the relative safety of the approved places, Ms Dunlop submitted that safety cannot be viewed in a vacuum. The context matters and so the question was whether the place approved was safe for what is to be done there. That was something that could and would evolve with science. It did not follow that in a comparison between an approved clinic and a woman's home the latter will be less suitable when all factors were taken into account including the wellbeing of the woman, her privacy and the avoidance of commercial exploitation. On the third proposition that the restriction must be based on features that all places of the class share, it was again important to recognise that the approval was not dealing with abortions *en bloc.* It was dealing only with the pharmaceutical method and so the approval resulted in a woman being able to be in her own home if she wished to take the second part of the pharmaceutical treatment there. It was not accepted by the respondents that there had to be a restriction based on any particular features of the class of place. In any event, the petitioner's fourth proposition that the features required to be based on the place and not the user ignored the threshold for the exercise of the power in section 1(3A). As it comes into play only in non-surgical abortions, there was no difficulty describing the place under reference to its link with the person. It was perfectly understandable that a woman undertaking a personal and intimate procedure would wish to do so in her own home. The tool of identification of "ordinarily resident" is one with which the law is familiar. The petitioner had not explained

what the boundaries of acceptable breadth would be. As the designation of a class is allowed by the legislation the only real question was whether the class was sufficiently identified bearing in mind there was no question of the creation of a right of women to have treatment at home or to insist on treatment at all. Abortion is still only lawful under certain conditions and those require to be met before any treatment may be carried out. Accordingly, it is inherent in the approval of a class of place that there will require to be individual clinical decisions on whether that place should be used. A number of considerations will come in to play in the doctor's decision about whether treatment will in fact take place at home. All that administrative law requires is identification of a class; what happens after that is an individual exercise on whether a particular course of action should be followed.

[22] The respondents disputed the central contention that a pregnant woman's home is not a permissible class. Ms Dunlop submitted that there was nothing inimical to approval of a class of place while at the same time acknowledging that an individual's circumstances would be relevant in deciding whether to use that place. Accordingly, while all places in the class had to be suitable it was sufficient that the restriction was to a woman's home where she wanted to have the treatment there. Accordingly, the petitioner's third and fourth propositions did not explain why the approval was somehow outwith the scope of section 1(3A).

[23] Turning to the case of the *Royal College of Nursing of the United Kingdom* v *Department of Health and Social Security (supra)* on which the petitioner had placed such reliance, Ms Dunlop submitted that Lord Diplock's comments (at page 827) about "all proper skill and in hygienic conditions" should not be treated as if they were a legislative provision. His Lordship was not prescribing criteria to be followed. In any event, if judicial commentaries

were being taken into account, the more recent statements by Lady Hale in *Doogan* v *Greater Glasgow and Clyde Health Board (supra)* should be preferred. On the issue of the parliamentary materials, including in the debates in 1967, these were available as a contextual aid. It can be seen that the debates at the time support the later comments by Lady Hale on the mischief the legislation sought to address by the introduction of a policy. That contextual material reveals where "place" sits in the scheme introduced. When the legislation was passed in 1967, there was no free standing restriction placed on where any part of an abortion could take place nor did the legislation make any statement about hygiene. The restriction was part of the control of activities to bring about the termination of pregnancy by non-NHS providers. That is supported both by the contemporaneous materials and by paragraph 3 of the decision of Supperstone J in the BPAS case. The positioning of section 1(3A) within section 1(3) fitted with a development for new forms of termination being available. The approval under challenge and the thinking behind section 1(3) were accordingly compatible in that section 1(3) was always wider in terms of approving places than concepts of cleanliness and hygiene. Section 1(3) was about both place and provider. Any approval of a place or a class of place would take note of a woman's safety (as opposed to a place's safety) which is a relevant factor in deciding what place or class of place to approve. However, the word "place" could not be elevated into a whole set of criteria for approval. All that is required is that the approval is consistent with the policy of the act and is rational in its choice of place/class of place. For these reasons the approval was not problematic in its choice of a woman's home as a class of place. There were attractions of privacy and comfort in selecting a woman's home as a place. It was somewhere that she could stay while the drug takes effect. Accordingly the requirement of suitability from the perspective of the woman was met.

