SECOND DIVISION, INNER HOUSE, COURT OF SESSION

[2019] CSIH 31
P61/18

Lord Justice Clerk
Lord Menzies
Lord Brodie

OPINION OF THE COURT

delivered by LADY DORRIAN, the LORD JUSTICE CLERK

in the Appeal

by

SPUC PRO-LIFE LTD

Appellant

for

JUDICIAL REVIEW OF A DECISION OF THE SCOTTISH MINISTERS

Appellant: M Ross QC; Komorowski; Burness Paull
Respondent: L Dunlop QC; O'Neill, Sol Adv; Scottish Government Legal Directorate

22 May 2019

Introduction

[1] This is a reclaiming motion by SPUC Pro-Life Scotland in respect of the Lord Ordinary's refusal on 15 August 2018 of a petition for judicial review of the Scottish Ministers' decision to issue the Abortion Act (Place for Treatment for the Termination of Pregnancy) (Approval) (Scotland) 2017 ("the Approval"), authorising a pregnant woman's home as a class of place where the second stage of treatment for an early medical

termination of pregnancy (EMT), which involves the taking of a drug by tablet or pessary, could be carried out.

[2] The reclaimer contended that the decision made by the respondent to grant the Approval was unlawful, on the basis that (i) a woman's "home" was not a permissible class under the Abortion Act 1967 ("the Act"); and (ii) the Approval ran counter to the requirement under the Act for an abortion to be carried out by a medical practitioner. The Lord Ordinary rejected these arguments, holding that a woman's home where she wishes to take the second stage of an EMT was a permissible "class of place" in terms of section 1(3A) of the Act; and that the treatment anticipated by the Approval continued to be a treatment "by a medical practitioner" in terms of section 1(1) of the Act.

The Abortion Act 1967

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

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

The terms of section 1(3) are in essence unchanged since enactment, when the provision was that treatment required to take place in an NHS hospital or a place approved by the Secretary of State. Subsection 1(3A) was added by the Human Fertilisation and Embryology Act 1990.

Early Medical Termination

[4] The Approval, and thus the subject matter of the reclaiming motion before this court, relates to the second stage of the termination of pregnancy by the use of pharmaceutical, rather than surgical, means. Our understanding is that it can take place only during the first 9 weeks + 6 days of pregnancy. The process involves the administration of two prescribed drugs normally taken some 24-48 hours apart following medical consultation. The first drug is mifepristone. It works by blocking progesterone, a hormone necessary for the continuation of pregnancy. It is taken, following consultation with a medical practitioner, in tablet form in a hospital, clinic, or other place or class of place approved under the Act. The second drug is misoprostol. It can be taken in tablet or pessary form. It is normally taken 24-48 hours after mifepristone. It has the medical effect of initiating the expulsion of the foetus, thus terminating the pregnancy.

The Approval

[5] In exercise of their powers under section 1(3) and (3A) of the Act the Scottish Ministers granted the Approval under challenge on 26 October 2017. In summary it approves, under paragraph 3, the home of the pregnant woman undergoing treatment as a "class of place" where termination of pregnancy may be carried out. Treatment is defined as the taking of the medicine known as misoprostol. "Home" is defined as a place in Scotland where the pregnant woman is ordinarily resident.

[6] The home as a class of place is only approved if the treatment is carried out in the manner specified in paragraph 4, namely that (a) the pregnant woman has attended a clinic where she has been prescribed mifepristone and misoprostol to be taken for the purposes of termination of her pregnancy; and (b) that the mifepristone has been taken at that clinic and that the woman wants to carry out the treatment at her home.

[7] The reclaimer's challenge relates only to the moment of the taking of or self-administration of misoprostol by the woman at home, not the period afterwards. The reason for this appears to be that, even if misoprostol were taken in a clinic, a woman would still be able to leave the clinic immediately after it is taken.

[8] For the purposes of their argument, the reclaimers thus accepted that the treatment was concluded once the second stage drug had been taken. For the purposes of this case the respondents accepted that treatment did not conclude in advance of the taking of the second tablet, and continued up to and including that point. In other words, it was a matter of agreement that prescription of the medication was not sufficient to constitute treatment.

