Michaelmas Term
[2014] UKSC 68
On appeal from: [2013] CSIH 36

JUDGMENT

Greater Glasgow Health Board (Appellant) *v* Doogan and another (Respondents) (Scotland)

before

Lady Hale, Deputy President
Lord Wilson
Lord Reed
Lord Hughes
Lord Hodge

JUDGMENT GIVEN ON

Wednesday 17 December 2014

Heard on 11 November 2014

Appellant
Brian Napier QC
Hugh Olson
(Instructed by NHS Scotland)

Respondents
Gerry Moynihan QC
Marie Clark
(Instructed by Brodies LLP)

Interveners (Royal College of Midwives and British Pregnancy Advisory Service)
Karon Monaghan QC
Barbara Hewson
(Instructed by Thompsons Solicitors)

LADY HALE: (with whom Lord Wilson, Lord Reed, Lord Hughes and Lord Hodge agree)

1. The Abortion Act 1967 provides a comprehensive code of the circumstances in which it is lawful to bring about the termination of a pregnancy in England, Wales and Scotland. It enlarged and replaced the limited circumstances in which this was recognised as lawful by the common law. It also regulated the procedure. Other than in an emergency, two doctors must be of the opinion that the grounds for bringing about a termination exist and the termination must take place either in a National Health Service Hospital or in a clinic approved for the purpose. While the Bill was going through Parliament, a clause protecting the right of conscientious objection to taking part in an abortion was introduced. This case is about the precise scope of that right.

The relevant legislation

2. As originally enacted, section 1 of the 1967 Act read thus:

> "(1) Subject to the provisions of this section, 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 if two registered medical practitioners are of the opinion, formed in good faith -
>
> > (a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or
> >
> > (b) 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) of subsection (1) of this section, account may be

taken of the pregnant woman's actual or reasonably foreseeable environment.

(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 Minister of Health or the Secretary of State under the National Health Service Acts, or in a place for the time being approved for the purposes of this section by the said Minister or the Secretary of State.

(4) Subsection (3) of this section, and so much of subsection (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."

3. Section 5 of the Act also provided:

"(1) Nothing in this Act shall affect the provisions of the Infant Life (Preservation) Act 1929 (protecting the life of the viable foetus).

(2) For the purposes of the law relating to abortion, anything done with intent to procure the miscarriage of a woman is unlawfully done unless authorised by section 1 of this Act."

4. The Human Fertilisation and Embryology Act 1990 modified the circumstances in which abortion is lawful in two ways. It substituted the following for paragraphs (a) and (b) of section 1(1) of the 1967 Act:

"(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."

5. Section 5 was also amended to read as follows:

(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 purpose 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 purpose 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. The broad effect, therefore, was to introduce a limit of twenty four weeks' gestation for abortions carried out on ground (a), which is far and away the most common of the four grounds (see para 13 below), but to remove the limit provided by the Infant Life (Preservation) Act 1929 for abortions carried out on grounds (b), (c) or (d). It also introduced the possibility of selective

abortion, where a woman is carrying more than one foetus, either in order to abort a foetus which may be seriously handicapped or because the reduction in the number of foetuses she is carrying is justified on one of the other grounds.

7. Section 1(3) has also been amended, and a new section 1(3A) added, by the 1990 and other legislation and now reads as follows:

> "(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 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 subsection (3) of this section to approve a place includes power, in relation to treatment consisting primarily in the use of such medication as may be specified in the approval and carried out in such manner as may be so specified, to approve a class of places."

8. Section 1(3A) reflects a change in the methods by which abortions are generally performed. When the 1967 Act was passed, pregnancies were terminated by surgical procedures to remove the foetus from the uterus. Now they are mostly terminated by the administration of drugs which prematurely induce labour. Current practice is that a patient is given an anti-progestogenic steroid in tablet form followed some 48 hours later by a prostaglandin in pessary form. The patient then undergoes a labour and delivers the foetus, placenta and membrane in the normal way unless surgical intervention is required. Selective reduction in the number of foetuses carried is performed by what is known as feticide, killing one of those foetuses in the womb. Feticide is also carried out where there is a risk of the foetus being born alive following the termination.