[24] On the second challenge in relation to treatment, it was accepted that the exoneration in the 1967 Act applies only when termination is by a "registered medical practitioner". In *Doogan* v *Greater Glasgow Health Board (supra)* Lady Hale made the point (at paragraph 29) that in pharmaceutical abortion the event is the administration of drugs and that such an event was not simultaneous with "delivery". For the purpose of section 4 which was under discussion in that case treatment covers the period from the administration of the drugs until the expulsion of the pregnancy. It is because treatment is interpreted widely that there is a corresponding entitlement on the part of staff to refuse to participate at certain stages. It follows that a doctor does not require to be present throughout, something that the petitioner had accepted. It was noteworthy that the petitioner's case related only to the moment of the self-administration of the drug.

[25] While it was accepted that the *Royal College of Nursing* case was the principal authority on the words "treatment by a registered medical practitioner" in the Act, it had to be borne in mind that the dicta in that case was pronounced at a time when the procedure for termination of pregnancy was infusion of prostaglandin. While that does not diminish the authority of the case, the medical context was slightly different. In any event, Ms Dunlop submitted that the decision was not at odds with the approval under challenge in this case. The main elements of the passage from Lord Diplock relied upon (at page 828) were first that Parliament contemplated a team effort in relation to the treatment. While that was accepted, it would be odd, particularly given recent ideas of a partnership between the doctor and the patient to conclude that the woman is somehow excluded from the team. Obvious difficulties would arise if staff had to administer a tablet in every case. Secondly, the case provided authority that a doctor should accept responsibility for all stages of the treatment for termination of pregnancy. However, it was accepted that he or she need not

be present throughout, then all that was required was that a doctor or his substitute should be able to be called on for assistance. If the woman was in a hospital, a clinic or a GP surgery and took the tablet that would be treatment and could not be presumed that the doctor would be the one immediately called upon to assist. In so far as the petitioner seemed to suggest that the doctor should be in the premises where the second stage of a pharmaceutical termination was being carried out, the RCN case was not authority for that. So long as the doctor could be called upon for assistance, that could be on the end of a phone. In any event there was no sharp dividing line. In many cases a doctor might be in the same building as a woman was having a termination but only available by phone. It was the issue of control that mattered. Further, in the guidelines issued by the respondents which do not form part of the approval but are of assistance to medical practitioners, there are listed certain contra-indications for prescribing misoprostol to be taken at home. For example if the woman had had a previous allergic reaction to misoprostol and that was known to the doctor the decision not to prescribe it again had to be categorised as treatment by that doctor. Finally, the statements by Lord Keith and Lord Roskill in relation to treatment could all be appropriately related to pharmaceutical abortion. Treatment has a wide reach but that width could not be used to frustrate the adoption of less invasive methods of termination.

[26] Reference was also made to the first instance decision of Woolf J in the *Royal College of Nursing* case (*supra)* at page 553, where Woolf J anticipated that termination of pregnancy by a patient taking a pill might come about. He made clear that the doctor would still be regarded as treating the patient even if someone handed the pill to her. Translating that to the current approval, where in all cases the first part of the treatment will still be at the clinic, it remains the case that the patient is being treated by a medical practitioner even

where she takes the second dosage required at home. It would be surprising if the woman could not in that circumstance be regarded as a member of the "team". Of course she could decide not to take the second stage of treatment but she might also refuse to do so in a hospital. While the motivation of a nurse might be different from the motivation of a woman who takes the pill herself, this did not take the situation out of the realm of treatment by a doctor. In the *British Pregnancy Advisory* case (*supra*), Supperstone J had looked at the Oxford English Dictionary definition of treatment in the medical context as being "management in the application of remedies; medical or surgical application or service".