The submissions for the reclaimer

[9] The reclaimer appeals the Lord Ordinary's decision on two grounds submitting that (1) the Lord Ordinary erred in holding that a pregnant woman's home, where the self-administration takes place, could be a "class of place" which might be approved in terms of section 1(3A) of the Abortion Act 1967; and

(2) the Lord Ordinary erred in holding that self-administration at home of the second stage abortifacient could constitute treatment "by a registered medical practitioner" ("RMP") in terms of section 1(1) the Act.

Introductory submissions

[10] The Act places significant restrictions on the carrying out of abortions. These relate to the duration of the pregnancy (not exceeding 24 weeks) and the conditions which must be met regarding the risk to the health of the woman or baby. For the present argument, there are important restrictions relating both to the person who may administer the treatment – the effect of section 1(1) is that the treatment has to be carried out by a registered medical practitioner; and the place – it must be in a National Health Service hospital or other approved place or class of place. The Act creates a strict scheme setting out the parameters within which abortion may lawfully be carried out: the Approval is *ultra vires* as being outwith that scheme. The restrictions contained in the Act have the purpose of ensuring that abortion takes place in conditions considered to be safe and suitable. The purposes of the Act were first, to broaden the grounds upon which abortions may lawfully be obtained; and second, to ensure that the abortion is carried out with all proper skill and in hygienic conditions (*Royal College of Nursing* v *DHSS* [1981] AC 800 ("*RCN*"), per Lord Diplock at 827D-E, cited with approval in *Doogan* v *Greater Glasgow Health Board* [2015] SC (UKSC) 32, para 9).

[11] At the time of the passing of the Act, the possibility of the development of pharmaceutical termination was anticipated, as can be seen from the discussion in the minutes of the meeting of Standing Committee F regarding the Medical Termination of Pregnancy Bill, 1 March 1967 at column 348 and the passages referred to by Supperstone LJ at paragraph 28 in *BPAS.* Both parties agreed to the use of and reference to Hansard for the limited purpose of the discussion before the court- namely the contextual circumstances under which the Act and any subsequent amendments were introduced (*R (Westminster City Council)* v *National Asylum Support Service* [2002] 1 WLR 2956, Lord Steyn at paragraph 5).

Pharmaceutical termination was certainly anticipated at the time of *RCN*, because that very possibility had been referred to at first instance by Woolf J. It could not be said therefore that the provisions of the Act, or the observations made in *RCN* were relevant only to surgical abortion or a more complex type of medical intervention. In these circumstances the Lord Ordinary had placed undue emphasis on changes in the practice of medical abortion.

[12] The Approval allows treatment to take place in the absence of a medical practitioner and at the woman's home, neither qualification being connected to restricting treatment to a safe and suitable location. These qualifications are incompatible with the legislature's assessment of what either safety or suitability requires. It is not open to the respondents to act in a way incompatible with the legislation, and the Approval is *ultra vires.*

The individual grounds of appeal were addressed in reverse order.

Treatment by a RMP

[13] The requirement for treatment to be by a RMP is over and above the requirement that at least one, and normally two, RMPs must have formed the opinion that the conditions for a lawful abortion were met. The extent of the required involvement of RMPs in the process was an important aspect of the Act. Self-administration at home does not constitute treatment by a registered medical practitioner in terms of section 1(1) of the Act. A registered medical practitioner must be responsible for, in the sense of being in charge of, the treatment throughout the termination and to its conclusion. The Approval does not require the misoprostol to be taken under supervision of a RMP or otherwise ensure that the RMP is in charge or control at the point when the drug is administered. A pregnancy is only terminated by a RMP where such a practitioner remains in charge or in control of the course

of treatment until its conclusion - *RCN* per Lord Diplock (828G/829A), Lord Keith of Kinkel (835B/C), and Lord Roskill (838B/D). In *RCN,* whilst accepting that every physical step did not require to be carried out by the RMP, Lord Diplock placed crucial reliance on section 1(3) of the Act which provided for hospitals to be the default location for treatment. Thus "Parliament contemplated …. like other hospital treatment, it would be undertaken as a team effort" (828C-D). In the present case, the treatment in question is only complete when the second medication is taken, it is not completed by prescription or dispensing, as the respondents have accepted (*British Pregnancy Advisory Service* v *Secretary of State for Health* [2012] 1 WLR 580 ("*BPAS"*), paras 23-25.)

