Commentary

Greater Glasgow Health Board (Appellant) v Doogan & Another (Respondents) [2014] UKSC 68

Conscientious objection and abortion

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Abstract:

This commentary considers the Supreme Court's recent judgement in Greater Glasgow Health Board (Appellant) v Doogan & Another (Respondents) and the challenging issue of conscientious objection in the context of abortion.

Background

The appeal in Doogan[1] concerned two midwives employed as Labour Ward Co-ordinators in the NHS in Scotland (the 'respondents'). Their role entailed a number of tasks including the admission of patients, the allocation of staff and the supervision and support of other midwives. They objected to these tasks in connection with patients undergoing terminations of pregnancy. They asserted a 'right' of conscientious objection under section 4(1) of the Abortion Act 1967 (as amended). That section is framed in negative terms 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'*

The conscience section is further limited by section 4(2)[2] that provides:

'(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'

The respondents were unhappy with the arrangements made to address their objections and mounted a grievance against their employers. They subsequently brought judicial review proceedings against the Health Board (the 'appellant'). The respondents were unsuccessful before the Lord Ordinary in the Outer House of the Court of Session[3] but succeeded on their

[1] Greater Glasgow Health Board (Appellants) v Doogan & Another (Respondents) [2014] UKSC 68
[2] Abortion Act 1967
[3] The judgement was delivered by Lady Smith

appeal before the Extra Division of the Inner House[4] who granted a declaration that the scope of section 4(1) included 'the entitlement to refuse to delegate, supervise and/or support staff in the provision of care to patients' undergoing terminations save as required by s 4(2)'. The difference between the Outer and Inner Houses rested on the interpretation of 'to participate in any treatment authorised by' the Abortion Act 1967. The Outer House adopted a narrow interpretation whereas the Inner House adopted a wide interpretation that extended section 4(1) to '**any involvement** in the process of treatment, the object of which is to terminate a pregnancy'.

The Health Board brought an appeal to the Supreme Court and Lady Hale gave the sole judgement that was formally agreed by the other four judges (Lords Wilson, Reed, Hughes and Hodge). The appeal was successful for the following reasons:

- The only question was the meaning of the words **'to participate in any treatment authorised by this Act to which he has a conscientious objection'**.[5]
- The House of Lords judgement in the Janaway case[6] did not specifically consider what those words meant in the context of hospital treatment.[7]
- Human rights' issues – for example, the right under article 9 of the European Convention on Human Rights to refuse to perform employment duties as a manifestation of religious belief - give rise to difficult questions relating to an employer's aims/ means that are context specific. As such, they did not assist the court on the appropriate construction of section 4.[8]
- Issues of discrimination under the Equality Act 2010 or any assertion that reasonable adjustments should be made to accommodate religion or belief are more appropriately addressed in the (separate and ongoing) employment tribunal proceedings.[9]
- As there was no available evidence, the court would not address any argument on the risks to abortion access[10] or the possible consequences[11] of any particular statutory interpretation.
- The policy or purpose of the Abortion Act 1967 was to broaden the grounds for lawful abortions; to ensure patient safety via proper skill and hygienic conditions; and to avoid the mischief of back street abortions. According to Lady Hale, there was also a policy to provide the service within the NHS and approved clinics in the private and voluntary sectors.[12]
- Sections 1 and 4 should be read together – the termination of pregnancy in section 1 must be the treatment referred to in section 4.[13]

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[4] [2013] CSIH 36
[5] Doogan (n1) at para 11
[6] R v Salford Health Authority, Ex p Janaway [1989] AC 537
[7] Doogan (n1) at para 11
[8] Doogan (n1) at para 23
[9] Doogan (n1) at para 24
[10] Doogan (n1) at para 27
[11] Doogan (n1) at para 25
[12] Doogan (n1) at para 27
[13] Doogan (n1) at para 28

