

COMMENTARY

WHEN CONSCIENCE ISN'T CLEAR: *GREATER GLASGOW HEALTH BOARD v DOOGAN AND ANOTHER* [2014] UKSC 68

ABSTRACT

The Supreme Court's judgment in *Doogan* is a judicial review of a decision by Greater Glasgow Health Board regarding the scope of the conscience-based exemption in section 4(1) of the Abortion Act 1967. The case progressed through the Outer and Inner Houses of the Court of Session in Edinburgh before final judgment was delivered in the Supreme Court by Baroness Hale on 17th December 2014. The Supreme Court eschewed consideration of the human rights dimension of the case (which had featured in the Outer House decision) and approached its judgment as 'a pure question of statutory construction'. This commentary engages with the judgment on its own terms, assessing it as an exercise in statutory interpretation, and leaves it to others who may wish to do so to comment on the human rights aspects of the case.

BACKGROUND AND FACTS OF THE CASE

Facts

Mary Doogan and Connie Wood are experienced senior midwives who worked, at the time this dispute originated, in the Southern General Hospital (SGH) on the south side of Glasgow. Both women have always refused, for reasons of conscience, to participate in abortions. On commencing her employment, each woman had duly notified the employer that she wished to exercise her statutory right to be exempt from participation under section 4(1) of the Abortion Act 1967.

The Health Board had found it possible for many years (since 1988 in Mary Doogan's case) to accommodate the women's exercise of their right, interpreted so as to exempt them from *any* involvement in the abortion process whatsoever. In the years leading up to the

dispute, however, maternity provision in Glasgow was reorganised. One of three hospitals providing maternity services, the Queen Mother's Maternity Hospital (QMH), was closed in 2010, and the pattern of provision in the remaining two hospitals was reconfigured. Most importantly, upon the closure of the QMH, its Foetal Medicine unit was relocated to the SGH. Although some late term abortions for foetal abnormality had always been carried out on the labour ward of the SGH, they had hitherto represented a tiny proportion of its work. The organisational changes meant that the number of late-term abortions on the labour ward, and the proportion of its overall work which they represented, would be likely to increase. Miss Doogan and Mrs Wood were concerned that this might make it more difficult for them to avoid contact with the abortion process, and sought reassurance that their employer would continue to respect their right to be exempt from any involvement in it. In the internal procedure that followed, the employer insisted that, although the women could not be expected to have any *direct* involvement in abortion, they could be required to perform what came to be referred to in the subsequent court proceedings as an '*indirect*' or 'hands-off' role in the abortion process. The women sought judicial review of the employer's decision. By the time the matter reached the courts, the disagreement between the parties had become focused on the question of whether or not the exemption in section 4(1) protected senior staff from having to undertake 'delegation, supervision and support' in relation to staff directly involved in the abortion process. The women argued that it did; their employer insisted that it did not.

History

The first court to review the decision of the Health Board was the Outer House of the Court of Session. There, it was argued for the midwives that 'treatment' included 'the whole medical or surgical process involved in termination...The treatment as a whole was a team effort and supervision was a necessary element of that effort.'¹ What this meant in terms of the scope of section 4(1) was that

[on] a purposive and plain reading of the Act, s4(1) should be construed as covering the whole medical process resulting in termination and as embracing all of those who are part of the hospital team with responsibilities in relation to any part of the treatment.²

¹ CSIH, [12]

² CSIH, [17]

On behalf of the Health Board it was argued that sections 1 and 4 ought to be treated as coextensive: only what was decriminalised by section 1 was ‘treatment authorised by the Act’ for the purposes of section 4(1). Conversely, anything which had been lawful prior to 1967 and thus could not be said to have been ‘authorised’ (‘decriminalised’) by section 1 could *not* be regarded as falling within the scope of section 4. The Outer House accepted this argument, and found in favour of the employer.

On appeal, the Inner House overturned the Outer House judgment, rejecting the ‘coextensiveness’ argument and pointing out that the protection for individual practitioners afforded by section 4 was not granted on the basis of previous unlawfulness:

The right in section 4 is given, not because the acts in question were previously, or may have been, illegal. The right is given because it is recognised that the process of abortion is felt by many people to be morally repugnant. As Lord Diplock observed in the RCN case, it is a matter on which many people have strong moral and religious convictions, and the right of conscientious objection is given out of respect for those convictions and not for any other reason. It is in keeping with the reason for the exemption that the wide interpretation which we favour should be given to it. It is consistent with the reasoning which allowed such an objection in the first place that it should extend to any involvement in the process of treatment, the object of which is to terminate a pregnancy.³

In a commentary on the Inner House judgment,⁴ I argued that, although the Inner House was correct to identify the asymmetry of purpose between sections 1 and 4 as one of the reasons why the ‘coextensiveness’ formula is faulty, asymmetry is only one of several reasons why the idea of ‘coextensiveness’ is problematic. (I discussed the shortcomings of the idea fairly fully in the previous commentary, and I summarise them below.)