[14] For the purpose of control, the Lord Ordinary relied upon there being knowledge of where the woman will be "coupled with the ability to make contact with the medical practitioner, should that be required." This involved a degree of speculation, but even if the ability to make contact with a medical practitioner existed, this was not an adequate means of control. The Lord Ordinary had also made certain assumptions (para 42) about the availability of medical assistance which were unwarranted on the basis of the information before her.

[15] Parliament had introduced section 1(3A) in respect of pharmaceutical abortion in 1990, at a point when it must be assumed that it was aware of the interpretation given to section 1(1) in *RCN.* Despite that knowledge it had not made changes to subsection 1 to remove or otherwise lift the restrictions on the need for treatment to be by a RMP, something which it could easily have done to facilitate the use of the methods presently in question.

[16] It was submitted that the patient's participation in pharmaceutical abortion made no material difference. The Lord Ordinary's focus on aspects of patient consent and

participation in her opinion (para [41]) was misplaced, and overlooked the fact that the very nature of the legislation limited the pregnant woman's freedom of choice in determining how or where termination might take place.

Specification of home as a class

[17] Sections 1(3) and 3(A) were intended to put meaningful restrictions on where treatment may take place, based upon the characteristics and suitability of the place or class of places. The power to approve a class presupposed that it was safer and or more suitable for abortions to take place in some places than in others. It could not be enough, to justify the breadth of the class, that the method of abortion was assessed to be safe wherever it took place, or that any place would be suitable, as this might permit the inclusion of any and every place, which Parliament had not allowed. Places within the approved class must be safer and or more suitable than those outwith the class.

[18] The Lord Ordinary was wrong to find that the class involved a "significant restriction" (para [31]), the basis of which was that "the medical practitioner is to have ongoing responsibility for the woman's treatment while she is at home". This does not explain why the woman's treatment ought to take place at her home rather than some other place notified to the medical practitioner, or why the medical practitioner would require to know the woman's location beforehand given that this could be intimated if and when medical assistance was called upon.

[19] The Lord Ordinary held that a pregnant woman's home was "*prima facie* suitable", from which it followed that not all of the places in the class would be suitable. It was not sufficient to rely upon the medical practitioner and pregnant woman to ensure that the administration of misoprostol did not take place in unsuitable homes. The nature of the

legislation entailed that all these matters should not be left in the hands of the practitioner or patient.

Submissions for the respondent

Introductory submissions

[20] It was important to note that these proceedings concerned termination of pregnancy by pharmaceutical rather than surgical treatment. The extent of the change permitted by the Approval was limited. Instead of administration of both drugs taking place at a hospital or other place specifically approved for the purpose, such as a clinic, the second drug could now be taken at home.

Treatment by a RMP

[21] The Lord Ordinary did not err in concluding that a woman ingesting a tablet or inserting a pessary at home was undergoing treatment by a registered medical practitioner. "Treatment" for the termination of pregnancy in terms of the Act had a wide meaning, (*BPAS; Doogan)* the corollary of which was that it was not necessary for a doctor to be in the physical presence of the pregnant woman throughout that treatment.

[22] It was not inherent in the Act that to ensure compliance there had to be some means of active control by a RMP throughout the treatment. Section 1(1) did not carry with it a requirement that a RMP did everything comprised in treatment by his or her hand: it did not require active control by a registered medical practitioner throughout the treatment, including at the moment of administration of misoprostol. Rather, a doctor should accept responsibility for all stages of the treatment for the termination of pregnancy; and in doing so he or she may give instructions as to the carrying out of such parts of the treatment which, in accordance with accepted medical practice, could be carried out by others. As *per*

RCN at 828B to 829A, a doctor or his substitute should be available to be called upon at all stages of the treatment.

Home as a class of place

[23] The respondent did not accept the reclaimer's position that an approval under section 1(3A) had to constitute a "meaningful restriction".