- Previous case law (the RCN case[14]) established that what is authorised by the Abortion Act 1967 is the 'whole course of medical treatment bringing about the ending of the pregnancy'.[15] It follows that section 4 (and the right to object on the basis of that section) applies to the whole course of medical treatment bringing about the termination of the pregnancy. In medical abortions, it begins with the administration of the drugs and normally concludes with the ending of the pregnancy by expulsion of the foetus etc. It includes medical and nursing care connected to the process of labour/giving birth and the disposal of any tissue bi products. Lady Hale acknowledges there may be aftercare required as a process of birth but section 4 would not extend to ordinary nursing and pastoral care of a patient who has just given birth because 'it was not unlawful before the 1967 Act and thus not made lawful by it'.[16]
- Completion of the statutory HSA1 forms is not covered by section 4(1) – the forms are a necessary precondition but are not part of the treatment process. Lady Hale refers to the judgement of Lord Keith in Janaway but it is fair to say he expresses no final opinion on this issue.[17]
- A narrow meaning to the words **'to participate in'** is more likely to have been in the contemplation of Parliament when the Act was passed.[18] This interpretation would restrict the words in section 4 to those 'actually taking part' in a 'hands-on capacity' and relate to those acts made lawful by section 1.[19] Ancillary, administrative and managerial tasks associated with those tasks are outside the acts made lawful by that section. The tasks carried out by the respondents were closer to the latter types of roles.
- A conscientious objector is under an obligation to refer a patient/case/task to a professional who does not share that objection.[20]

[14] Royal College of Nursing of the UK v Department of Health and Social Security [1981] AC 800
[15] Doogan (n1) at para 33
[16] Doogan (n1) at para 34
[17] Janaway (n6)
[18] Interestingly, David Steel stated during the 3rd reading of the Medical Termination of Pregnancy Bill in the House of Commons on 13/14 July 1967: *'The doctor would still have the general duty to care for his patients, and someone with a conscientious objection could still be guilty of negligence if he declined advice or did not refer the matter to a colleague, with disastrous results for his patient.* ***The Clause also gives nurses and hospital employees a clear right to opt out****.'* HC Deb 13 July 1967 Vol 1750 [1318]
[19] Doogan (n1) at para 37/38
[20] Doogan (n1) at para 40

Comment:

The Choice

Janaway and Doogan highlight the practical difficulty of drawing the line in conscientious objection cases. Janaway made it clear that conscientious objection did not extend beyond the confines of hospital treatment but left open its limits. This paper will explore the narrow interpretative choice taken by the Supreme Court and the manner in which that choice has been framed. Before doing so, we should briefly consider the alternative and broader construction of section 4 favoured by the Inner House namely '**any involvement** in the process of treatment, the object of which is to terminate a pregnancy'.[21] This definition would not extend to all hospital employees (ie those with no real involvement in the process of treatment) and leaves open whether protection would be available for indirect provocations to conscience? For example, would the Inner House construction cover those engaged in the administrative elements of abortion treatment; or the ward receptionist who books in patients who might opt for an abortion? Whilst abortion opponents may argue (with force) that they should be protected from both direct and indirect provocation to their moral conscience, there are practical difficulties in framing that protection, particularly in the context of mixed health care provision. Whatever the construction, the Act represents a compromise for opponents because subsection 4(2) excludes the ambit of protection in the context of emergency/ life threatening or grave permanent risk abortions. Further whether we adopt a broad or narrow approach to conscientious objection, there will be implications for those who work in and manage reproductive health care; albeit implications that the Supreme Court was not prepared to evaluate without evidence.

Original legislative purposes

Little emphasis is placed by Lady Hale on the role played by the 1967 Act in enabling or achieving compromise. Apart from one comment - which has section 4 as a 'quid pro quo'[22] for the new law - she gives the impression of a one-sided debate and outcome to the legislative process in 1967. There is certainly no express recognition of the 'vital strategic' purpose played by the Act or by section 4 in achieving compromise back in 1967.[23] According to Mary Neal it is:

'the compromise' character of the Act that makes it not only possible but durable'[24]

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[21] Doogan (n4) at para 38
[22] Doogan (n1) at para 27
[23] Mary Neal, 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, Med Law Rev (2014) 22(3): 409
[24] Neal (n23) at 419

It is pleasing to see the court looking for Parliament's original intention, but has this been fairly represented in Lady Hale's judgement? She states that the policy of the Abortion Act was clear but her only support comes from the interveners and Lord Diplock in the RCN case[25]. She does not appear to have seen any ambiguity or lack of clarity that justified the use of Hansard. Nor does she does mention the dissenting judgement of Lord Edmund Davies in the RCN case that makes it clear that the 1967 Act was:

'a product of considerable compromise between violently opposed and emotionally charged views. In its preamble it is described as an Act "to amend and clarify the law relating to termination of pregnancy by registered medical practitioners", and, far from simply enlarging the existing abortion facilities, in the true spirit of compromise it both relaxed and restricted the existing law' [26]

Diane Munday (a lobbyist who supported the Private Member's Bill promoted by David Steel that ultimately became the 1967 Act) describes the legislative outcome as:

'The price that had to be paid for legislation at all.'[27]

Further evidence of compromise can be found in the Parliamentary debate that ultimately produced the legislation.[28] David Steel also talks of the compromises made to get the Medical Termination of Pregnancy Bill through Parliament.[29] Clearly compromise was a feature of the legislative process and the final Act.

Lady Dorrian states in her judgement for the Inner House that:

'the right of conscientious objection is given out of respect for those convictions (moral and religious) and not for any other reason' [30]

Lady Hale does not address this point beyond the brief reference to 'quid pro quo'[31]. Was section 4(1) introduced to protect individuals from conflicts with their perceived moral responsibilities;[32] as a means to object to what were criminal acts; out of respect for different beliefs;[33] or simply as a mechanism to achieve compromise?[34] This is a point that required resolution by the Court

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[25] RCN (n14)
[26] RCN (n14)
[27] Abortion Law Reformers: Pioneers of Change, Interviews with people who made the 1967 Abortion Act possible, 1997, BPAS at 11. See also pages16 and 27.
[28] For example, see Lord Silkin in Hansard HOL 30 November 1965 Vol 270 cc 1139 and David Steel in Hansard HOC 22 July 1966, Vol 732 cc 1067-165.
[29] The Abortion Act 1967 edited by Michael Kandiah & Gillian Staerck, ICBH Witness Seminar Programme
http://www.kcl.ac.uk/sspp/departments/icbh/witness/PDFfiles/AbortionAct1967.pdf
at 48 accessed 19/11/14. See also Diane Munday at 49/50 in the same document.
[30] Doogan (n4) at para 38
[31] Doogan (n1) at para 27
[32] As per Mary Neal (n23) at 417
[33] As per Lady Dorrian (n30)
[34] In the 3rd reading of the Medical Termination of Pregnancy Bill in the House of Commons, David Steel stated: *'To deal with the substance of her argument, it is true that the profession*

because original purpose cannot be disconnected from statutory construction. Is it legitimate and consistent for our highest courts to take a broad non-literal interpretation to section 1 (to accommodate medical advances not specifically envisaged in 1967),[35] and a narrow interpretation to the scope of section 4? The interpretation in Doogan stands or falls on the correctness of the courts' view on original parliamentary purpose and, in that respect, there must be some doubt. Compromise was an essential feature of the legislative process that created the 1967 Act and it should not have been ignored in the interpretative process.

Synergistic interpretation

Despite these criticisms, it is not surprising that the court concluded that sections 1 and 4 had to be given a synergistic interpretation. The poor drafting in the original act (mixing terminates, terminated, termination and treatment) and the earlier decision in the RCN case[36], made that outcome more likely. However, there are consequences for requiring the two sections to be read together. Restricting section 4 to the 'acts made lawful by section 1'[37] provides simplicity but only if the law was clear and certain before the 1967 Act. Such an interpretation restricts section 4 to those acts that were unlawful before the Act and made lawful following implementation of the statutory regime. By example, Lady Hale states:

'*Ordinary nursing and pastoral care of a patient who has just given birth was not unlawful before the 1967 Act and thus not made lawful by it'* [38]

Mary Neal argues that the law relating to abortion was not in a state of clarity before 1967 and varied depending on where you were in the UK?[39] The introductory text of the original Abortion Act 1967 supports her view on ambiguity:

*'An Act to amend **and clarify** the law relating to termination of pregnancy by registered medical practitioners'*

If the law was clear, why would the Act purport to clarify it? Both the judgements of Lord Diplock and Lord Edmund Davies in the RCN case[40] lend credence to the view that the law was unclear. Further support can be found in Hansard in the debates on the original version of the bill supported by Lord