[27] Finally, Ms Dunlop returned to the issue of safety. It was noteworthy that neither party in these proceedings had set forth any averments as to the safety or otherwise of medical abortions completed at home. Whether something was safe clearly involved matters of fact. There was material available which, if safety is an issue, that matter could be determined following examination of the pertinent facts at a second hearing. However, Ms Ross confirmed in response that she considered there was no need for any factual enquiry. She was content to rest on an acceptance by the respondents that there could be some women's homes that would be unsuitable for treatment which had been accepted. Accordingly there was no need for evidence about general safety.

Discussion

[28] It may be useful to start with the chronology of events leading to the approval under challenge. When the Abortion Act 1967 was passed nearly all abortions were performed by surgical methods. As Ms Dunlop set out in her submissions, the mischief that the Act was designed to remedy was the danger to which women who undertook illegal abortions prior

to the coming into force of the legislation were exposed. In the 1970s medical induction was introduced as a method of termination of pregnancy. This involved infusion of prostaglandin into the womb such that the foetus is then expelled. The use of medical induction to terminate pregnancy was the type under discussion in the case of *Royal College of Nursing* v *Department of Health and Social Security* [1981] AC 800. The context of the decision in that case was that there were two distinct stages in the process of termination of pregnancy by medical induction. The first stage was carried out physically by a doctor who administered a general anaesthetic to a woman. The second stage was carried out by nurses who administered the prostaglandin fluid. All of the pertinent passages in that case require to be understood against that background, an issue to which I will return. The next development, chronologically, was the introduction of a method of terminating early pregnancy by a combination of drugs rather than surgery or medical induction. This process became known as "early medical abortion" (EMA) and might also be termed "pharmaceutical termination of pregnancy". The drug mifepristone was licensed for use in Great Britain in 1991, more or less simultaneously with the coming into force on 1 August 1991 of the Human Fertilisation and Embryology Act 1990 which amended the Abortion Act 1967 by the insertion of section 1(3A) to permit the approval of a class of place for medical termination. From that time, pregnant women seeking an early termination or EMA have attended a clinic or similar place where medicines have been administered to achieve that result. These proceedings have arisen, as already indicated, because of a development on 26 October 2017 when the Chief Medical Officer for Scotland intimated to doctors in this jurisdiction that the respondents had granted approval for the second stage of early medical abortion treatment to be undertaken in a patient's home. That practice is referred to as early

medical abortion at home (EMAH) and is intended to be used only during the first 9 weeks of pregnancy.

[29] The power of the Executive to approve a place for the termination of pregnancy in terms of section 1(3) has been in place since the enactment of the original legislation in 1967, the various amendments to the wording of that sub-section having no bearing on the issue for discussion in this case. The respondents, the Scottish Ministers, are the Executive for the purpose of section 1(3) and (3A) and have been since the coming into force of the Scotland Act 1998. For the avoidance of doubt, while the Scotland Act 2016, section 53, removes abortion from the list of specific matters reserved to the Westminster Parliament, this case is not concerned with that transfer of primary legislative power on the subject of abortion to the Scottish Parliament. The decision under challenge is an administrative act of the Scottish Ministers in terms of section 1(3A) of the 1967 Act, namely the exercise of a power conferred upon them to "approve a class of places" for the termination of pregnancy where the treatment of that consists primarily in the use of medicines. I proceed on the basis that no issue is taken with the administration of mifepristone followed up to 24 hours later by misoprostol as a safe method to terminate pregnancy. The challenge is only to the alteration of the classes of place in which a treatment can be carried out so that it includes a woman's home and not to any claim that the method itself is unsafe. That is inevitably so, as pharmaceutical abortion has been taking place in terms of the legislation for many years. While the current petition is restricted only to the decision to approve a woman's home as a class of place for the purpose of medical termination, the issues of social policy that termination of pregnancy involves continue to be both complex and controversial. This opinion cannot be regarded as contributing in any sense to that social policy discussion.

