Neutral Citation Number: [2011] EWHC 235 (Admin)

Case No: CO/4028/2010

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT
IN THE MATTER OF THE ABORTION ACT 1967

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14 February 2011

Before :

THE HONOURABLE MR JUSTICE SUPPERSTONE

- -

Between :

BRITISH PREGNANCY ADVISORY SERVICE	**Claimant**
- and -	
SECRETARY OF STATE FOR HEALTH	**Defendant**

- -
- -

NATHALIE LIEVEN QC and RICHARD TURNEY
(instructed by **Messrs Reynolds Porter Chamberlain LLP**) for the **Claimants**
JAMES EADIE QC and ELEANOR GREY
(instructed by **Department of Health**) for the **Defendants**

GEMMA WHITE (instructed by **Messrs Child & Child**)
for the Interveners, the Society for the Protection of Unborn Children

Hearing dates: 28 January and 4 February 2011

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HON. MR JUSTICE SUPPERSTONE

Mr Justice Supperstone :

Introduction

1. In these proceedings the British Pregnancy Advisory Service, the Claimant, seeks a declaration that:

> "…For the purposes of section 1 of the Abortion Act 1967, a pregnancy is 'terminated by a registered medical practitioner' where the registered medical practitioner prescribes an abortifacient drug with the intention of terminating a pregnancy and the administration of that drug to the pregnant woman is not 'any treatment for the termination of pregnancy'."

2. Abortion remains a controversial subject in respect of which there are differing deeply-held views. It is important to appreciate that the present claim is made under Part 8 of the Civil Procedure Rules 1998 because the Claimant seeks the court's decision on a question which does not involve a substantial dispute of fact, rather it involves statutory construction and a question of law.

3. The purpose of the Claimant's application is to establish that it would be lawful, under the Abortion Act 1967, to pilot and if successful adopt, subject to regulation, a process of providing "early medical abortion" ("EMA") whereby part of the treatment is self-administered by the woman at home.

The legislative framework

4. The Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990 ("the 1990 Act"), in particular by the addition of section 1(3A), reads, so far as is material, as follows:

> "**1. Medical Termination of Pregnancy**
>
> (1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion where a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith—
>
> (a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or
>
> (b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
>
> (c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or

(d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

(2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) or (b) of sub-section (1) of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

(3) Except as provided by sub-section (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 Primary Care Trust or 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 sub-section (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.

(4) Sub-section (3) of this section, and so much of sub-section (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

…

4. Conscientious objection to participation in treatment

(1) Subject to sub-section (2) of this section, no person shall be under any duty whether by contract or by any statutory or other legal requirement to participate in any treatment authorised by this Act to which he has a conscientious objection:

Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

(2) Nothing in sub-section (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

> **5. Supplementary provisions**
>
> (1) No offence under the Infant Life (Preservation) Act 1929 shall be committed by a registered medical practitioner who terminates a pregnancy in accordance with the provisions of this Act.
>
> (2) For the purposes of the law relating to abortion, anything done with intent to procure a woman's miscarriage (or, in the case of a woman carrying more than one foetus, her miscarriage of any foetus) is unlawfully done unless authorised by section 1 of this Act and, in the case of a woman carrying more than one foetus, anything done with intent to procure her miscarriage of any foetus is authorised by that section if—
>
> (a) the ground for termination of the pregnancy specified in subsection (1)(d) of that section applies in relation to any foetus and the thing is done for the purposes of procuring the miscarriage of that foetus, or
>
> (b) any of the other grounds for termination of the pregnancy specified in that section applies.
>
> **6. Interpretation**
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> In this Act, the following expressions have meanings hereby assigned to them:-
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> 'The law relating to abortion' means sections 58 and 59 of the Offences Against the Person Act 1861, and any rule of law relating to the procurement of abortion."