[24] The mischief that the Act was directed at was the unsatisfactory and uncertain state of the previous law, and the consequent reliance by many women on the services of "back street" abortionist which were often unsafe – see *Doogan* at [27]. This was addressed by a policy of bringing abortion under public administration, rather than it being a covert activity. At the time of the Act the "place" where the procedure, which was a surgical operation, was to be carried out was a NHS hospital or in particular places specifically approved. An initial provision for termination to take place in "registered nursing homes" was removed at the committee stage. The context of that removal was due to what was referred to as "racketeering" in Hansard. While the Act did not present the sort of difficulty in interpretation such as to bring it within the territory of *Pepper* v *Hart [1993] AC 593*, it was permissible to consult Hansard in order to appreciate the context of the Act as part of the process of construing the legislation. Parliamentary material from 1967, namely Hansard minutes of Standing Committee F regarding the Medical Termination of Pregnancy Bill on 1 March 1967 at columns 346-347, revealed that an additional element addressed in the creation of the legislative framework for the Act was the regulation of activity in the private sector, preventing racketeering or exploitation of human suffering for financial gain. For this reason, private or voluntary clinics, unlike NHS hospitals, were not approved *en bloc* but individually.

[25] The fact that a hospital might have been the default place in 1967 did not justify a general conclusion about the nature of the place which might be subject of later approval, either on an individual or class basis.

[26] It was accepted that safety was relevant to the question of place, the safety of NHS hospitals having been part of the reason for their general approval in relation to surgical terminations. However, "safety" in that context at the time the Bill was enacted meant safety in relation to surgical operations. As the Lord Ordinary had explained (para [28]), the remarks made by Lord Diplock on hygiene (and safety) in *RCN* at 827D, should be understood within the context of the process which was under examination at that time, which was akin to a surgical procedure. Judicial commentary made in the authorities referred to had to be considered in the context of and with reference to the facts and the procedure concerned in each case. Such dicta should not be given quasi legislative effect.

[27] When the whole decision of *RCN* was read and understood in context of the medical procedure in use at the time, there was no basis for isolating any single feature to be preserved for all time.

[28] The principle underlying the specification of "place" was suitability. Safety was part of suitability, but suitability was not restricted to safety. It also included the issues of monitoring and control already referred to. Once the provision concerning "place" was understood in that context, the amendment forming subsection (3A), as introduced in 1991, could be construed. Its introduction coincided with the licensing of the drug mifepristone for use in the UK. The purpose of the amendment was to permit the approval of places to proceed by way of designation of a class rather than of individual premises, where abortion by pharmaceutical means was concerned.

[29] There was no suggestion of an intention to approve a class of place only if those places were safer than places not included in the class. Approval of places was also connected to prevention of exploitation. As the Lord Ordinary observed at paragraph [32] of her opinion, as with the original provision 1(3), the issue was one of suitability, and suitability in the context of the activity to be undertaken. The activity that the court was concerned with here was the taking of a tablet or the insertion of a pessary. The question therefore was whether, in general, the homes of women undergoing abortion could be regarded as suitable places in which to take a tablet or insert a pessary. The reclaimer had failed to evidence why it was not so. In answering the question, it was legitimate to take in to account factors such as comfort, privacy and avoidance of further travel while the medication took effect. The respondent had accordingly acted *intra vires*. The Lord Ordinary had not erred.

Analysis and decision

Treatment by a RMP

[30] In our view the concept of "treatment" requires to be given a wide interpretation, in common with the authorities to which we were referred. Moreover, it is important to bear in mind that what constitutes "treatment" may vary according to context, and in particular in light of the nature of the procedure being undertaken. We therefore agree with the Lord Ordinary that a purposive rather than a literal interpretation is called for. In *RCN* the process involved was one which took a period of some 18-30 hours involving the infusion of an abortifacient drug, prostaglandin, into an extra-amniotic catheter and the introduction into the blood stream via a cannula of another drug oxytocin. The part played by nurses in the treatment was noted to be of greater importance as well as longer than when a purely

surgical method was employed. It was in this context of a "hospital" having been designated as the place of such treatment that the concept of treatment as part of a "team" was discussed (Lord Diplock, p 828 C-D). It does not follow, however, either that only a hospital may be classed as a place for treatment, or even that it will be an inevitable fact that treatment will involve a team effort. Much will depend on the individual facts of the case.

[31] As Lord Keith noted in *RCN* (p 835 A-B) the question for the court in that case was to consider whether, "on the facts of this case" the termination could properly be regarded as being by a registered medical practitioner. In our view, in *RCN* the court was not laying down a fixed definition of treatment to apply in all cases and in all circumstances. In each case the context is vitally important. Accordingly, whilst we accept that there is a requirement for the RMP to have responsibility for the treatment and to retain a degree of control over it, what will satisfy that requirement will be a matter of fact and degree according to the nature of the process involved in the treatment. The Lord Ordinary was correct to note the way in which medical practice in this field had evolved over time, and to consider these changes to be relevant to the issues which she required to address.