9. The change from surgical operations to medical methods of induction of labour led to the first of two cases under the 1967 Act to reach the House of Lords. In *Royal College of Nursing of the United Kingdom v Department of Health and Social Security* [1981] AC 800, the issue was pithily explained by Lord Denning MR in the Court of Appeal:

> "when a pregnancy is terminated by medical induction, who should do the actual act of termination? Should it be done by a doctor? Or can he leave it to the nurses? The Royal College of Nursing say that a doctor should do the actual act himself and not leave it to the nurses. The Department of Health and Social Security take a different view. They say that the doctor can initiate the process and then go off and do other things, so long as he is 'on call'." (p 802)

The majority of the House of Lords (Lord Diplock, Lord Keith of Kinkel and Lord Roskill) held that "when a pregnancy is terminated" in section 1(1) of the 1967 Act meant the whole process of treatment designed to bring that about, and not just the actual ending of the pregnancy. Furthermore, that process was carried out "by a registered medical practitioner" when it was a team effort carried out under his direction, with the doctor performing those tasks that are reserved to a doctor and the nurses and others carrying out those tasks which they are qualified to perform.

10. One reason for reaching that conclusion was that the Act uses the words "termination" and "treatment" apparently interchangeably. In particular, the "conscience clause" in section 4 is headed "Conscientious objection to participation in treatment" and reads:

> "(1) Subject to subsection (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 subsection (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.
>
> (3) In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging

the burden of proof imposed upon him by subsection (1) of this section."

It is common ground in this case that subsection (3) was enacted because of the requirement of corroboration in civil proceedings in Scotland which has since been abolished.

11. It will immediately be apparent 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". That question was addressed by the House of Lords in *R v Salford Health Authority, Ex p Janaway* [1989] AC 537, a case which all parties accept was rightly decided. Mrs Janaway was a secretary and receptionist in a health centre, who objected to typing a letter from a GP at the health centre referring a patient to a hospital consultant with a view to a possible termination. It was held that "any treatment authorised by this Act" meant the process of treatment in hospital for the termination of pregnancy and "participating" meant actually taking part in that process. It did not have the extended meaning given to participation by the criminal law. The House was not concerned, as we are in this case, with what those words mean in the context of hospital treatment.

How this claim came about

12. The petitioners are both experienced midwives employed at the Southern General Hospital in Glasgow. The job which they both held now has the title Labour Ward Co-ordinator. Miss Doogan has worked predominantly in the Labour Ward since 1988, but has been absent through ill-health since March 2010. Mrs Wood worked in the Labour Ward from 1992 until March 2010 when she transferred to work in maternity assessment. Both are practising Roman Catholics who believe that human life is sacred from the moment of conception and that termination of pregnancy is a grave offence against human life. They also believe that any involvement in the process of termination renders them accomplices to and culpable for that grave offence. Each informed their employer, the Greater Glasgow Health Board, of their conscientious objection to taking part in the termination of pregnancy when they began work in the Labour Ward in 1988 and 1992 respectively.

13. Maternity services in Glasgow used to be provided in three hospitals, but in 2004 it was decided to close one of them down. Maternity facilities at the remaining two hospitals, the Southern General Hospital and the Princess Royal Maternity Hospital, were extended and refurbished. The first babies

were born in the new maternity unit at the Southern General Hospital in December 2009. The Fetal Medicine Unit at the closed hospital was transferred to the Southern General Hospital. The vast majority of abortions performed in the United Kingdom are performed on ground (a) (98% in England and Wales and 98.7% in Scotland in the year to 31st December 2012). All medical terminations of pregnancy on that ground at the Southern General Hospital (which by definition are now under 24 weeks' gestation) take place in the Gynaecology Ward, not the Labour Ward.

14. Medical terminations (after 12 weeks' gestation) on the remaining grounds, that is on grounds (b), (c) and (d) in section 1(1) and in the emergencies provided for by section 1(4), take place in the Labour Ward. These are a tiny proportion of all terminations and a tiny proportion of the work of the Labour Ward. Since 2010, there have been about 6000 births a year at the Southern General Hospital and just under 60 terminations a year in the Labour Ward. The majority of these are because of foetal abnormalities (ground (d)) and are particularly distressing for everyone concerned, because these were often wanted babies who may have to be aborted at a late stage of gestation.