The regulatory framework

5. The Abortion Act 1967 as amended ("the Act") provides that any treatment for the termination of pregnancy (whether surgical or medical) must be carried out in a hospital vested in the Secretary of State, an NHS Trust, Primary Care Trust (PCT) or Foundation Trust, or in a place approved for the purpose by the Secretary of State: section 1(3). The Secretary of State for Health is therefore responsible for approving independent sector service providers for the purpose of treatment for the termination of pregnancy. Independent sector providers, after having registered with the Care Quality Commission (CQC) and on receipt of approval from the Secretary of State for Health, can carry out abortions up to 24 weeks' gestation.

6. In England both NHS and independent sector healthcare providers are subject to the regulatory oversight of the CQC which was established by the Health and Social Care Act 2008 ("HSCA 2008"). The termination of pregnancy is prescribed as a "regulated activity" under section 8 of HSCA 2008. Under section 20 of HSCA 2008, the Secretary of State may issue regulations in relation to regulated activities. The Care Quality Commission (Registration) Regulations 2009 ("the 2009 Regulations") and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 ("the

2010 Regulations") have been made. Registered healthcare providers within the independent sector which undertake terminations of pregnancy are subject to regulation 20 of the 2009 Regulations. This sets out general provisions relating to the appropriate management of abortions. It does not specifically cover the issue of what techniques may be used to procure an abortion, or the subject of early medical abortion. There are no Regulations specifically governing the abortion practices of English NHS bodies, although both the NHS and the independent sector are subject to the general obligations set out in the 2010 Regulations, and the Abortion Regulations 1991 impose requirements on all practitioners carrying out terminations, as to the information which must be recorded by the practitioner.

7. Under section 35 of HSCA 2008, Regulations may provide that a contravention of or a failure to comply with any specified provision of the Regulations is an offence. Under Regulation 27 of the 2010 Regulations, a failure to comply with any of the provisions of Regulations 9 to 24 is an offence, triable summarily only. The CQC must have issued a warning notice, setting out a time for compliance, and that time must have expired, before it may prosecute. A fine of up to £50,000 may be levied: HSCA 2008, s.162(3)(b). An offence under the 2009 Regulations is triable summarily only. The penalty is a fine of up to Level 4 (currently £2,500): see Regulation 25. Breaches of Regulations made under section 20 may not be punishable by imprisonment or triable on indictment: HSCA 2008, s.35.

8. Other regulatory tools include the use of guidance issued by the CQC under section 23 of HSCA 2008 and the use of conditions of registration by the CQC: see s.12(3). Breaches of conditions are offences, triable summarily and subject to a maximum fine of £50,000: HSCA 2008, s.33. Before issuing guidance or making changes of substance, the CQC must consult stakeholders: HSCA 2008, s.24(2).

Factual background

9. When the Act was passed in 1967, the normal method of abortion then in use was surgical abortion. The term "early medical abortion" (EMA) is used to describe the termination of pregnancy of up to nine weeks, by means of a combination of drugs rather than surgery. With the licensing of the drug mifepristone in Great Britain in 1991, medical abortion became an alternative to surgical abortion.

10. Ms Furedi, the Claimant's Chief Executive, at paragraphs 7-8 of her first witness statement dated 22 March 2010 and Ms Duncan at paragraphs 17-19 of her first witness statement, on behalf of the Defendant, dated 4 June 2010, describe the current process for EMA. A woman visits a hospital or clinic for consultation and counselling, if required, and an examination to ensure that she is legally eligible and clinically suitable for abortion. If she is sure of her decision to have an abortion, then after consultation and when two doctors sign the statutory certificate HSA1, an oral dose of mifepristone 200mg is taken. That is stage one of the EMA. Following a short wait to ensure that the drug has absorbed properly women leave the hospital or clinic. Ms Duncan describes the second stage of the EMA which involves attendance at the hospital or clinic, up to 48 hours later, when a drug called misoprostol 800mcg is administered, either orally or vaginally. (The Claimant's evidence is this occurs up to 72 hours later, but the difference in time is not material). NHS practice tends to be for the woman concerned to remain in the hospital following the administration of misoprostol for 3-6 hours or until the expulsion of the pregnancy, whichever is the