[30] Turning then to the approval itself, reproduced at paragraph [3] of this opinion, paragraph 4 thereof makes clear that the only circumstances in which a woman's home is approved as a class of place are where she has already attended a clinic where she has been prescribed mifepristone, that she has taken that mifepristone at the clinic and wants to carry out the stage of taking misoprostol at home. The effect of paragraphs 3 and 4 of the approval read together is, in my view, that a woman's home is approved as a class of place only where the following conditions are met; first that she is ordinarily resident at the home in question, secondly that she wants to carry out the stage of the treatment that involves the taking of misoprostol at that ordinary residence, thirdly that she does so having been prescribed both mifepristone and misoprostol at a clinic and fourthly that she has taken the mifepristone at that clinic. The petitioner makes a number of arguments in support of a conclusion that a pregnant woman's home is not a permissible class and so cannot be lawfully approved in terms of section 1(3A) of the 1967 Act.

[31] The theme running through the petitioner's various propositions is that the home where a woman is ordinarily resident and where she wants to take the second part of the treatment is too broad and unrestricted to be properly approved as a class of place. The first form of restriction said to be essential is as to location. It is contended that as all homes are potentially a class of place this is not a proper restriction at all. This first point is in my view misconceived. There can be no doubt that there must be a rational basis for the class of place being approved and that approval of "all places in Scotland" might be challengeable as devoid of a rational basis. However, the restriction on location in the approval under challenge is one of substance. That it is a very real restriction is easily illustrated by considering the case of a woman who may wish to go to the home of a relative who is providing her with emotional support in order to take the misoprostol that is required for

the second part of the treatment. She would not be permitted to do so by the terms of the approval as it currently stands. That may be regarded by some as unduly restrictive in terms of location but that is what the approval states. It is easy to understand the basis for this significant restriction. The pregnant woman is being treated by a medical practitioner who will require details of, amongst other things, her ordinary residence. If the medical practitioner is to have ongoing responsibility for the woman's treatment while she is at home, as he or she must, there is at least a rational basis for identifying the place of ordinary residence as a clearly defined restriction. Whether there are other restrictions, broader or narrower, that would have been more appropriate, or equally appropriate, does not matter for the purposes of this first question. It seems to me that there is little doubt that the restriction of the class of place to a woman's ordinary residence (in circumstances where she wants to take the misoprostol there) represents a real and substantive restriction on location.

[32] The other main challenge to the breadth of the class of place identified in the approval is that the identity of a class of place must, it is said, be based on the relative safety of the class approved. The example given was that of the approval of all premises with odd street numbers which would by definition significantly restrict where abortions could take place but would be unconnected with the aims of section 1 of the 1967 Act. It seems to me that restricting a class of place to homes with odd numbers would be so irrational that it could be challenged on that basis alone. The more important issue is what relationship is required as between the aims of the legislation and the approval of a class of place. This involved considerable discussion at the hearing in relation to the issue of safety. The petitioner's contention is essentially that an approval purporting to introduce an alternative venue to a clinic or hospital for the termination of pregnancy can only be lawful if all places in the class meet the requirements of safety and hygiene. The objection is to the respondents

delegating to or relying on the judgement of doctors in relation to whether a specific place is suitable. Unless it could be said that all women's homes are safe they do not all share the necessary features. The respondents on the other hand characterise the requirement as suitability rather than safety, with safety being effectively a subset of that overall requirement. I am of the view that it is important to distinguish in this part of the discussion between a class of place that is capable of being suitable for the limited purpose stated in the approval from a requirement that, as a matter of fact every place in the category is safe in a general sense. That distinction is the logical consequence of extending the requirement to approve specified places to specifying the class or type of place at which the second stage of certain medical terminations can be performed. Of course any class of place selected requires to be one that is suitable for the performance of the act in question. The issue is whether the fact that there could be homes that are not suitable is a sufficient basis to render unlawful the approval under challenge.