The Supreme Court heard the oral argument in this case on 11th November 2014 and gave judgment on 17th December, allowing the appeal by the Health Board and setting aside the declarator of the Inner House. Baroness Hale of Richmond delivered the opinion of the Court and the other four justices (Lords Wilson, Reed, Hughes, and Hodge) agreed with her.

³ CSIH, [38]

⁴ M Neal, ‘Commentary – The Scope of the Conscience-Based Exemption in Section 4(1) of the Abortion Act 1967: *Doogan and Wood v NHS Greater Glasgow Health Board* [2013] CSIH 36’ (2014) 22 *Med. L. Rev.* 409, 421

THE SUPREME COURT JUDGMENT

The Supreme Court proceeded on the basis that ‘the question in this case, and the only question, is the meaning of the words “to participate in any treatment authorised by this Act to which he has a conscientious objection”’.⁵ The Court decided that this question was to be determined ‘according to the ordinary principles of statutory construction’.⁶ It explicitly declined to consider *either* Article 9 of the European Convention on Human Rights (which protects the right to freedom of thought, conscience and religion) *or* claims about the likely social consequences of adopting a wide or a narrow interpretation of the conscience right in section 4(1).⁷ Despite its obligation under section 3(1) of the Human Rights Act 1998 to read legislation in a manner compatible with the European Convention, the Court decided that consideration of Article 9 would not be fruitful, since the question of compatibility was ‘context specific and would not necessarily point to either a wide or a narrow reading of section 4’.⁸ Likewise, the Court decided that it was ‘not equipped to gauge what effect either a wide or a narrow construction of the conscience clause would have upon the delivery of [abortion], which may well differ from place to place.’⁹ Instead, it decided simply to follow ‘the ordinary principles of statutory construction’¹⁰ and ‘to make the best sense...of what [section 4(1)] actually says.’¹¹ In the paragraphs that followed, the Court sought to establish the meanings of two key words, ‘treatment’ and ‘participation’.

The Court addressed the meaning of ‘treatment’ first. Both sides accepted that the phrase ‘treatment authorised by the Act’ referred to a process, rather than to an isolated action or event. The Health Board had accepted as much even before the court proceedings began; their letter to the midwives informing of them of the outcome of the internal grievance procedure referred to ‘the termination process’.¹² The insistence that treatment was both a ‘process’ and a ‘team effort’ was also the central plank of the case for the midwives.¹³ The Supreme Court agreed that, following the judgment of the House of Lords in the case of *Royal College of Nursing of the United Kingdom v Department of Health and Social Security*

⁵ UKSC, [11]

⁶ UKSC, [24]

⁷ These were dismissed as ‘two distractions’ at paragraphs 23-27.

⁸ UKSC, [23]

⁹ UKSC, [27]

¹⁰ UKSC, [24]

¹¹ *Ibid.*

¹² CSIH, [6]

¹³ CSIH, [12], [17], [18]

[1981] AC 800, treatment must be understood as a ‘process’, so that ‘what is authorised by the Act is *the whole course of medical treatment bringing about the ending of the pregnancy*.’¹⁴

What the Court had to determine in this case were the parameters of this ‘treatment process’: where did the process begin, and where did it end? Lady Hale acknowledged a ‘spectrum of constructions’¹⁵ of the treatment process, within which she identified four distinct and competing claims. At one end of the spectrum, according to Lady Hale, was the assertion by the Royal College of Midwives (RCM), in its intervention in this case, that

‘the treatment authorised by this Act’ is limited to the treatment which actually causes the termination, that is, the administration of the drugs which induce premature labour. It does not extend to the care of the woman during labour, or to the delivery of the foetus, placenta and membrane, or to anything that happens after that.¹⁶

Moving along the spectrum slightly, Lady Hale distinguished the foregoing view from the view the RCM had taken in 1997 in a position paper on ‘conscientious objection’. There, it had maintained that section 4(1) should be interpreted only as protecting staff against ‘*direct* involvement in the procedure of terminating pregnancy’.¹⁷ Lady Hale suggested that the RCM’s view in 2014 ‘may be a little narrower’ than its 1997 position, presumably because the latter contemplates the exemption in the Act covering *any* involvement which is ‘direct’, whereas the upshot of the former is that however ‘direct’ involvement is, it would not be covered unless it ‘*actually causes* the termination’.¹⁸ The 2014 view, according to Lady Hale, would mean that the only act from which practitioners would be able to exempt themselves for reasons of conscience would be the actual administration of the abortifacient drugs.¹⁹

A third construction was proposed by the Health Board, who claimed that the treatment process authorised by the 1967 Act ‘begins with the administration of the drugs and ends with the ‘expulsion of the products of conception – foetus, placenta and membrane, from the womb.’²⁰ According to this construction, the scope of section 4

¹⁴ UKSC, [33], emphasis in original.