[32] The Lord Ordinary's observation that the "team" continues to exist but that the woman now requires to be an active participant in it is consistent with the modern approach to patient autonomy, but we do not consider it to be a crucial part of the analysis under which she concluded that the Approval was *intra vires*. The real significance of the *RCN* case is the determination that not all acts directed to the termination of pregnancy require to be carried out personally by the RMP. The fundamental point, made by Lord Diplock (p828H – 829A), is that:

> "the requirements of the subsection are satisfied when the treatment for termination of a pregnancy is one prescribed by a registered medical practitioner carried out in

> accordance with his directions and of which a registered medical practitioner remains in charge throughout."

[33] The RMP in charge of the treatment, who has advised the patient and arranged for the administration of the first medication in the clinic, does not cease to be in charge of the treatment merely by virtue of prescribing the second medication to be taken or administered at home, any more than he would cease to be in charge in a clinic by prescribing a medicine to be handed to the patient by a nurse. We agree with the Lord Ordinary (para 40) that:

> "patients who self-administer medication at home may still be described as being treated by their medical practitioner who remains in charge of that treatment."

The reclaimer argued that even if the woman could make contact with a medical practitioner after returning home, this did not constitute an adequate means of "control" as required under the Act. The extent to which a woman would actually find it necessary to contact a doctor for the purpose of self-administration of the pill (or pessary), rather than in relation to subsequent events, in respect of which the woman at home would be in exactly the same position as the woman sent home after taking the pill in a clinic, is questionable. The potential to require further medical intervention seems more likely to apply to the period after the administration of misoprostol, which is not the subject of the reclaimer's argument before this court. The reclaimer gave the example of a woman being uncertain or being unable to distinguish between the mifepristone and an analgesic prescribed to relieve the pain which may be suffered subsequently during the expulsion of the pregnancy. Such an example is verging on fanciful and gives very limited credit to the medical professional who will speak to the woman at the clinic, provide advice and dispense the medication. Even if an issue arose at the time when the woman wanted to take the pill or pessary, there is no requirement that she must be able to make contact with the treating doctor personally – a substitute may be nominated (*RCN* at 828 H). The argument that the RMP cannot be

considered in charge of the treatment when the medication is taken at home ignores the general clinical setting in which this process occurs: it is important to recognise that the Approval only operates at the second stage of the procedure, namely after the woman has attended a clinic, been prescribed mifepristone and misoprostol, has in fact taken the first drug at the clinic and wants to take the second drug at home. It is inevitable that the method of taking the drug, or applying the pessary, will have formed part of the discussion between doctor and patient.

[34] The Lord Ordinary concluded (at paragraph [41]) that the requirement for control was sufficiently met by the doctor's knowledge of where the woman would be "coupled with the ability to make contact with the medical practitioner, if required". We agree with her conclusion. We do not accept that this involves a degree of speculation about any arrangements which might be made. Given the nature of the treatment which is being undertaken, the terms of the Guidance (binding or not), the doctor's overriding duty to patients and his or her knowledge of the specific requirements of the Act, it is a logical inference that details of the patient's location would be noted on file and available to the doctor or those under his supervision to facilitate contact with the woman and for contact details of a suitable practitioner to be made available to the woman to do likewise. We have no difficulty in sharing the Lord Ordinary's view that the topic of where the drug is likely to be taken and who may be available to assist the woman is more than likely to have been the subject of discussion. We do not consider that the process under the Approval differs substantially in the element of control from the pre-Approval practice where the drug is taken at the clinic and the patient thereupon returns home. We do not accept that the doctor's control or supervision over the treatment differs in any material way between the situation of taking the tablet within the clinic and then leaving; and that of delaying the

taking of the tablet to allow the woman to travel home. Both result in the termination of the pregnancy taking place outside of the clinic. In each case the RMP can properly be described as taking responsibility for the treatment of the termination of the pregnancy and control in the appropriate sense is maintained.

[35] Nor do we agree with the contention that the Lord Ordinary (at para [42]) made certain unwarranted assumptions about the availability of medical assistance to a woman taking misoprostol at home but seeking to make contact with a doctor. How hospitals, clinics, and GP practices operate generally and the availability of appropriately trained staff to respond to all queries, concerns and emergencies via out-of-hours services and NHS 24 phone lines, are concepts within the knowledge of the general public. The Lord Ordinary's approach was no more than a logical application of this information to the specific treatment under consideration.