[33] There are good reasons for considering that a woman's home, in circumstances where she wants that to be the place for the second stage of the pharmaceutical termination of her pregnancy, will be *prima facie* suitable for that purpose. Approving a category of places as suitable for the second stage of an EMA does not and cannot override clinical decisions as to whether a woman will in fact take misoprostol at home. That is because the approval itself does not determine that the second stage of an EMA will take place at home, it simply makes that possible on certain conditions as outlined earlier [para 30]. That a pregnant woman with full capacity will know whether or not her home is a place in which she will feel comfortable and secure self-administering misoprostol can be readily inferred. It follows that fulfilment of the second requirement, that she must want to take the misoprostol there, will normally coincide with her ordinary residence being a suitable place

in which to do so. The petitioner's arguments tended, in my view, to ignore or at least underplay that the woman's wish to take the misoprostol at home is an important restriction contained within the approval. Where the medical practitioner, in discussion with the pregnant woman, raises a concern about the suitability of the woman taking misoprostol at home, perhaps due to contra-indicators known from her medical history, one can anticipate that the result may be that the doctor will not prescribe the misoprostol to be taken at home. That may raise an issue or disagreement between doctor and patient but it does not impact on the legitimacy of approving the woman's home as a class of place. In my opinion, properly understood, the approval does not delegate to the medical profession the decision on suitability of the home as a class of place. While I accept that some sort of nexus between the purpose of the treatment enabled by the primary legislation and the basis of identifying a class of place is required, it is not necessary that the respondents be satisfied that every woman's home (where she wishes to take medication there) is safe and hygienic in the way that a hospital or clinic is expected to be. The class of place need only be suitable for the specific purpose permitted. Many patients self-administer medication for relatively serious conditions at home without the need for any assessment of the levels of hygiene in their property. Of course the difference is that, unlike the self-administration of powerful controlled drugs, where the legislature does not restrict the location in which they can be taken, for termination of pregnancy the primary legislation does continue to require identification of where that will be carried out. However, there is nothing in the legislation that restricts the classes of place that can be approved to those in a similar category to hospitals or clinics. The power to approve a class of place is given without limitation as to specific features, subject always to the respondents requiring to meet the administrative law tenets of reasonableness and rationality.

[34] Counsel at the hearing before me agreed that the issue for determination was one of statutory construction. It is often necessary to interpret or construe an Act of Parliament in the light of developing medical knowledge or practice. The case of *Royal College of Nursing* v *Department of Health and Social Security (supra)* provides a good example of that. It seems to me that construction of the expression "class of place" in section 1(3A) must be carried out against the chronological background, which includes the development of pharmaceutical termination of pregnancy. The petitioner in this case challenges the lawfulness of the approval only in relation to the stage of self-administration of the drug misoprostol and not the period thereafter when it is accepted the woman might be at home. Accordingly, in order to challenge the woman's home as a class of place that can be approved by the respondents, it would be necessary to explain or offer to prove why an outpatient clinic or GP's premises would necessarily be a safer place to take a tablet or pessary as the second stage of a pregnancy termination treatment than the woman's home, bearing in mind that, absent the approval, a woman would still be able to leave the clinic immediately after the misoprostol was administered. This is not something that has been done in this case.

[35] In relation to the respondents' reliance in submissions on the decision of Supperstone J in *British Pregnancy Advisory Service* v *Secretary of State for Health* [2012] 1WLR 580, that was a case involving a challenge to whether the administration of abortifacients where the second stage was taken at home constituted "treatment" under the legislation. Accordingly, although the case involved similar subject matter to the present case in that BPAS wanted the court to approve early medical abortion at home, it sought to do so in a vacuum and without any approval as to class of place having been granted by the Secretary of State. The *ratio* of the decision is that the use or administration of abortifacient drugs such as mifepristone and misoprostol constitutes treatment in terms of the legislation. The court

could not grant the declaration sought by the claimant in the absence of such approval. There is nothing in that decision which assists the question of whether the approval under challenge in this case is lawful or not. The remark by Supperstone J (at paragraph 32) that the home was "potentially" a place where medical termination could take place impliedly acknowledges that any proposed approval could be subject to a challenge. There was no argument about what the Executive could or could not identify as a class of place in that case.