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as a whole is greatly concerned about the difficulty of the conscience Clause. As the Minister of Health said earlier, it is the view of a substantial body of the profession that this Clause is unnecessary and raises all sorts of unnecessary complications. I said that, despite this, I think that we should pursue the effort to secure a Clause which will satisfy those who believe that there should be some clear conscience Clause in the Bill.' Hansard HC 13 July 1967 Vol 750[1331]

[35] RCN (n14)

[36] RCN (n14)

[37] Doogan (n1) at para 38

[38] Doogan (n1) at para 34

[39] Neal (n23) at 416

[40] RCN (n14)

Silkin[41]. Lord Denning notably commented in the Bill's second reading in the House of Lords:

'My lords, the law as at present known is quite uncertain, in regard to doctors at least'

At the second reading of his Private Members Bill in the House of Commons on 22 Jul 1966, David Steel said:

'there is total uncertainty about the exact legal position. It is left far too much to the judgment of individual practitioners whether they are or are not within the law.'

The different sources of criminal law – statutory in England, Wales & Northern Ireland and the common law in Scotland – and the jurisdictional application of the Infant Life (Preservation) Act 1929, make it likely that legal variations did exist within England, Wales & Scotland in 1967[42].

So what does this mean for section 4? According to the Supreme Court, it can only apply and provide objection to acts that were unlawful prior to the 1967 Act. If there were differences before the Act, then those differences endure for the purposes of section 4. If there was uncertainty before the Act, then uncertainty remains as to the scope of section 4. This is a rather unsatisfactory situation. An alternative interpretation would be that section 4 applies to acts that section 1 says are lawful irrespective of whether they were lawful or not pre 1967. Such an approach addresses any prior lack of clarity, jurisdictional variation and is consistent with the view that the Abortion Act 1967 both extended and restricted the law (as per Lord Edmund Davies in the RCN case).

Other problems

The court's interpretation means that section 4 does not extend to the signing of the HSA1 statutory forms that record the opinion of the authorising doctors.[43] In Janaway, Lord Keith said:

'It does not appear whether or not there are any circumstances under which a doctor might be under any legal duty to sign a green form, so as to place in difficulties one who had a conscientious objection to doing so. The fact that

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[41] Hansard, HOL 30 November 1965 Vol 270 cc 1139

[42] David Steel emphasised the differences between the laws of Scotland and England & Wales in the second reading of the Medical Termination of Pregnancy Bill in the House of Commons on 22 July 1966: *'In Scotland, the situation is slightly better ordered—as it frequently is. There the procuring of an abortion is a Common Law offence; there is no Statute Law. But criminal intent must be proved. The Scots law therefore recognises that in certain circumstances it may be necessary, in the interests of the mother and in good faith, to carry out an abortion —something which English law does not specifically recognise.' Hansard, HOC 22 July 1966 Vol 750 cc 1069*

[43] Doogan (n1) at para 36

during the 20 years that the Act of 1967 has been in force no problem seems to have surfaced in this connection may indicate that in practice none exists. So I do not think it appropriate to express any opinion on the matter.'[44]

The Court in Doogan appeared to be content with the (usual) practice to permit conscientious objection in this context via contract. It is, nonetheless, an oddity that the authorisation stage is not covered by section 4. Again was that Parliament's original intention? David Steel said during the second reading of his bill that:

'There is also nothing in the Bill which compels a Catholic patient or a Catholic doctor to ***be in any way*** *involved in the termination of a pregnancy'*[45]

The emphasis is mine but clearly demonstrates the view of the Bill's supporter at that stage of the legislative debate.[46]

Alternative routes to conscientious objection

The uncertainty presented by this judgement extends beyond the 1967 Act. By declining to address the human rights issues, and, by highlighting alternative routes to claim conscience-based objections, the Court has added rather than reduced legal uncertainty. It also creates a potential burden of employers in this field (see below). Although Parliament will have been aware of Convention rights in 1967, it is doubtful that they envisaged alternative legal routes to conscientious objection beyond section 4. If Parliament intended that the section should encompass all the objections to 'participation', as well as enabling agreement, is there not a risk that the majority approach[47] could unbalance the terms of that compromise? Of course, part of that risk now exists because of Parliament - directly or indirectly via the enactment of the Human Rights Act 1998 and the Equality Act 2010.