sooner. There is evidence that some NHS providers allow women to go home after the administration of misoprostol. Some independent sector providers, including the Claimant, permit women to leave the clinic immediately following the administration of the drug, with instructions on what is likely to happen and advice on self-care. The extent of the practice of allowing women to go home after the administration of misoprostol before termination is complete is in dispute (see second witness statement of Ms Duncan dated 8 December 2010 at para 9); however this is not a material issue for the purposes of determining this claim. A follow up visit is advised 7-14 days later in order to ensure that the abortion is complete and there are no complications.

11. It is the Claimant's view that the present arrangements are "sub-optimal" in terms of meeting the needs of women undergoing EMA. Ms Furedi explains at paragraphs 9-13 of her first witness statement the problems for women with the current system. First, it is potentially time-consuming and cumbersome in that each visit may involve rearranging work and childcare commitments, and the expense of travel, all of which can cause very real problems. Second, it puts women in the position where they may be very worried about whether the miscarriage will commence on the way home. It is acknowledged that one solution to this problem would be to require all women to remain at the clinic until the abortion is complete and that this is a requirement in some NHS facilities. However it is said most women would not find this solution acceptable.

12. The Secretary of State accepts that a number of other countries permit the administration of the second stage drug, misoprostol, to take place in places other than the equivalent of "hospitals or places approved by the Secretary of State", for example at home. The experience of such countries has been that the process is, broadly speaking, safe, effective and acceptable to the women who elect to adopt this procedure. However the Secretary of State would not wish to introduce a new practice simply because it is deemed safe elsewhere in the world without fully piloting, evaluating the system and developing the appropriate protocols and standards to ensure that it is safe and acceptable for women in Great Britain.

Submissions

13. The critical issue in this case is the meaning of the words "any treatment for the termination of pregnancy" in section 1(3) of the Act. Ms Nathalie Lieven QC, for the Claimant, submits that a primary concern of Parliament in passing the 1967 Act was to ensure that abortions were carried out safely and in proper conditions. At that time when Parliament was considering the meaning of both "termination" and "treatment" abortion was considered an invasive form of medical/surgical intervention with potentially serious possible complications. The concerns about the safety of women undergoing abortions could, in 1967, only be met by ensuring that the abortion process was undertaken in a hospital or another medical facility, such as a nursing home. Although early medical abortion was available in France when the 1990 Act was passed there was no contemplation that women could safely undergo the treatment, or even part of the treatment, at home. The position of medical science and the process for early medical abortion is now entirely different. The Claimant wishes to achieve the position whereby women can be prescribed misoprostol at the same time as being given mifepristone. They can then take the misoprostol home and self-administer there, in the comfort and support of their own home.

14. Ms Lieven accepts that in 1967 Parliament would have envisaged that the "treatment" in question was the entire process of termination and that would have taken place in its entirety in a hospital or an approved place. However the "treatment" now undertaken is totally different from that envisaged in 1967. Parliament could not have had in mind the present medical position in 1967. The court should apply an "updating construction" to ensure that the Act has kept up with medical science. Ms Lieven submits that because of the medical and scientific progress that has been made since 1967, the treatment is able to end with the prescription of the abortifacient drug for self-administration.

15. Ms Lieven prays in aid two principles of statutory construction. First, the court should seek to construe a statute to meet the purpose or mischief for which it was enacted. This was considered by the House of Lords in *RCN v Department of Health and Social Security* [1981] AC 801. Lord Diplock at 827D said:

> "…The policy of the Act, it seems to me is clear. There are two aspects to it: the first is to broaden the grounds upon which abortions may be lawfully obtained: the second is to ensure that the abortion is carried out with all proper skill and in hygienic conditions."

Ms Lieven submits that the safety of the abortion is unaffected by whether the relevant medication, namely misoprostol, is taken in an approved place or at home. The mischief of the Act is therefore met by defining the treatment as the prescription of the medication rather than the administration.