[36] The requirement within the Guidance (but not the Approval) that someone be at home with the woman at the time of self-administration was said to indicate a deficiency in the Approval. It was argued that if such a requirement were necessary, it should be in the Approval, not left to a Guidance document. However, in the course of argument we were advised that while each NHS health board in Scotland has its own guidance, a woman who is prescribed and takes misoprostol at a clinic and then returns home is also recommended to have someone at home with her. There is accordingly no difference between an EMT carried out under the Approval and one where the woman returns home following administration in this regard. The Approval does not specify that the second stage administration **must** be carried out at the woman's home, it merely permits it to take place there. Whether the Approval will be taken advantage of will be an issue of professional, clinical judgment by the professionals involved in the treatment.

Home as a class of place

[37] Although it was asserted on behalf of the reclaimer that the two grounds of appeal stood alone it is hard in our view to see that this is so. Pressed on the issue, concerning the class argument, counsel for the reclaimer was repeatedly drawn back to arguments relating to the absence of, or lack of control by, a RMP which formed the basis of the second ground of appeal, or which tended towards an argument on rationality. Such an argument had not been raised hitherto and counsel for the reclaimer specifically eschewed such an argument, confirming that her submissions were based solely on an argument that the Approval was, in respect of both grounds, *ultra vires*. The legislation confers a very broad discretion on Ministers to approve a place or class of place where the termination of pregnancy may take place. The submission for the reclaimer was that the conditions of the Approval, as to place or in relation to RMP, were "incompatible with the legislature's assessment as to what suitability and safety require." However, qualifications that the place be safe and suitable are not in the legislation. Whilst we would have little difficulty in accepting that safety and suitability may be relevant considerations in the choice of place, these are very relative terms, which take their real meaning from the nature of the activity to be carried on there. The arguments advanced regarding safety and suitability would appear to be arguments more suited to a rationality challenge than the *vires* challenge mounted by the reclaimer. Reference during argument to features such as the degree of hygiene within the home, and similar issues, would appear to have no relevance to the question whether it was within the power of Ministers to approve such a place, as opposed to a question of the rationality of doing so, a line of argument which was clearly disavowed. The reality is, it seems to us, that the reclaimer's argument on the first ground of appeal is inextricably linked with the second:

in essence the argument is that the home is not a valid class because an RMP is not present or in active control.

[38] Even if it may be implied that safety and suitability are essential requirements of a class of place to be approved, the relative nature of these terms must be taken into account. In the present case the activity taking place is restricted to the taking of a tablet or use of a pessary. The Lord Ordinary was correct in our view to say that the class of place need only be safe and suitable for the specific purpose permitted in the Approval, namely the taking of the medication. The Lord Ordinary was right to differentiate between "a class of place that is capable of being suitable for the limited purpose stated in the Approval from a requirement that, as a matter of fact every place in the category is safe in a general sense". It is not possible, from the mere fact that an NHS hospital was selected as the default location for surgical abortions in 1967, to infer an absolute standard of safety and suitability which must apply to all places where pharmaceutical termination may take place. We agree with comments made by counsel for the respondent about the 'absolutist' nature of the arguments advanced for the reclaimer in this respect. If safety and suitability are concerns, they must relate to the activity in question and should not be assessed by reference to the qualities of other premises which may be safe to a greater or lesser degree. The reclaimer's submission that there is an assumption that places inside the class are safer and more suitable than those outside the class fails in our view as there may be other reasons, including policy ones, why establishments, perfectly safe and suitable, are nevertheless not approved as a class. In the reclaimer's note of argument it was submitted that the Lord Ordinary's findings that a home was *prima facie* suitable meant that it followed that some homes would not be and that "this raised a question as to the nature of the exercise of approval entailed in approving a class if not all the members of the class needed to be

suitable". That appears to us to be a clear rationality issue and not a *vires* one. The reclaimer has been unable convincingly to explain why an outpatient clinic or GP's premise would necessarily be a "safer" or more suitable place to take a tablet or pessary than the woman's home.

[39] For all of the foregoing reasons the reclaiming motion will be refused.