¹⁵ UKSC, [28]

¹⁶ UKSC, [29]

¹⁷ UKSC, [30], emphasis added

¹⁸ UKSC, [29], emphasis added.

¹⁹ UKSC, [29]

²⁰ UKSC, [32]

does not cover making bookings or aftercare for patients. Nor does it cover fetching the drug before it is administered...It does not cover administrative and managerial tasks, such as allocating ward resources and assigning staff. Nor does it cover supervisory duties which are concerned with ensuring that general nursing care of an appropriate standard is provided to women undergoing a termination.²¹

The fourth construction, argued for by the respondents (midwives), took the treatment process to include the *whole* process of termination and argued that section 4 entitled practitioners to be exempt from involvement in any part of it:

[from] the initial telephone call booking the patient into the Labour Ward, to the admission of the patient, to assigning the midwife to look after the patient, to the supervision of the staff looking after the patient, both before and after the procedure, as well as to the direct provision of any care for those patients, apart from that which they are required to perform under section 4(2) [in emergencies].²²

As noted already, Lady Hale presented all of these alternatives as existing on a ‘spectrum’ which ranged from the narrowest construction of the ‘treatment process’ (the position of the RCM in 2014) to the broadest (the respondents’ interpretation). She regarded the construction proposed by the Health Board as being located somewhere in the middle of the spectrum, and endorsed it, elaborating:

[Treatment] begins with the administration of the drugs designed to induce labour and normally ends with the ending of the pregnancy by delivery of the foetus, placenta and membrane. It would also, in my view, include the medical and nursing care which is connected with the process of undergoing labour and giving birth – the monitoring of the progress of labour, the administration of pain relief, the giving of advice and support to the patient who is going through it all, the delivery of the foetus...and the disposal of the foetus, placenta and membrane.²³

²¹ UKSC, [32]

²² UKSC, [31]

²³ UKSC, [34]

The second stage of the Court's statutory interpretation exercise involved considering the meaning of 'participation'. Here, once again, Lady Hale sees the choice as being between 'broad' and 'narrow' readings, although this time, instead of a spectrum of possible constructions, there are only two options: either 'participation' is to be understood as 'hands-on' involvement only, or it also covers involvement that is more indirect, or 'hands-off'. She decides, at paragraph 38:

In my view the narrow meaning is more likely to have been in the contemplation of Parliament when the Act was passed. *The focus of section 4 is on the acts made lawful by section 1.*²⁴

Having agreed with the Health Board about the parameters of the 'treatment process', and determined that 'participation' means hands-on involvement, Lady Hale proceeds, in paragraph 39, to test these conclusions 'against the agreed list of tasks included in the petitioners' role as Labour Ward Co-ordinators',²⁵ saying for each task whether it falls within or outside the scope of section 4(1) as she has interpreted it. By and large, tasks involving one-to-one contact or the exercise of clinical judgement are held to be covered, including: personally providing break relief for midwives on duty; 'being present to support and assist if medical intervention is required'; forming a judgment that care requires to be escalated to a more senior/specialist level; and 'directly providing care in emergency situations' (except if covered by section 4(2)).²⁶

Tasks held not to be covered because they are considered to be 'administrative' or 'managerial', include: 'management of resources within the Labour Ward', including taking calls to arrange terminations; 'providing a detailed handover...to the new Labour Ward Co-ordinator coming on shift'; allocating staff to patients; 'providing guidance, advice and support' to midwives on duty, except where it would be 'directly connected with the care of a particular patient undergoing a termination'; 'responding to requests for assistance' from

²⁴ Emphasis added.