[36] During the course of argument Ms Ross referred to "Guidelines" issued by the Scottish Abortion Care Providers (SACP) Network which were sent to medical practitioners with the approval under challenge. At their highest, these guidelines provide advice on the matters that practitioners should take into account if utilising the approval so that a patient is prescribed misoprostol to be taken at home as part of the treatment process. They are not part of the approval and so they are not part of the decision under challenge. Ms Dunlop did not suggest that the letter, approval and guidance should be read together; she sought only to defend the lawfulness of the approval itself. Accordingly, while the guidance suggests that the second stage of treatment should not take place at home if there is no adult (other than the pregnant woman) available there, that is in no sense a condition attaching to the approval. Thus the absence of another adult at home has no bearing on the permissibility or otherwise of the home as a "class of place" for the purpose of section 1(3A). What the Guidelines do set out are examples of the factors that may affect the clinical decision making process in relation to a particular patient. There are list of "absolute contra-indications" (e.g. uncontrolled severe asthma) and also a note of circumstances in which caution is required (e.g. severe anaemia) before any decision on this form of treatment is undertaken. That is useful to the extent that it illustrates the nature of the decision that is within the province of

clinical decision making, namely whether receiving part of the treatment at home is appropriate on health grounds for a particular patient. There is no delegation of the safety and so suitability of the class of place (the home) to the medical practitioner as that has already been determined by the approval. If the patient informed her doctor that there was to be no adult at home during the time she would be taking the misoprostol, it would be for the medical practitioner to decide whether or not the guidance could be departed from in that respect, but any consequences of not doing so would have no impact on the approval. It does seem to me to be unsatisfactory that the guidance as currently framed appears to convey to doctors that there is something tantamount to a requirement that there be an adult at home with the woman when that is not in any sense a condition of the approval, although as the terms of the guidance are not part of the decision challenged its terms have ultimately had no impact on my decision in this case.

[37] For all of the reasons given I reject the proposition that a woman's home where she wishes to take the second stage of an EMA cannot be a permissible "class of place" in terms of section 1(3A) of the 1967 Act.

[38] I turn to the second main challenge made by the petitioner, namely that the requirement in the primary legislation that treatment be carried out by a registered medical practitioner cannot be satisfied if the second stage of an EMA is self-administered at home and that this renders the approval unlawful. In *Royal College of Nursing* v *Department of Health and Social Security (supra)*, the House of Lords adopted a purposive interpretation of the word "treatment" in this context. The conclusion of the majority was to reject a literal interpretation that would require all acts inducing termination of pregnancy to be performed by the doctor himself. As Lord Diplock put it, the treatment (in a hospital) would be undertaken as a "team effort" and delegating to those such as nurses to assist with

part of the treatment did not offend the requirement of section 1(1). The central part of Lord Diplock's reasoning is contained in the following passage:

> "What limitation on this exoneration is imposed by the qualifying phrase: "when a pregnancy is terminated by a registered medical practitioner"? In my opinion in the context of the Act, what it requires is that a registered medical practitioner, whom I will refer to as a doctor, should accept responsibility for all stages of the treatment for the termination of the pregnancy. The particular method to be used should be decided by the doctor in charge of the treatment for termination of the pregnancy, he should carry out any physical acts, forming part of the treatment, that in accordance with accepted medical practice are done only by qualified medical practitioners, and should give specific instructions as to the carrying out of such parts of the treatment as in accordance with accepted medical practice are carried out by nurses or other members of the hospital staff without medical qualifications. To each of them, the doctor, or his substitute, should be available to be consulted or called on for assistance from beginning to end of the treatment. In other words, the doctor need not do everything with his own hands; the requirements of the subsection are satisfied when the treatment for termination of a pregnancy is one prescribed by a registered medical practitioner carried out in accordance with his directions and of which a registered medical practitioner remains in charge throughout."