15. The practice since 2010 has been that where a foetal abnormality is detected the patient will be transferred to the Fetal Medicine Unit, where she will be counselled about the test results and the options available to her. If she decides on termination, the Fetal Medicine Unit will liaise with the Labour Ward to decide upon a suitable time for her admission and will administer the first dose of medication to induce labour. She will return to the Fetal Medicine Unit 48 hours later. They will contact the Labour Ward to make sure that there is suitable accommodation available and escort her round to the Labour Ward where the remainder of the process will take place. The aim is for no more than one medical termination a day to be scheduled in the ward. Other scheduled work in the Labour Ward includes elective caesarean sections and inductions of labour. Unscheduled work includes normal spontaneous labours or foetal losses and emergency operations. Scheduling the Labour Ward workload is the job of the Labour Ward Co-ordinator.

16. When a patient undergoing a termination is admitted to the Labour Ward, a midwife will be assigned to give her one to one care. This will involve all the usual care of a patient in labour and giving birth - monitoring her condition and stage of labour, pain relief, toileting, delivering the foetus and placenta, supporting the patient and her family through an emotional and upsetting experience, and making the arrangements for the baby once delivered. These will depend upon the family's wishes, but may include helping them with, for example, taking photographs and making funeral arrangements.

17. Terminations where there are medical rather than foetal abnormality issues will generally only reach the Labour Ward because its high dependency care is required and this is rare. Between 2006 and 2010, feticide was carried out in the ultra-sound department at Southern General Hospital and the Labour Ward Co-ordinator would assign a midwife to take care of the patient there. Since 2010, feticide has been carried out in the Fetal Medicine Unit which has its own midwifery staff and the Labour Ward Co-ordinator is no longer involved.

18. The Labour Ward has midwifery staff in bands 5, 6 and 7. Midwives in each band may be assigned to looking after a particular patient. They have to update the Labour Ward Co-ordinator and to seek her guidance, advice and support where appropriate. There is always a band 7 Labour Ward Co-ordinator on duty. The parties have agreed a detailed list of 13 tasks included in her role, covering the management of resources within the ward, booking in patients from the Fetal Medicine Unit, allocating staff to patients, providing guidance, advice, and support to midwives, and on occasions taking a direct part in patient care. It will be helpful to return to that list after the applicable principles have been decided (see para 39 below).

19. These proceedings came about because the petitioners became concerned that the reorganisation of maternity services would result in an increased number of abortions being carried out on the Labour Ward. Up until then it had been possible to "work around" their conscientious objections to playing any part at all in these procedures, by getting someone else to do the tasks which might otherwise have fallen to them. They sought assurances from management that their objections would continue to be respected and accommodated. Being dissatisfied with what they were told, they first raised an informal grievance in September 2009, which was completed in March 2010. They then began the formal grievance procedure, which went through three stages until their grievance was finally rejected at Board level in June 2011. By that stage the outstanding issue was their continued objection to "delegating, supervising and/or supporting staff to participate in and provide care to patients throughout the termination process". The hospital took the view that this did not constitute providing one to one care to patients and that the petitioners could be required to do it.

20. The petitioners then brought judicial review proceedings challenging the decision letters received as a result of the grievance procedure. They were unsuccessful before the Lord Ordinary, Lady Smith, but successful before an Extra Division of the Inner House (Lord Mackay of Drumadoon, Lady Dorrian, and Lord McEwan). The Inner House granted a declarator that:

> "the petitioners' entitlement to conscientious objection to participation in treatment for termination of pregnancy and feticide all in terms of section 4(1) of the Abortion Act 1967 includes the entitlement to refuse to delegate, supervise and/or support staff in the provision of care to patients undergoing termination of pregnancy or feticide throughout the termination process save as required of the petitioners in terms of section 4(2) of the said Act".