²⁵ UKSC, [39]

²⁶ UKSC, [39]. Interestingly, Lady Hale's suggestion that only those tasks that involve clinical judgement are covered by section 4(1) appears to be at odds with the approach taken recently by Miola, who argues in this journal (developing Ian Kennedy's distinction between technical and non-technical decisions) that conscientious refusal can be appropriate only in relation to decisions that do not involve the exercise of clinical judgement (J Miola, 'Making decisions about decision-making: conscience, regulation, and the law', *Medical Law Review* (published online first, April 24, 2015)). The disagreement between Hale and these academic authorities is peripheral to my analysis, since I do not regard the distinction between tasks which do and do not involve clinical judgment as being the relevant one; nevertheless, it is interesting.

staff, and acting as their first point of contact in the event of any concerns regarding patients (although the specific assistance which turns out to be required may be covered); organising break relief for staff (short of providing that relief personally); ‘communicating with other professionals’, for example acting on the judgment of the duty midwife that a patient’s care needs to be escalated (forming the judgment oneself would be ‘involvement in treatment’, but contacting an obstetrician at the request of the duty midwife is ‘a managerial task’); and providing support to the family of a patient (Lady Hale considers this not to be covered by section 4(1), but discusses the ‘reasonableness’ of accommodating employees’ conscientious positions nevertheless, since staff who do not object to abortion may be able to provide the family with a more ‘effective service’).²⁷

ANALYSIS

Statutory construction

‘Treatment’

Although Lady Hale does not provide an explicit reason for favouring the construction of the ‘treatment process’ proposed by the Health Board, there is some evidence that her choice rests upon the questionable notion that sections 1 and 4 of the Act are coextensive such that section 4(1) entitles practitioners to opt out only of activity decriminalised by section 1. For example, the Court’s preferred construction is announced in paragraph 34 in a manner which seems to imply that it follows from the discussion in paragraph 33 (paragraph 34 begins: ‘Thus I agree with the appellants...’²⁸). The discussion in paragraph 33 had just attempted to shed light on the meaning of the phrase ‘treatment authorised by this Act’ in section 4 by reference to various aspects of section 1. Later, in paragraph 38, Lady Hale remarks that ‘the focus of section 4 is on the acts made lawful by section 1’. Again, this seems to imply that the ‘coextensiveness’ approach, which persuaded the Outer House of the Court of Session at first instance, but which the Inner House rejected, is being resurrected to some degree in the Supreme Court’s judgment.

In my commentary on the Inner House judgment, I acknowledged that the idea of symmetry between sections 1 and 4 has ‘a certain amount of superficial appeal’.²⁹ Given a

²⁷ UKSC, [39]

²⁸ Emphasis added.

²⁹ Neal, above n4, 415.

range of competing constructions of the ‘treatment process’ and no other obvious basis on which to choose between them, the suggestion that a neat formula is inherent in the statute itself must be very enticing indeed for the judge who believes she is faced with ‘a pure question of statutory construction’.³⁰ Unfortunately for Lady Hale, however, the formula is unsound.

In my previous commentary I identified several reasons why it is a mistake to suppose that we can regard the scope of section 4 as neatly coextensive with the decriminalisation effected by section 1.³¹ It is (unfortunately) necessary to recap them again here, briefly.

First, the law relating to abortion prior to 1967 seems to have been subtly different in Scotland than in England and Wales, and to have been clear in neither jurisdiction. Lady Hale herself acknowledges that the mischief the 1967 Act set out to address was ‘the unsatisfactory and uncertain state of the previous law’,³² and indeed the Act was, explicitly, ‘[an] Act to amend *and clarify* the law relating to termination of pregnancy’.³³ This has three implications for the suggestion that sections 1 and 4 are coextensive. The first is a simple point: if the law was unclear before 1967, how can we be certain precisely what section 1 did decriminalise? If we cannot, but we insist nevertheless that section 4 covers only what was decriminalised by section 1, then it follows that we cannot know with any certainty what section 4 covers. The second implication is that if the law in Scotland was different from that in England and Wales prior to 1967, the decriminalising effect of section 1 must also have been different in each jurisdiction, which in turn means that, on a ‘coextensiveness’ approach, the scope of section 4 must currently be different in Scotland than in England and Wales. It seems unlikely that Parliament would have intended such a difference. (I explain this point more fully in my previous note,³⁴ so will not elaborate here.) The final implication is that, insofar as clarification of the law was a purpose of the Act, it seems highly unlikely that Parliament would have intended for the scope of section 4 to be determined by indirect reference to the pre-1967 position. In setting out to clarify the law, Parliament acknowledged that the existing law was unclear, and it would be strange if, cognisant of this, Parliament decided to import the old law’s lack of clarity into the brand new statutory regime by the back door.

The second main problem with the ‘coextensiveness’ approach is that it seems fundamentally to misunderstand the nature and purpose of a conscience clause. Conscience

³⁰ UKSC, [33]

³¹ Neal, above n4.

³² UKSC, [27]

³³ Abortion Act 1967 (as enacted), emphasis added.