[39] I have recorded the various arguments for and against that *dictum* being more or less determinative of the issue in these proceedings. The *Royal College of Nursing* case has been cited with approval in subsequent decisions, including by the UK Supreme Court in *Doogan* v *Greater Glasgow Health Board* [2015] SC (UKSC) 32. There, Lady Hale (at paragraph 9), having cited the passage from the Court of Appeal stage where Denning MR had referred to the argument as being about whether a doctor could initiate the process and then go and do other things so long as he was "on call", referred to the decision of the House of Lords that the treatment was a team effort with doctors, nurses and others participating. What is important, from all of that, in my view, is that the authorities support that the whole process designed to bring about termination of pregnancy constitutes "treatment" for the purpose of section 1. That is why the case brought by the *British Pregnancy Advisory Service* (*supra)* was doomed to fail. Prescribing and administering drugs with the intention of terminating a pregnancy is included within the ambit of treatment. Where those drugs are administered

at a hospital or clinic, whether by a nurse or some other person assisting the doctor, the petitioner accepts that the requirements of section 1, as set out by the House of Lords, are met. Where, however, the woman is sent home to self-administer the second stage drug questions arise as to whether the medical practitioner still has responsibility for all stages of the treatment and whether the pregnant woman can somehow be regarded as part of the "team" referred to by Lord Diplock. The petitioner contends that the woman would not then be under the control of the practitioner in the way envisaged by the House of Lords.

[40] As a generality, it seems to me that patients who self-administer medication at home may still be described as being treated by their medical practitioner who remains in charge of that treatment. To take but one example, insulin dependent diabetics may require to self-administer the insulin prescribed to them regularly at home, but they do so under the direction of their doctor and would ordinarily be described as receiving treatment from that doctor regardless of a lack of physical presence by the practitioner in the same building or even in the locality. Again, however, termination of pregnancy is not general treatment and has been separated out for very specific legislative control. It is clear from the *Royal College of Nursing* case that was it was acknowledged that the nurse would carry out the action leading directly to termination of the pregnancy by inserting the device and infusing the prostaglandin. Even under a hospital procedure, then, the action that precipitates the expulsion of the foetus need not be performed personally by a medical practitioner. Similarly, with pharmaceutical termination, regardless of place, there is no need for a doctor to hand the medication to the woman personally. The doctor's role is to assess the suitability of the woman for treatment, to ensure that the other conditions of section 1(1) are met, to consider any clinical contra-indications for the particular woman and then, if appropriate, to prescribe mifepristone and misoprostol. Where the woman is handed both

the mifepristone and the misoprostol for self-administration at the clinic, no issue arises because the petitioner would accept that the doctor continues to be in charge or in control of the treatment. The situation that has arisen in this present case was anticipated to some extent by Woolf J (as he then was) at the first instance stage of *Royal College of Nursing* v *DHSS [1981] 1 All ER 545*. There the reconciliation between section 1 of the 1967 Act and taking of medication to terminate pregnancy was specifically addressed in the following way:

> "No doubt the time is not far ahead when a pregnancy can be terminated merely by the patient taking a pill. If in such circumstances the doctor, having examined the patient, decides that it is a case where in accordance with s1 the pregnancy should be terminated, and he complies with the other conditions of s1, then the fact that the pill may be handed to the patient by a nurse rather than the doctor so that the patient can take the pill will not mean that the treatment is not that of the doctor. If such a patient was asked who was treating her she would say the doctor, and the nurse would be assisting the doctor in the treatment. So in the case of the procedure laid down by the department, this makes clear that the registered medical practitioner must decide on the termination; the process must be initiated by him and he must remain throughout responsible for its overall conduct and control in the sense that any actions needed to bring it to a conclusion are done by appropriately skilled staff acting on his specific instructions, but not necessarily in his presence, though he or another registered medical practitioner must be available to be called if required. I can see no reason of interpreting the provision of s1 (1) of the 1967 Act so narrowly that if anyone other than the registered medical practitioner participates in the treatment the defence is not available."