16. The second principle of statutory construction, on which Ms Lieven relies, is that it is to be presumed that Parliament intends the court to apply to an ongoing Act a construction that continuously updates its wording to allow for changes since the Act was framed. *Bennion on Statutory Interpretation* (5th Ed, 2008) at p.893 states:

> "In construing an onging Act, the interpreter is to presume that Parliament intended the Act to be applied at any future time in such a way as to give effect to the true original intention. Accordingly the interpreter is to make allowances for the relevant changes that have occurred, since the Act's passing."

In support of her submission that the court can take into account changes in medical science and practice since 1967 in deciding what is meant by "treatment" in the Act Ms Lieven referred to the decision of the House of Lords in *R (Quintavalle) v Secretary of State for Health* [2003] 2 AC 687. That case concerned the scope of the regulatory regime in the 1990 Act and, in particular, how it should be applied to embryos created by cell nuclear replacement. Lord Steyn said as follows:

> "[23] How is it to be determined whether a statute is an always speaking statute or one tied to the circumstances existing when it was passed? In *R v Burstow* [1998] AC 147, 158, the House of Lords held:
>
> 'In cases where the problem arises it is a matter of interpretation whether a court must search for the historical

> or original meaning of a statute or whether it is free to apply the current meaning of the statute to present day conditions. Statutes dealing with a particular grievance or problem may sometimes require to be historically interpreted. But the drafting technique of Lord Thring and his successors have brought about the situation that statutes will generally be found to be of the 'always speaking' variety: see *Royal College of Nursing of the United Kingdom v Department of Health and Social Security* [1981] AC 800 for an example of an 'always speaking' construction in the House of Lords.'
>
> In response to a specific question counsel for the Appellant did not contend that the 1990 Act falls in the exceptional category. Given its subject matter he was right not to do so. The result is that the 1990 Act may be construed in the light of contemporary scientific knowledge.
>
> …
>
> [25] In such a case involving the application of a statute to new technology it is plainly not necessary to ask whether the express statutory language is ambiguous … in order to give effect to a plain parliamentary purpose a statute may sometimes be held to cover a scientific development not known when the statute was passed. Given that Parliament legislates on the assumption that statutes may be in place for many years, and that Parliament wishes to pass effective legislation, this is a benign principle designed to achieve the wishes of Parliament."
>
> (See also Lord Hoffmann at [36] and Lord Millett at [49].)

17. Ms Lieven does not accept that the Claimant's interpretation of section 1 of the Act is inconsistent with section 4 of the Act. Ms Gemma White, for the Society for the Protection of Unborn Children, intervening, submits that it is, as there will continue to be many situations in which medical professionals, in particular nurses and midwives, are asked to administer abortifacient drugs; if this claim is successful they will not be entitled to the protection of section 4. Mr James Eadie QC, on behalf of the Secretary of State, makes submissions to the same effect. Ms Lieven recognises there is a potential lacuna here, but submits that there is similarly a lacuna at an earlier stage, on the basis of the decision of the House of Lords in *Janaway v Salford AHA* [1989] 1 AC 537.

18. Mr Eadie cautions against acceptance of Ms Lieven's description of "the critical issue" as being "whether the words *'any treatment for the termination of pregnancy'* are capable of including treatment by the prescription of a drug" (Claimant's supplementary skeleton, para 5). He submits that is not the issue. The Claimant's case must necessarily be that "treatment" stops at the point of prescription.