³⁴ Neal, above n4, 415-416.

clauses exist primarily to protect people from moral responsibility for what they regard as wrongdoing; this, it seems to me, has little if anything to do with whether activity was previously criminal. A highlight of the Inner House's judgment is its recognition of this, although it could perhaps have articulated the point more fully. I will return to the theme of moral responsibility later in this commentary, so will not dwell on it now save to acknowledge that there is simply no reason to suppose that the scope of a section designed to protect practitioners from involvement in *moral* wrongdoing ought to depend on what was previously *criminal*. Sections 1 and 4 are concerned with two distinct (albeit connected) kinds of normativity, and this asymmetry of purpose ought further to weaken the appeal of a 'coextensiveness' approach.

Both of the problems I have identified so far are problems with trying to determine the scope of section 4(1) by reference to what section 1 *decriminalised*, not what it 'authorised' (which is the wording actually used in section 4(1)). The third main problem with coextensiveness is precisely this tendency to interpret the key phrase 'treatment authorised by this Act' in the very narrow sense of 'behaviour decriminalised by this Act'.

'Authorised by this Act'

It is surprising, given all of the focus on the phrase 'to participate in any treatment authorised by this Act', and on the meanings of the words 'treatment' and 'participate' within this phrase, that none of the three courts that have considered this case has given any explicit consideration to what 'authorised' means in the context of section 4(1). The Outer House simply assumed that 'authorised' meant 'decriminalised':

The 1967 Act authorises, in certain defined circumstances, action in relation to a woman's pregnancy which would, prior to its coming into force, have been an offence under the common law [in Scotland].³⁵

This assumption was never seriously questioned at any subsequent stage of the judicial review. The Inner House came closest to contemplating a fuller meaning for 'authorised', saying: 'In our view it is not only the actual termination which is authorised by the Act for the purposes of section 4(1), but any part of the treatment which was given for that end

³⁵ CSOH, [38]

purpose.³⁶ However the Outer House's conviction that 'the key words are "participate" and "treatment"',³⁷ together with its simple assumption that 'authorised' means 'decriminalised', ultimately set the pattern for the higher courts' consideration. This is a pity: clearly, 'authorisation' bears a wider interpretation than mere 'decriminalisation', and there appears to be no sound basis for such a restricted understanding of the term.

What the Act 'authorised', I have argued previously, was the creation of a whole 'treatment context' for abortion:

in decriminalising *and medicalising* termination, the Act did not simply authorise the central acts themselves; it authorised and indeed *created* a surrounding process – a treatment context – involving a team of healthcare workers with a variety of roles.³⁸

For this reason, in my view, the phrase 'treatment authorised by this Act' is best understood as covering not only the narrow set of actions the Act decriminalised, but everything that the Act allowed for, or enabled: 'the whole process for which the Act provided'.³⁹ This approach to the meaning of 'authorised' is more harmonious with the acceptance that treatment is a process involving a team. To acknowledge the latter (as the Supreme Court does), yet simultaneously cling to the idea that the definition of treatment is somehow dependent on historical decriminalisation, feels like a contradiction. If 'authorise' is given the meaning I have proposed, this tension is avoided.

Of course, however justified a Court would be in understanding 'authorised by this Act' in its fuller sense, understanding the Act as having 'authorised' the whole treatment context does require us to address the possibility of over-breadth. If the 'treatment authorised by this Act' is the whole of abortion provision, on what basis can we then deny the protection of section 4(1) to anyone associated with that provision, however remotely? I will return to this later, when discussing moral responsibility.

'Participate'

In paragraph 38, the preference for the narrow, 'hands-on' meaning of 'participate' is juxtaposed very directly with the idea that sections 1 and 4 are coextensive. For the reasons

³⁶ CSIH, [37]

³⁷ CSOH, [43]

³⁸ Neal, above n4, 417.

³⁹ *Ibid.*

set out above, that idea is problematic when it focuses on the *decriminalising* effect of section 1, and this is clearly the case in paragraph 38, with its reference to ‘acts made lawful’. Insofar as Lady Hale’s conclusion that ‘participate’ means ‘taking part in a “hands-on” capacity’⁴⁰ is influenced by this idea, the conclusion must also be problematic. But she also says, in a crucial passage:

It is unlikely that, in enacting the conscience clause, Parliament had in mind the host of ancillary, administrative and managerial tasks that might be associated with [the acts made lawful by section 1]. Parliament will not have had in mind the hospital managers who decide to offer an abortion service, the administrators who decide how best that service can be organised within the hospital...the caterers who provide the patients with food, and the cleaners who provide them with a safe and hygienic environment. Yet all may be said in some way to be facilitating the carrying out of the treatment involved.⁴¹