The prediction contemplated in that passage came to fruition some years ago. In the general scenario postulated by Woolf J, a nurse would hand a pill to a woman and the woman takes it. Thus, "self-administration" is restricted to the ingesting of a tablet (or a pessary) prescribed by a doctor and handed to the woman at the clinic by a member of staff. It seems to me that the extension of the place at which that self-administration can be carried out, from a clinic to home, does not offend the requirement that treatment be carried out by a registered medical practitioner any more than when the medication is given to the woman at a clinic. In this respect I would align myself with the approach taken by Supperstone J in the

British Pregnancy Advisory Service case (supra) where, at para 23, he reminded himself that the Oxford English Dictionary definition of treatment in the medical context included **management** in the application of remedies. If the doctor is the manager of the team providing the treatment then he or she need not be present in the same place as those performing the activities over which he or she has overall control. The nature of that control has necessarily evolved as the treatment for the termination of pregnancy has developed. The "team" referred to by Lord Diplock still exists, but the pregnant woman herself requires to be an active participant in it, otherwise the termination will not take place. That characterisation is not affected by the locus at which the second stage administration of misoprostol takes place.

[41] The words of Lord Diplock in the *Royal College of Nursing* case are not inapposite to the situation envisaged by respondents' approval, but they must be read in the context that there was no question at that time of abortions being performed other than in a hospital setting. I accept that the passages from that decision, while authoritative, cannot be construed as if they were primary legislation. It would be as wrong today to adopt a literal interpretation of the 1967 Act that produced an absurd result as it would have been in 1980 when *Royal College of Nursing* was decided. Accordingly, there is in my view no difficulty in construing the words of section 1(1) of the Act that require treatment "by a registered medical practitioner" as permitting the second stage of pharmaceutical termination to take place in the pregnant woman's home (where she so wants) with self-administration of misoprostol. The parts of the treatment that require the positive actions and presence of a medical practitioner will continue to take place at a clinic with limited delegation to other staff and then to the woman herself, for certain aspects of it. The woman is an active participant who has the ability to refuse to continue with treatment at any stage, whether at

a clinic, GP surgery or at home. The relationship between the requirement that home be the woman's ordinary residence where she wants to take the misoprostol and the role of the medical practitioner is important in this context. The requirement that the medical practitioner be in charge or in control throughout the treatment is met by there being knowledge of where the woman will be when she takes the misoprostol coupled with the ability to make contact with the medical practitioner, should that be required.

[42] While there was some criticism on behalf of the petitioner about what was described as a "virtual presence" contemplated by the respondents, I do not consider that advice and/or management in such a situation is any less valid if performed by telephone or even electronic communication as opposed to in person. Standing the concession that physical presence is not required, it matters not whether the doctor performs his or her responsibilities from within the building where the woman is present or from some other location. This is particularly so because the petitioner acknowledges that the challenge is limited to the point of self-administration of the drug misoprostol and not for the period afterwards. While there is a window of 24 hours between the mifepristone administered at the clinic and the misoprostol taken at home, it cannot be assumed that the medical practitioner will be less available at times when the woman chooses to take the misoprostol at home than he or she would be if it was administered in a clinical setting. That is the sort of issue that can properly be left to a discussion between patient and doctor. For these reasons, I consider that the second challenge to the approval also fails in respect that the treatment anticipated by the approval continues to be treatment by a medical practitioner in terms of section 1(1) of the 1967 Act.

Disposal

[43] I have concluded that the decision of the respondents to approve a woman's home as a place where one stage of the termination of pregnancy can be carried out is not unlawful on either of the grounds contended for by the petitioner. Accordingly, I will repel the petitioner's pleas-in-law, sustain the respondents' second and third pleas-in-law and refuse the petition, reserving meantime all questions of expenses.