19. Mr Eadie submits that the Claimant's construction is wrong for the following reasons. First, the natural and ordinary meaning of "treatment" involves, and on any view includes, the taking of the abortifacient drug. If a drug is merely prescribed by a

doctor, but not taken by the patient, the "treatment" would not have occurred. Second, the concept of "treatment" is a broad one, as is clear from the reference to "any" treatment. It covers all types of treatment: good, bad, safe and unsafe treatment. The only limitation in the phrase is that the treatment must be "for the termination of pregnancy". Third, section 1(3A) refers expressly to "treatment consisting primarily in the use of … medicines as may be specified…". Plainly Parliament considered the use of medicines as a species of treatment. Ms Lieven submits that the 1990 amendment by introducing sub-section (3A) cannot change the correct approach to the words in sub-section (3) which were in the 1967 Act. Mr Eadie submits that in construing legislation the court can have regard to a later amendment to primary legislation as an aid to interpretation of other parts of that legislation.

20. Fourth, Mr Eadie submits that section 1(3A) makes clear that Parliament made a choice about where responsibility for approval of a wider range of place (including potentially the home), and for the conditions on which such approval might be given relating to the particular medicine and the manner of its administration or use, should lie: it is with the Secretary of State, and not with the medical profession.

21. Fifth, the consequence of the Claimant's interpretation is that it would apply to the prescription and administration of the abortifacient drug at any stage of pregnancy, not merely up to nine weeks' gestation. It would also apply to the administration of abortifacients which did not enjoy the same record of safety and effectiveness, at home, as those currently administered have demonstrated in countries outside Great Britain.

22. Mr Eadie accepts that in principle it may be necessary to read or construe an Act of Parliament in the light of present day conditions or medical knowledge or practice. However in his submission the doctrine of the "always speaking" statute does not advance the Claimant's case. There is, he submits, no scope for the application of the principle in the present context because when enacting section 1(3A) Parliament specifically considered what the appropriate legislative position should be in relation to medical abortions and where they should be permitted to take place.

Discussion

23. The Claimant's case is that the concept of treatment does not include the taking of an abortifacient because treatment refers only to the act of prescription of such a drug. The Secretary of State submits that "treatment" includes the use or administration of the abortifacient drug. In my view the Claimant's submission runs counter to the natural and ordinary meaning of the word "treatment". The Oxford English Dictionary defines "treatment", in the medical context, as "management in the application of remedies; medical or surgical application or service". The words "medical… application" plainly, in my view, embrace the taking of an abortifacient drug.

24. The critical phrase in s.1(3) is "any treatment for the termination of pregnancy". "Treatment" is not, in my view, properly restricted to the act of diagnosis and the prescription of drugs or medicine. If the drugs or tablets were prescribed by the registered medical practitioner and not taken by the woman, the opportunity for treatment would have been available but it would not have been taken. The aim of the

treatment, whether medical or surgical, must be the termination of a pregnancy. Termination is the consequence of the treatment; it is not itself treatment.

25. The interpretation put by the Claimant on the words "any treatment for the termination of pregnancy" requires it to submit that the pregnancy is terminated by a registered medical practitioner in s.1(1) when that person merely prescribes an abortifacient drug. However termination may or may not be the consequence of the prescription. A woman may decide not to proceed to take the drug.

26. In *Royal College of Nursing of the United Kingdom v Department of Health and Social Security* [1981] AC 800 the House of Lords considered the phrase "is terminated by a registered medical practitioner" in s.1(1) of the 1967 Act. The House of Lords held that a pregnancy was "terminated by a registered medical practitioner" within the meaning of that section when the treatment prescribed and initiated by that practitioner, who remained in charge of it throughout, was carried out in accordance with his directions by qualified nursing staff, entrusted with its execution in accordance with accepted medical practice. Referring to the side note to section 1 ("medical termination of pregnancy") Lord Keith said at 834D-F:

> "'Termination of pregnancy' is an expression commonly used, perhaps rather more by medical people than by laymen, to describe in neutral and unemotive terms the bringing about of an abortion. So used, it is capable of covering the whole process designed to lead to that result, and in my view it does so in the present context. Other provisions of the Act make it clear that termination of pregnancy is envisaged as being a process of treatment."