There is also an added complication here. The Court emphasised the duty of a state employer (here the NHS) to respect employee rights and, presumably, had in mind section 6 of the Human Rights Act 1998. The corollary is the absence of any directly enforceable duty on non-state employers (those engaged in the voluntary or private provision of abortion services). It is doubtful that Parliament had these variables in mind when they enacted section 1(3) in 1967 or the subsequent amendments to the Abortion Act.[48]

The court also highlights the statutory duty under the Equality Act 2010 on all employers to refrain from direct or unjustified indirect discrimination against employees on the ground of their religion or belief. Again it is arguable whether Parliament had this type of discrimination in mind in 1967 and prior to

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[44] Janaway (n6)
[45] David Steel (n42) at 1077
[46] As for the legitimacy of using statements from the promoter of a bill to identify statutory mischief /clarify ambiguity - see Lord Browne-Wilkinson in Pepper v Hart [1993] AC 593.
[47] As per Doogan (n1) at paragraphs 23/24
[48] As per section 37 of the Human Fertilisation & Embryology Act 1990

substantive statutory protection against discrimination in the workplace. The reference to reasonable adjustments[49] acknowledges the potential for challenges following the decision in Eweida v UK.[50]

The key point is that this judgement highlights and tacitly endorses the use of alternative means of pursuing conscience based objections outside the terms of the 1967 Act and the original terms of compromise and does so in relation to a class of employees - those engaged in ancillary, administrative and managerial tasks - which they say Parliament had not intended to cover under section 4. So in effect the Court is acknowledging the scope to unsettle the original terms of compromise.

Other employment considerations

At first blush, this appears to be a good outcome for employers in this sector. Certainly it has been welcomed by the British Pregnancy Advisory Service (BPAS), one of the interveners in the case:

"'We welcome this ruling. BPAS supports the right to refuse to work in abortion care, not least because women deserve better than being treated by those who object to their choice. But the law as it stands already provides healthcare workers with these protections. Extending this protection to tasks not directly related to the abortion would be to the detriment of women needing to end a pregnancy and the healthcare staff committed to providing that care. There are enough barriers in the way of women who need an abortion without further obstacles being thrown in their way." '[51]

One of the issues raised by the interveners was that a broad construction of section 4 (and 'participating in') would put at risk the accessibility to abortion.[52] Although the court found that they did not have the evidence to resolve this issue, the employment implications of the judgement are worthy of consideration. Mary Neal addresses the risks of a narrow construction in her commentary on the Inner House decision;[53] her points ranging from the imposition of employee burden; the need for objection on a task by task basis, to isolation and vulnerability in the work place. I will concentrate on her 'task by task' point and do so because of the guidance provided by Lady Hale.[54] She tests her analysis against the tasks performed by the respondents and the outcome was that most of the duties (but depending on context not necessary all) fell outside the protection of section 4. The court's analysis reinforces Neal's argument that a narrow construction requires employees and employers to consider - and in the case of employees to assert - objections on a task by task basis. This is an onerous obligation for both parties, although in light of the Eweida decision,[55] the burden probably falls more heavily on the employer to accommodate religion/belief or to justify why

[49] Doogan (n1) at para 24
[50] Eweida v United Kingdom (2013) 57 EHRR 213
[51] http://www.bpas.org/bpasknowledge.php?year=2014&npage=0&page=81&news=693 accessed 19/11/14
[52] Doogan (n1) at para 26
[53] Neal (n23) at 418-419
[54] Doogan (n1) at para 39
[55] Eweida (n50)

it is not reasonable/proportionate in relation to a particular task. Despite stating that these are matters more suited for resolution by the employment tribunal, Lady Hale gives us a flavour of where the ultimate balance may fall. In the context of family support, she says:

'it may be reasonable to expect an employer to accommodate an employee's objections, in the interest of providing the family with the most effective service'[56]

So the reality may not be as straightforward as employers may hope for.