In my commentary on the Inner House decision, I argued just the opposite: that the purpose of Parliament in enacting the 1967 Act

was to ensure that terminations of pregnancy would, thereafter, be carried out within a highly-organised clinical context full of reporting structures, job descriptions, professional bodies, codes of ethics, and so on. As such, the Act deliberately brought a range of new people (and their consciences) into contact with the abortion process.⁴²

I continued,

Parliament would have been well aware of the fact that the Act [would] provide for a medical *context* within which lawful termination could take place, and that this context would *necessarily* involve a range of other employees besides the clinician immediately responsible for destroying the foetus.⁴³

⁴⁰ UKSC, [38]

⁴¹ UKSC, [38], emphasis added.

⁴² Neal, above n4, 417.

⁴³ *Ibid.*

In my view, the claim that these other employees must have been beyond the contemplation of a Parliament enacting a statute to provide for the provision of abortion as ‘treatment’ is simply unconvincing. Lady Hale’s own acknowledgment that ‘the policy behind the Act was also to provide such a service within the National Health Service...’⁴⁴ makes her subsequent denial that Parliament could have had the members of a healthcare team in an NHS hospital in mind when legislating all the more improbable. Thus, whether the preference for a ‘hands-on’ understanding of ‘participate’ is grounded in a belief in the coextensiveness of sections 1 and 4, or in a narrow view of who Parliament must have had in mind, or in both, it is faulty.

The Supreme Court’s approach to the meanings of ‘treatment’ and ‘participate’ lacks a sound rationale. In each case, the court’s interpretation seems to be influenced by the assumption that sections 4 and 1 are coextensive *in the specific sense* that section 4 protects practitioners only from activity which is *decriminalised* by section 1. In the case of ‘participate’, Lady Hale’s problematic assertion that Parliament simply could not have intended section 4 to protect any employees other than those who would otherwise be involved in the direct act of termination in a ‘hands-on’ capacity ought to cast additional doubt on her conclusion.

‘Moral responsibility’ versus a binary approach

At every stage of the *Doogan* litigation, the courts understood the choice before them as being between ‘broad/wide’ and ‘narrow’ interpretations of section 4(1). Interpretations which understood the provision as covering indirect or ‘hands-off’ participation in abortion were characterised as ‘wide’, and those which restricted protection to direct or ‘hands-on’ involvement were characterised as ‘narrow’. Yet to approach the scope of a conscience provision in terms of simplistic binaries — such as ‘hands-on’/‘hands-off’, direct/indirect, and broad/narrow — is to pay insufficient attention to the main purpose of such provisions. Whatever other purpose a conscience provision may serve (as part of a political compromise, for example), its most direct and explicit purpose is to protect individuals from sharing in moral responsibility for what they perceive as wrongdoing. Unless it is interpreted in a way that achieves this, its purpose is frustrated.

Rather than asking whether the provision should be interpreted broadly or narrowly, then, the appropriate question is whether the action from which the individual seeks to be

⁴⁴ UKSC, [27]

exempt would render her *morally responsible* for the outcome she perceives as immoral. In considering the scope of section 4(1) specifically, the appropriate question to ask is whether a midwife doing what these midwives seek *not* to do would share in any moral responsibility (blame or credit, depending upon one's view) for the abortion. If the task renders the practitioner morally complicit in the outcome, it must be covered, regardless of whether it is 'hands-off', or was lawful prior to 1967; if it does *not* render her morally responsible, she can be expected to undertake it, even if it involves direct, one-to-one contact with patients undergoing terminations.

In contexts where most of us are agreed about the immorality of the activity in question, it is by no means accepted that 'mere' indirect/'hands-off'/administrative involvement avoids moral responsibility. At the time of writing, a German court is considering whether an elderly man who worked as an administrator at Auschwitz during the Holocaust bears any criminal responsibility for the mass murder perpetrated there. The man, 93-year-old Oskar Gröning, argues that since he did not participate directly in the murder of prisoners, he is not criminally responsible; interestingly, however, he accepts that, because he worked at the camp willingly, he deserves a share of the *moral* guilt for what went on.⁴⁵ The administrative, indirect, 'hands-off' nature of his participation does not, in his own view, exclude *moral* responsibility, and the forgiveness bestowed on Gröning by Eva Kor, one of the Holocaust survivors who has testified against him, *presupposes* agreement with Gröning's own assessment that he bears moral guilt (since forgiveness would otherwise be inappropriate).⁴⁶ To be clear, the point here is not to assert any moral equivalence between abortion and Nazi atrocities; it is rather that when the immorality of a project is widely acknowledged, those performing hands-off, administrative roles can plausibly be regarded as morally blameworthy (and may regard themselves as such).