27. Lord Diplock in his opinion in *Royal College of Nursing* referred to "all stages of the treatment for the termination of the pregnancy" (828F-G). Lord Diplock said at 827G-828D/E as follows:

> "I have spoken of the requirements of the Act as the way in which 'treatment for the termination of the pregnancy' is to be carried out rather than using the word 'termination' or 'terminated' by itself, for the draftsman appears to use the longer and the shorter expressions indiscriminately, as is shown by a comparison between sub-sections (1) and (3) of section 1, and by the reference in the conscience clause to 'treatment authorised by this Act'. Furthermore if 'termination' or 'terminated' meant only the event of miscarriage and not the whole treatment undertaken with that object in mind, lack of success which apparently occurs in one or two per cent of cases, would make all who had taken part in the unsuccessful treatment guilty of an offence under section 58 or 59 of the Offences Against the Person Act 1861. This cannot have been the intention of Parliament.
>
> The requirement of the Act as to the way in which the treatment is to be carried out, which in my view throws most light upon the second aspect of its policy and the true construction of the

> phrase in sub-section (1) of section 1 which lies at the root of the dispute between the parties to this appeal, is the requirement in sub-section (3) that, except in cases of dire emergency, the treatment must be carried out in a National Health Service hospital (or private clinic specially approved for that purpose by the minister). It is in my view evident that in providing that treatment for termination of pregnancies should take place in ordinary hospitals, Parliament contemplated that (conscientious objections apart) like other hospital treatment, it would be undertaken as a team effort in which, acting on the instructions of the doctor in charge of the treatment, junior doctors, nurses, para-medical and other members of the hospital staff would each do those things forming part of the whole treatment, which it would be in accordance with accepted medical practice to entrust to a member of the staff possessed of their respective qualifications and experience."

28. The method of abortion under consideration in that case was termination of pregnancy by medical induction, that is a non-surgical termination. It is to be noted that even in 1967 when terminations were normally by a surgical method, during a debate in Parliament on a clause which became section 4 of the Act, Mr Braine MP, the mover of the Amendment said "It is designed to take account of the fact that the termination of a pregnancy is not always and certainly may not in the future, be a surgical operation" (Hansard, 13 July 1967 at 1314). He added, "I am told that probably in the next decade, a safe chemical method of inducing therapeutic abortion may be developed and may be accepted by the medical profession." (at 1315). Ms Lieven accepts that Parliament must be taken to have contemplated both surgical and non-surgical treatment in 1967. What she says was not then contemplated was the medical development that has only in recent years taken place which has made safe the taking of drugs and medicine, at home, for the purpose of termination.

29. During the course of argument the issue between the parties in relation to the 1990 amendment became clearer. Section 1(3A) refers expressly to "treatment consisting primarily in the use of such medicines as may be specified". So, submits Mr Eadie, it is clear that Parliament considered and intended that treatment for termination using medicines fell within the concept of treatment in the same way as did treatment using surgical or other interventionist forms of treatment. Ms Lieven does not argue to the contrary. The Claimant accepts that EMA is "treatment" and that it involves the use of medicines. What the Claimant does not accept is that the physical administration of the medicines by the woman to herself is part of that treatment. That being so, section 1(3A), Ms Lieven submits does not advance the Defendant's case as to the meaning of "treatment". On the Claimant's case the Secretary of State would still be able to approve a class of place where the "treatment", that is the prescription, could take place.

30. However, in my view, section 1(3A) is consistent with the Secretary of State's submissions as to the meaning of the concept of "treatment". Section 1(3A) refers to treatment consisting primarily in the "use" of medicines; it is not limited to the prescription of medicines. Furthermore the section does make clear Parliament's

decision that it is the Secretary of State, not the medical profession, who has the responsibility for approval of the place where the treatment may take place.

31. In my view it is permissible for the Defendant to have regard to a later amendment to primary legislation as an aid to interpretation of other parts of that legislation. *Bennion on Statutory Interpretation* states at p.293:

> "*Statutory exposition*
>
> Where the legal meaning of an enactment is doubtful, and a later enactment having power to override it is so worded as to show that the legislator treated it as having a particular meaning, this is said to be a statutory exposition of it. Whether statutory exposition is equivalent to implied amendment depends on whether the later enactment indicates an intention to clarify the meaning of the earlier one (thus serving as a *declaratory* enactment) or merely refers to it. In the latter case it is of persuasive authority only."