21. The Opinion of the Court, delivered by Lady Dorrian, expanded upon this at para 38:

> "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*." (emphasis supplied)

22. The employers appeal to this Court.

Two distractions

23. There was some discussion, at an earlier stage in these proceedings, of the relevance of the petitioners' rights under article 9 of the European Convention on Human Rights. This protects the "right to freedom of thought, conscience and religion," including the freedom "to manifest his religion or belief, in worship, teaching, practice and observance". It is our duty, under section 3(1) of the Human Rights Act 1998, to read and give effect to legislation, whenever it was passed, in a way which is compatible with the Convention rights, so far as it is possible to do so. However, the article 9 right is a qualified right, which may be subject to "such limitations as are prescribed by law and necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others". Refusing for religious reasons to perform some of the duties of a job is likely (following the decision

of the European Court of Human Rights in *Eweida v United Kingdom* (2013) 57 EHRR 213) to be held to be a manifestation of a religious belief. There would remain difficult questions of whether the restrictions placed by the employers upon the exercise of that right were a proportionate means of pursuing a legitimate aim. The answers would be context specific and would not necessarily point to either a wide or a narrow reading of section 4 of the 1967 Act.

24. The better course, therefore, is for this court to decide what that section means according to the ordinary principles of statutory construction. That will then set a limit to what an employer may lawfully require of his employees. But a state employer has also to respect his employees' Convention rights. And the Equality Act 2010 requires that any employer refrain from direct or unjustified indirect discrimination against his employees on the ground of their religion or belief. So, even if not protected by the conscience clause in section 4, the petitioners may still claim that, either under the Human Rights Act or under the Equality Act, their employers should have made reasonable adjustments to the requirements of the job in order to cater for their religious beliefs. This will, to some extent at least, depend upon issues of practicability which are much better suited to resolution in the employment tribunal proceedings (currently sisted pending the resolution of this case) than in judicial review proceedings such as these.

25. It is also not for this court to speculate upon the broader consequences of taking a wide or a narrow view of the meaning of section 4. On the one hand, the interveners have argued that to give a broad scope to the right of conscientious objection will put at risk the provision of a safe and accessible abortion service, available to all pregnant women who need and want it, in accordance both with the purpose of the 1967 Act and with a number of international instruments dealing with women's reproductive rights. Furthermore, it may encourage other employers to adopt the policy adopted by the British Pregnancy Advisory Service, of refusing to employ anyone who has any conscientious objection to abortion (on the basis that the lack of such objection is a genuine occupational qualification for the jobs they offer).This reduces the job opportunities available to highly skilled and experienced midwives whose objections may not be as extensive as those of these petitioners.

26. Coming as they do from the Royal College of Midwives and the British Pregnancy Advisory Service, such views are obviously worthy of respect. On the other hand, the petitioners argue that to adopt a narrow interpretation of their right of conscientious objection will unreasonably restrict, not only what they say is a fundamental right, but also the job opportunities which will be available to them. Both sides, in other words, argue that adopting a wide or a

narrow interpretation of section 4 will restrict the job opportunities of qualified midwives and other health care professionals and workers and in doing so may put at risk the accessibility of the service.

27. We do not have the evidence with which to resolve those arguments. We can agree with Lord Diplock, in the *Royal College of Nursing* case (p 827D), that the policy of the 1967 Act was clear. It was to broaden the grounds upon which an abortion might lawfully be obtained and to ensure that abortion was carried out with all proper skill and in hygienic conditions. For my part, I would agree with the interveners that the policy was also to provide such a service within the National Health Service, as well as in approved clinics in the private or voluntary sectors. The mischief, also acknowledged by Lord Diplock, was the unsatisfactory and uncertain state of the previous law, which led to many women seeking the services of "back-street" abortionists, which were often unsafe and, whether safe or unsafe, were offered by people who were at constant risk of prosecution and, as Lord Diplock put it, "figured so commonly in the calendars of assizes in the days when I was trying crime" (p 825F). The conscience clause was the *quid pro quo* for a law designed to enable the health care profession to offer a lawful, safe and accessible service to women who would previously have had to go elsewhere. But we are not equipped to gauge what effect either a wide or a narrow construction of the conscience clause would have upon the delivery of that service, which may well differ from place to place. Our only safe course is to make the best sense we can of what the section actually says.