In general, approaching the scope of a conscience-based exemption by acknowledging the nature and purpose of such provisions must be preferable to approaching it in a way that ignores them; and when the issue is viewed through the lens of moral responsibility it is immediately apparent that someone who *authorises* a process (for example, the general practitioner who signs the form) has moral responsibility for it, as do those who support the

⁴⁵ BBC News, 'Auschwitz guard trial: Oskar Groening admits "moral guilt"', BBC News website, accessed at <http://www.bbc.co.uk/news/world-europe-32392594> on 20/05/2015.

⁴⁶ S Kaplan, 'An Auschwitz Survivor's Radical Forgiveness as she Hugs Nazi Guard', *The Washington Post*, 27 April 2015, accessed at <http://www.washingtonpost.com/news/morning-mix/wp/2015/04/27/the-radical-forgiveness-of-an-auschwitz-survivor-who-hugged-a-nazi-guard/> on 20/05/2015: "In her statement, Kor wrote that her forgiveness doesn't absolve him of guilt. But it does grant her peace of mind."

process by arranging practicalities, allocating tasks, and supervising those directly involved. Viewed through this lens, the phrase ‘delegation, supervision and support’ (which came to sum up the role of Labour Ward Co-ordinator in this case) clearly describes a role which is not morally-neutral, but rather involves *actively supporting* the abortion process.

It is necessary, however, to address the question of over-breadth: this litigation is, after all, about the *scope* of the section, i.e. its limits. If we begin, as I have claimed we must, from the premise that the direct purpose of section 4(1) is to enable practitioners to avoid moral responsibility — and if we reject the notion that the scope of section 4 can be determined by reading it as coextensive with section 1 — what limits can we recognise, apart from the statutory limit in section 4(2))?

Lady Hale cited the roles of hospital caterers and cleaners as clear examples of roles *not* covered by the exemption, albeit that those who perform these roles ‘may be said in some way to be facilitating the treatment involved’.⁴⁷ Section 4(1) refers specifically to ‘treatment’, and it would be difficult to construe catering and cleaning as ‘treatment’, even in the widest sense (since the non-artificial supply of food and the provision of cleaning services are not characterised as ‘treatment’ in any other context). So, *contra* Lady Hale, who regards the roles as similar for the purposes of the Act, it seems perfectly straightforward to differentiate between the contributions of caterers and cleaners who are *clearly* not involved in ‘treatment’, and midwives, who are healthcare professionals and part of the team carrying out a treatment process.

But the question I must consider is whether the ‘moral responsibility’ approach I am proposing allows us to distinguish between the two. I suggest that it does. It might be tempting to try to distinguish the contribution of caterers and cleaners to the abortion process on the basis that when they provide food or clean areas of the hospital, only a small part of what they do contributes to the abortion process; much of the food they provide is consumed by other patients, and the areas they clean are used for other purposes besides abortion. Individual staff members who cook and clean may even be unaware that they are cogs in the abortion process at all. But I believe this is the wrong type of argument, and that even if a caterer knowingly provides food only to abortion patients, or a cleaner knowingly cleans only wards used exclusively for abortions, he or she cannot be acting immorally even if abortion is immoral. Sara Fovargue and I have recently observed that genuinely-held conscientious

⁴⁷ UKSC, [38]. In the same paragraph, Lady Hale expressed the view that: “The managerial and supervisory tasks carried out by the Labour Ward Co-ordinators are closer to these roles than they are to the role of providing the treatment which brings about the termination of the pregnancy.”

positions are embraced ‘on the basis that [they are] believed to be in accordance with the requirements of ethics’⁴⁸ and that, ‘[i]nsofar as conscientious positions are ‘ethical’ in this...sense, it seems impossible to acknowledge as truly conscientious any position which fails to meet basic ethical requirements’.⁴⁹ We have argued that ‘[t]he duty to behave respectfully toward others is a general (arguably the *most* general) ethical duty,’⁵⁰ and further, that

‘a genuinely ethical position cannot entail a lack of compassion or care. Good conscience never demands that a HCP avoid feeding, toileting, comforting, listening, and other basic acts of care. Even if I regard the treatment a patient is receiving as immoral, it cannot be immoral for me to dry her tears if she is distressed, fetch her a glass of water if she is thirsty, or adjust her pillows if she is uncomfortable. It would be immoral not to do these things.’⁵¹