Mr Eadie submits, on this basis, section 1(3A), the later enactment, is of persuasive authority, and I agree. Ms Lieven points out that no authority is cited in support of this statement in *Bennion*. That is so, however neither of the two authorities to which I have been referred appear to be in point and accordingly they do not undermine the validity of the proposition. First, *Boss Holdings Ltd v Grosvenor West End Properties Ltd* [2008] 1 WLR 289: in that case Lord Neuberger, delivering the only speech with which all their lordships agreed, said at 295A-B:

> "In my opinion, the legislature cannot have intended the meaning of a sub-section to *change* (emphasis added) as a result of amendments to other provisions of the same statute, when no amendments were made to that sub-section, unless, of course, the effect of one of the amendments was, for instance, to change the definition of an expression used in the sub-section."

Second, *Isle of Anglesey County Council v Welsh Ministers* [2010] QB 163: in that case Carnwarth LJ, delivering the lead judgment with which Pill LJ and Lawrence Collins LJ, as he then was, agreed, said at para 43:

> "Where an Act has been interpreted in a particular way without dissent over a long period, those interested should be able to continue to order their affairs on that basis without risk of it being upset by a novel approach. That applies particularly in a relatively esoteric area of the law such as the present, in relation to which cases may rarely come before the courts, and the established practice is the only guide for operators and their advisers."

Mr Eadie does not submit that the meaning of the concept of treatment was changed by the 1990 amendment (as was argued in *Boss Holdings*), nor are we concerned with "established practice" (which was under consideration in *Anglesey*).

32. Section 1(3A) is also significant in another respect. Mr Eadie does not take issue with Ms Lieven's analysis of the interpretive technique of "updating" construction. However that principle of statutory construction is not relevant in the present context. Section 1(3A) makes clear that "treatment" which in 1967 was normally surgical treatment covers medical treatment. Moreover, it enables the Secretary of State to react to further changes in medical science. He has the power to approve a wider range of place, including potentially the home, and the conditions on which such approval may be given relating to the particular medicine and the manner of its administration or use.

33. In *Royal College of Nursing* Lord Diplock noted at 826D-E that "What the [1967] Act sets out to do is to provide an exhaustive statement of the circumstances in which treatment for the termination of a pregnancy may be carried out lawfully." Ms Lieven submits that the position now is that the safety of the abortion is unaffected by whether the relevant medication is taken in an approved place or at home. Accordingly, she submits, that the mischief of the Act (see Lord Diplock at para 15 above) is met by defining the treatment as the prescription of the medication rather than the administration. However, in my view it is clear that in section 1(3) Parliament has placed responsibility for approving a place of treatment (other than those specified) on the Secretary of State, and in section 1(3A) it has done so for approval of a wider range of place and in relation to types of medicine and the manner of their administration or use. The Claimant acknowledges that the effect, and indeed the very purpose, of the declaration sought would be that the Secretary of State's approval is no longer needed to enable the home to be designated as an approved place for the purposes of section 1 of the Act. In my view this would be directly contrary to Parliament's clear intention.

34. The development in medical science on which the Claimant relies is that the drug, misoprostol, is capable of being administered by the woman to herself at home. However in the light of the express wording of section 1(3) and section 1(3A) I am of the view, applying the test of Lord Wilberforce in *Royal College of Nursing* at 822A-G, this "new state of affairs, or … fresh set of facts … fall within the same genus of facts as those to which the express policy has been formulated"; alternatively, in my view, there is a clear purpose in the legislation which can only be fulfilled if the Secretary of State's interpretation of the concept of treatment is adopted.