The construction of section 4

28. We have been presented with a spectrum of constructions of "participating in any treatment authorised by this Act to which he has a conscientious objection". This must be read together with section 1 of the Act, which prescribes the conditions under which a pregnancy may lawfully be terminated. As was pointed out in the *Royal College of Nursing* case, although section 1(1) does not use the term "treatment" at all, the termination of pregnancy must be the treatment referred to in section 4.

29. However, no-one suggests that the conscience clause is limited to the actual ending of the pregnancy, that is, when the pregnancy comes to an end because the woman has been delivered of the foetus. In a surgical termination of pregnancy, the events are simultaneous, but in a medical termination, they are not. In a medical termination, it would make no sense to make lawful the ending of the pregnancy without also making lawful the prescribing and administration of the drugs which bring that termination about. Rather, at one end of the spectrum, the Royal College of Midwives argue 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.

30. This may be a little narrower than the guidance given by the Royal College in their 1997 position paper on conscientious objection. This states that "[t]he RCM believes that the interpretation of the conscientious objection clause should only include direct involvement in the procedure of terminating pregnancy" and "[t]he RCM is of the opinion that the conscientious objection clause solely covers being directly involved in the procedures a woman undergoes during the termination of pregnancy whether surgically or medically induced".

31. At the other end of the spectrum, the petitioners argue that they have the right to object to any involvement with patients in connection with the termination of pregnancy to which they personally have a conscientious objection. The exercise of conscience is an internal matter which each person must work out for herself. It is bound to be subjective. In their case, as practising Roman Catholics, their objections extend to receiving and dealing with 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).

32. The appellant employers argue for an interpretation in between the other two. "Treatment authorised by this 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". So the conscience clause does not cover making bookings or aftercare for patients who have undergone a termination. Nor does it cover fetching the drug before it is administered. "Participating" is limited to direct participation in the treatment involved. 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.

Discussion

33. This is, as already stated, a pure question of statutory construction. Section 4(1) of the 1967 Act refers to "treatment authorised by this Act" but section 1(1) does not in so many words refer to "treatment" at all. Nevertheless, the section is headed "Medical termination of pregnancy". Section 1(1) makes lawful the termination of a pregnancy by a registered medical practitioner in certain circumstances. Section 1(4) also refers to the termination of a pregnancy by a registered medical practitioner and modifies the circumstances in which it is lawful. Section 1(3) refers to "any treatment for the termination of a pregnancy". Hence, as the House of Lords decided in the *Royal College of Nursing* case, what is authorised by the Act is *the whole course of medical treatment bringing about the ending of the pregnancy*. By virtue of section 5(2), any other conduct which is prohibited by sections 58 and 59 of the Offences against the Persons Act 1861 in England and Wales or by any rule of law in Scotland remains a criminal offence.

34. Thus I would agree with the appellants that the course of treatment to which the petitioners may object is the whole course of medical treatment bringing about the termination of the pregnancy. It 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, which may require the assistance of forceps or an episiotomy, or in some cases an emergency Caesarian section, and the disposal of the foetus, placenta and membrane. In some cases, there may be specific aftercare which is required as a result of the process of giving birth, such as the repair of an episiotomy. But the ordinary nursing and pastoral care of a patient who has just given birth was not unlawful before the 1967 Act and thus was not made lawful by it.

35. These conclusions are supported by the exception in section 4(2), which provides that the right of conscientious objection does not 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. One would expect this duty to cover any medical and nursing care during the process of termination and delivery which was necessary for those purposes.

36. In *Janaway* [1989] AC 537, 572 Lord Keith pointed out that such an interpretation would not cover the doctors forming the opinions required by

section 1 and signing the certificates to that effect (provided for in the Regulations made under section 2(1)(a) of the Act). These certificates have to be given before the "treatment for the termination of pregnancy" begins. It is in any event hard to see them as part of the treatment process. They are a necessary precondition to it. It follows that they are not covered by the conscience clause in section 4(1). Nevertheless, we understand that the contractual arrangements made by the NHS with GPs, and the employment contracts made with hospital doctors, do in practice contain such clauses.