Providing basic human needs like nutrition and hygiene is a moral duty; it can never be a moral duty to withhold them. The *necessarily ethical* character of conscientious positions, rather than any simplistic distinction between broad/narrow or ‘hands-on’/‘hands-off’, or any coextensiveness between sections 4 and 1, is why basic ethical duties such as ‘responding to requests for assistance’ are not covered by section 4(1), and nor are drying tears, making cups of tea, listening, toileting, feeding, and so on: there cannot be a moral obligation not to care. Conscientious positions are delimited by their character as ethical positions; it would be counter-intuitive to interpret them so as to ‘exempt’ individuals from basic ethical duties and simple acts of humanity to vulnerable others. We may disagree vigorously about the morality of abortion, but there is no room for disagreement about the everyday duties of respect and care we owe to one another.

CONCLUSION

Notwithstanding that this judgment’s rationale appears to lie in some combination of the ideas of (i) coextensiveness between sections 1 and 4 and (ii) the distinction between ‘hands-

⁴⁸ S Fovargue and M Neal, “‘In Good Conscience’: Conscience-Based Exemptions and Proper Medical Treatment’ (2015) 23 Med. L. Rev. 221, 241, 230.

⁴⁹ *Ibid*, 230

⁵⁰ *Ibid*, 233, emphasis in original.

⁵¹ *Ibid*, 238, emphasis in original.

on’/‘hands-off’ participation, it is far from clear that either idea is actually decisive in Lady Hale’s analysis of what is and is not covered by section 4(1). ‘Guidance, advice and support’ is acknowledged to be covered if it is ‘directly connected with the care of a particular patient undergoing a termination’,⁵² notwithstanding that it is ‘hands-off’ involvement. Conversely, ‘responding to requests for assistance, including responding to the nurse call system and the emergency pull’ is not covered *per se*, although it involves direct, one-to-one contact with patients undergoing terminations.⁵³ As for coextensiveness, Lady Hale lists as ‘not covered’ several tasks which amount to *arranging* abortion, including ‘taking telephone calls...to arrange medical terminations of pregnancy’,⁵⁴ managing resources,⁵⁵ and allocating staff to patients.⁵⁶ She also agrees with Lord Keith in *R v Salford Health Authority, ex parte Janaway [1989] AC 537* that a GP who signs a certificate to the effect that a woman satisfies the statutory grounds for abortion is not involved in the ‘treatment process’ (since ‘treatment’ cannot commence until *after* such certification has taken place) and so is not covered by section 4(1).⁵⁷

These findings seem at odds with a ‘coextensiveness/decriminalisation’ approach: arranging and facilitating abortion *would* have been unlawful prior to 1967, amounting to ‘conspiracy to procure abortion’,⁵⁸ so tasks which amount to arranging/facilitating abortion nowadays ought to be covered by the section 4(1) exemption if a coextensiveness test is being applied consistently. But not only are coextensiveness and the ‘hands-on’/‘hands-off’ distinction not *actually* decisive in Lady Hale’s scheme; I contend that neither *can* validly determine the scope of a conscience provision such as that in section 4(1), precisely because such tests fail to capture the essence of conscience provisions: a concern with moral responsibility.

The fact that four competing definitions of the ‘treatment process’ existed and had to be considered by the Court demonstrates that, prior to this case, the scope of the exemption in section 4(1) was anything but clear. This undermines any suggestion that Lady Hale’s judgment simply confirms what the vast majority of stakeholders have always understood the scope of section 4(1) to be. If there was any such widespread understanding, it did not

⁵² UKSC, [39], item (4)

⁵³ UKSC, [39], item (6). The particular assistance requested may be covered, however, if it forms ‘part of the treatment for a termination’

⁵⁴ UKSC, [39], item (1)

⁵⁵ UKSC, [39], item (1)

⁵⁶ UKSC, [39], item (3)

⁵⁷ UKSC, [36]

⁵⁸ This offence was indicted and convicted in *R v Whitchurch (Thomas William) and Others* (1890) L.R. 24 Q.B.D. 420; the English common law of conspiracy was much wider in the pre-1967 Act era.

encompass major players such as the Royal College of Midwives, since neither of the RCM's constructions of the treatment process was adopted by the Court.

Following the Inner House judgment, it seemed that the lower court had left scope for the judgment of the Supreme Court to 'add value'.⁵⁹ Instead, the highest court relied upon a simplistic formula which rightly found no favour in the Inner House and which collapses under scrutiny. Perhaps the most remarkable thing of all about Lady Hale's judgment is that all of her colleagues were persuaded to join her in it, despite its shortcomings.

⁵⁹ Neal, above n4, 420