The judgement also highlights an interesting employment practice allegedly adopted by BPAS to address the issue of 'conscientious objection'.[57] According to Lady Hale they refuse to employ anyone who has any conscientious objection to abortion – on the basis that the lack of such objection is a genuine occupational qualification (OQ) for the jobs they offer. Presumably BPAS do so because they are confident that:

1. A substantive and core component of those jobs relate to the termination of pregnancy;
2. That any asserted OQ does not amount to a contractual or 'legal requirement' to participate within the meaning section 4(1) Abortion Act 1967;
3. The OQ is a proportionate means of achieving a legitimate aim.

Points 1 and 3 are interlinked. Whilst it may be relatively easy for BPAS to demonstrate a legitimate aim, establishing proportionate means is likely be more challenging for a mixed role involving tasks not related to abortion.

Duty to refer

In her concluding remarks, Lady Hale states:

'the conscientious objector be under an obligation to refer the case to a professional who does not share that objection…another health care professional should be found who does not share the objection'.[58]

This duty goes further than the latest General Medical Council Guidance:

'You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right…If it is not practical for a patient to arrange to see another doctor, you must

[56] Doogan (n1) at para 39
[57] Doogan (n1) at para 25
[58] Doogan (n1) at para 40

make sure that arrangements are made for another suitably qualified colleague to take over your role'.[59]

According to this guidance, the duty of referral is a conditional one (dependent on practicality) and extends only to the provision of a 'suitably qualified' colleague. According to Lady Hale, the obligation is an absolute one and extends to finding a colleague who does not share their objection to the procedure. Is she envisaging that medical professionals must investigate and challenge the moral views of colleagues prior to referral? What about the professionals who privately object to abortion on moral grounds but are willing to participate in the context of their professional lives. It is unclear whether Lady Hale is saying that such individuals are excluded because she does not distinguish between those who hold opinions and those who manifest their beliefs in practice. This has important implications for healthcare workers and required more discussion than was afforded in the judgement.

Terminations in multiple pregnancies

Lady Hale refers to the 1990 amendments[60] that introduced the possibility of '**selective abortion'** and defines it as:

'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 fetuses she is carrying is justified on one of the other grounds'[61]

She goes onto make reference to '**selective reduction** in the number of fetuses'.[62] It is interesting that no terminological distinction is being made between terminations of anomalous and healthy foetal life. The scientific literature reveals confusion and inconsistency in this context and so her language is of some interest.[63] Further, the term 'selective' - in the context of fetal reduction in multiple pregnancy - is contested by many clinicians.[64]

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[59] General Medical Council, (2013), Good Medical Practice, London, GMC at para 52; see also the GMC (2013), Personal beliefs and medical practice, London, GMC at paras 12-16.
[60] HFEA 1990 (n48)
[61] Doogan (n1) at para 6
[62] Doogan (n1) at para 8
[63] Legendre, C-M, Moutel, G, Drouin, R, Favre, R and Bouffard, C, Differences between selective termination of pregnancy and fetal reduction in multiple pregnancy: a narrative review, *Reproductive BioMedicine Online (Elsevier Science)*, *(2013)* 26 (6), 542-554
[64] Patkos, P, Embryonic reduction, selective termination, 2003, *Ultrasound Rev. Obstet. Gynecol., 3, 290*/ Berkowitz, R. L. and Lynch, L, Selective reduction: An unfortunate misnomer. *Obstetrics and Gynecology*, 1990, 75 (5), 873-874 at 873/ FIGO Committee for the Ethical Aspects of Human Reproduction & Woman's Health, *Ethical Recommendations on multiple pregnancy and multifetal reduction,* International Journal of Gynecologists & Ostretricians (2006), 92, 331-332 at 332

Conclusions

Whilst the result was not unexpected, Doogan show the dangers of repeat and ongoing interpretation of an ethical and legal compromise struck many years ago. This compromise mattered to those who worked tirelessly to achieve the legislative outcome in 1967. This compromise was struck across a wide range of strongly held moral beliefs. The legacy is ill served by continued attempts to second-guess past intentions. The world and context (at least in the UK) has changed dramatically since the 1960s and the time has come for Parliament to revisit the compromise and the archaic criminal law that it sought to address.[65]

[65] The Offences Against the Person Act 1861 in England, Wales & Northern Ireland and the common law in Scotland