37. The more difficult question is what is meant by "to participate in" the course of treatment in question. The employers accept that it could have a broad or a narrow meaning. On any view, it would not cover things done before the course of treatment began, such as making the booking before the first drug is administered. But a broad meaning might cover things done in connection with that treatment after it had begun, such as assigning staff to work with the patient, supervising and supporting such staff, and keeping a managerial eye on all the patients in the ward, including any undergoing a termination. A narrow meaning would restrict it to "actually taking part", that is actually performing the tasks involved in the course of treatment.

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. 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 those acts. 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 (for example, by assigning some terminations to the Labour Ward, some to the Fetal Medicine Unit and some to the Gynaecology Ward), 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. 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. "Participate" in my view means taking part in a "hands-on" capacity.

39. It is helpful to test these principles against the agreed list of the tasks included in the petitioners' role as Labour Ward Co-ordinators:

(1) management of resources within the Labour Ward, including taking telephone calls from the Fetal Medicine Unit to arrange medical terminations

of pregnancy; this is not covered by the conscience clause as interpreted above;

(2) providing a detailed handover within the Labour Ward to the new Labour Ward Co-ordinator coming on shift; this is not covered by the conscience clause as interpreted above (but a way round would be to refer to the allocated midwife for details);

(3) appropriate allocation of staff to patients who are already on the ward at the start of the shift or who are admitted in the course of the shift; this is not covered by the conscience clause as interpreted above;

(4) providing guidance, advice and support (including emotional support) to all midwives; this is only covered insofar as it relates to guidance, advice and support directly connected with the care of a particular patient undergoing a termination, such as whether to administer another round of drugs, as opposed to the ordinary monitoring of any patient on the ward;

(5) accompanying the obstetricians on ward rounds; this would not be covered by the conscience clause as interpreted above, except to the patients undergoing terminations; but there would be little that a midwife with conscience objections could contribute to such a ward round for patients undergoing a termination;

(6) responding to requests for assistance, including responding to the nurse call system and the emergency pull; responding by itself is not covered; it would depend upon the assistance requested whether it was part of the treatment for a termination;

(7) acting as the midwife's first point of contact, if the midwife is concerned about how a patient is progressing; in itself, this is not covered; but the assistance required may be, depending upon what it is; and if assistance is required with the course of treatment leading to a termination, the Labour Ward Co-ordinator should refer to someone else who does not share her conscientious objection to assisting;

(8) ensuring that midwives on duty receive break relief, which may mean that the Labour Ward Co-ordinator provides the break relief herself; ensuring break relief is not covered but providing it oneself is covered;

(9) being present to support and assist if medical intervention is required, for example, instrumental delivery with forceps; this is covered by the conscience clause as interpreted above;

(10) communicating with other professionals, eg paging anaesthetists; this is a managerial task which is not covered by the conscience clause as interpreted above;

(11) monitoring the progress of patients to ensure that any deviations from normal are escalated to the appropriate staff level, eg an obstetrician; responding to and passing on the judgment of the treating midwife is an administrative task not covered by the conscience clause as interpreted above; however, forming the judgment personally would be taking part in the treatment;

(12) directly providing care in emergency situations; this is covered by the conscience clause, unless falling within section 4(2) as it normally would;

(13) ensuring that the family are provided with appropriate support; this is not covered by the conscience clause as interpreted above. It is not treatment authorised by the Act as it has never been unlawful. However, as with helping with arrangements after the baby is delivered, it may be reasonable to expect an employer to accommodate an employee's objections, in the interests of providing the family with the most effective service.

40. Whatever the outcome of the objectors' stance, it is a feature of conscience clauses generally within the health care profession that the conscientious objector be under an obligation to refer the case to a professional who does not share that objection. This is a necessary corollary of the professional's duty of care towards the patient. Once she has assumed care of the patient, she needs a good reason for failing to provide that care. But when conscientious objection is the reason, another health care professional should be found who does not share the objection.

41. I would therefore allow this appeal and set aside the declarator made in the Inner House. I would invite further submissions on quite what, if any, order or declarator should replace it.