35. The wording of section 4 of the 1967 Act also, in my view, supports the Secretary of State's submission that "treatment" includes the use or administration of abortifacient drugs. Section 4 provides that "no person shall be under a duty … to participate in any treatment authorised by this Act to which he has a conscientious objection". In *Janaway v Salford Area Health Authority* [1989] 1 AC 537 the House of Lords held that the word "participate" in section 4(1) should be given its ordinary and natural meaning and that to "participate in any treatment authorised by this Act" meant actually to take part in treatment administered in a hospital or other approved place in accordance with section 1(3) for the purpose of terminating a pregnancy. The declaration sought by the Claimant would cover the administration of abortifacient drugs not only at home, but also at a hospital or any place approved by the Secretary of State. The drugs can be self-administered, however there may be many situations in which nurses and midwives and other medical professionals are asked to administer them. If the Claimant's construction of what constitutes "treatment authorised by the

Act" is correct, no such person will be entitled to the protection of section 4. Ms Lieven accepts that there would be this lacuna but she points to the lacuna created by the decision in *Janaway* where the House of Lords held that the applicant, a secretary, in typing a letter referring a patient to a consultant with a view to a possible termination of pregnancy under section 1 would not have been participating in treatment authorised by the Act, and that, accordingly her refusal to do so had not been protected by section 4(1). The principle would apply equally to doctors in a similar situation. That is no answer, in my view, to Ms White's submission that Parliament clearly did not intend that an action which directly causes the termination of pregnancy should be outside the scope of section 4. I am also not persuaded by Ms Lieven's response that in practice the position of nurses and midwives can be dealt with by regulations and codes of conduct. The advice that the Nursing and Midwifery Council can give necessarily depends on the statutory right in the Act as construed by the courts.

36. In *Royal College of Nursing* Lord Diplock referred at 824G-H to "the legalisation of abortion, at any rate in circumstances in which the termination of the pregnancy is not essential in order to save the mother's life, [as] a subject on which strong moral and religious convictions are held" (see also Lord Wilberforce's description (at 822F) of the Act as "dealing with a controversial subject involving moral and social judgments on which opinions strongly differ"). Yet, as Mr Eadie submits, the consequences of the Claimant's interpretation of the concept of treatment in the Act include the following: first, the declaration the Claimant seeks would apply to the prescription and administration of the abortifacient drug at any stage of pregnancy, not merely up to nine weeks' gestation. Second, the declaration refers to "an abortifacient drug" which is wide enough to cover the administration of mifepristone, the first-stage drug, outside the clinical setting as well as the administration of misoprostol, the second-stage drug. Third, the Secretary of State has not entered into debate in these proceedings as to whether what is proposed by the Claimant is safe. However, the declaration the Claimant seeks would apply equally to the administration of abortifacients which do not enjoy the same record of safety and effectiveness, at home, as those currently administered have demonstrated in countries outside Great Britain.

37. The response of Ms Lieven to these concerns is that the regulatory regime (see paras 5-8 above) is entirely effective to protect the safety of patients. She submits that the consequences that the Secretary of State identifies are unrealistic and ignore all the other statutory safeguards. In my view this is not a satisfactory answer to the point that Parliament has decided by section 1(3A) to give the Secretary of State the responsibility for approval of the types of medicine that can be used, the manner in which they can be used and the places where they can be used. Moreover the regulatory regime is not subject to the same controls as the statutory regime (see paras 7 and 8 above, for example, in relation to sanctions). Mr Eadie makes the additional point, which I accept, that there is a possibility that different standards or measures may be adopted by the Westminster authorities and the devolved administrations. Health and social care is a devolved matter (for Wales, see the Care Standards Act 2000, and for Scotland, see the Regulation of Care (Scotland) Act 2001), whereas abortion is a "reserved matter" for the Westminster Parliament (for Wales see para 9 of sch.7 to the Government of Wales Act, and for Scotland, see para J1 of sch.5 to the Scotland Act 1998).

Conclusion

38. In my judgment, for the reasons that I have given, this claim fails.