Abortion care in Ireland: Developing legal and ethical frameworks for conscientious provision

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Synopsis

Recent changes in provision of abortion care in Ireland are welcome, but impediments to conscientious provision remain. Addressing these requires political and professional leadership.

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Abstract

This article celebrates the remarkable changes which have occurred in the provision of abortion care in Ireland following the vote to remove the restrictive Eighth Amendment to the Constitution of Ireland in May 2018. However, it also identifies ways in which the emerging legal, ethical and clinical landscape is still impeding the conscientious provision of abortion care. It argues that in order to address these impediments, more attention needs to be paid to the ethical context for conscientious provision. This requires political leadership as well as ongoing leadership by professional bodies to develop both the clinical and the ethical guidance for conscientious provision.

1. Background and change

On January 1, 2019, the Health (Regulation of Termination of Pregnancy) Act 2018 (2018 Act) came into legal force, extending significantly the circumstances in which abortion care may lawfully be provided in Ireland. The 2018 Act followed on from the repeal of Art. 40.3.3 of the Constitution of Ireland (the 'Eighth Amendment'), which had afforded explicit constitutional protection to the right to life of the 'unborn'. The effect of the Eighth was an almost total ban on access to abortion care except where there was a 'real and substantial risk to the life of the mother' [1] (whether for physical reasons or because of a risk of suicide) [2]. On 25 May 2018, the Irish people voted by a majority of 66.4% in a referendum to remove the Eighth Amendment from the Constitution. This important result reframed the pregnant woman as an equal rights-holder under Irish law, recognising her rights to autonomy, dignity and bodily integrity [3-5]. However, the Irish journey is by no means over. Legal change does not assure the provision of appropriate abortion care, nor does it guarantee a shift in the dominant narratives around pregnancy and abortion.

This article celebrates the changes in the Irish legal framework, but also identifies ways in which the emerging legal, ethical and clinical landscape impedes the conscientious provision of abortion care. It argues that in order to address impediments, more attention

needs to be paid to the ethical context for conscientious provision. So as to move in that direction, the article begins by setting out why it is important to recognise that the provision of abortion care by clinicians and other healthcare providers is a conscientious act. By foregrounding the role of conscience, we seek to emphasise that the provision of abortion care must be perceived not just as a legal/clinical issue but also as a matter of ethics and human rights. The article then moves to outline the new Irish legal framework and some of the ongoing impediments to conscientious provision, before concluding by setting out steps which would help to develop ethical frameworks for conscientious provision of abortion care in post-referendum Ireland.

2. Ethical guidance for conscientious provision

The constitutional exclusion of access to abortion care in Ireland, except in very limited life-threatening situations, meant that until recently discussion of the issue has had a profoundly legalistic slant. The legal rights of the foetus were pitted against, and almost inevitably defeated, the legal rights of the pregnant woman. Discourse around conscience has tended to focus on the right of individuals or institutions not to be compelled to participate in the provision of care which is contrary to their ethical/religious values [6]. This is not just an Irish phenomenon. Harris shows that in the over 40 years of debate in the United States, the 'idea that conscience-based care means *not* providing or referring for abortion … has become naturalized' (p. 981) [7].

Yet, as many medical professionals recognise, the delivery of abortion care is, and long has been, an ethical choice [7-11].Obstetrician Lisa Harris recognises that this is not a simple or straightforward choice but a choice which is morally fraught and which is made at often considerable personal and professional cost [10]. Yet many providers make this choice because of their conscientious commitment to women's autonomy, health and wellbeing, as well as in broader concerns of justice.

2.1 Ethical Grounding for Conscientious Provision of Abortion Care

The decision to provide abortion care respects women's autonomy and choice as well as women's rights to bodily integrity, privacy and self-determination. It recognises pregnant

women as moral agents, while also acknowledging the unique context within which the pregnant woman and foetus co-exist. As Joan McCarthy et al. observe 'because pregnancy results in profound and irreversible physiological, psychological and emotional changes to her body, her sense of self and her life the pregnant woman or girl has a special moral claim to make decisions about whether or not to continue the pregnancy' (p. 514) [12]. It is this belief that 'women themselves best understand the life contexts in which childbearing decisions are made' that motivates many providers (p. 982) [9]. Provision of abortion care also recognises the inherently relational context of pregnancy as something which affects 'an interconnected and interactive unit and … the functioning of a family unit' (p. 200) [13]. This richer understanding of pregnancy is evident in the stories told during the referendum campaign where many Irish women identified the need to care for existing children and the impact of pregnancy on other relationships as the reasons for not continuing a pregnancy [14].

Provision of abortion care is also ethically grounded in a recognition that women's health, both mental and physical, is important. FIGO past-President Mahmoud Fathalla identifies the ethical imperative to take public health action to eliminate unsafe abortions [11]. Yet, as the Irish experience makes clear, the threats to women's health do not just arise from unsafe abortions. The legally enshrined view of the maternal-foetal relationship prior to the repeal of the Eighth Amendment meant that women's healthcare needs were too often overlooked in Ireland [12,15,16]. Provision of abortion care seeks to redress this imbalance. It also recognises and seeks to address the dignitary harms experienced by women and girls in circumstances where they cannot effectively access the full range of legally permissible reproductive healthcare services, resulting in additional expense, delays and increased distress [17].

Finally, conscientious provision addresses the justice gap and ensures access to abortion care to those who, because of social and/or economic disadvantage, would not otherwise be able to access such care (p. 16) [18]. Access to abortion care has long been more available for those with economic, social and educational resources [19]. In Ireland, prior to the introduction of the 2018 Act, those who could afford to do so travelled abroad (usually to the UK) for abortion care [20] while migrant women without the necessary visa [21], some young women and girls, and women in abusive relationships were left with the

option of continuing with an unwanted or unviable pregnancy or of illegally importing abortion pills and taking them without medical supervision [22]. Conscientious provision recognises that access to safe abortion should be not only for people with assets, and that there is an ethical imperative to ensure that the most vulnerable and marginalised in society can avail of adequate reproductive healthcare.

2.2 The Importance of Ethical Guidance for Conscientious Provision

Harris argues that the '[p]ersistent neglect of the compatibility between conscience and abortion provision … has consequences for law, clinical practice, and bioethics' (p. 982) [9]. One such consequence is the absence of opportunities for conscientious providers to acknowledge and discuss ethical complexities and challenges in the delivery of abortion care. Harris describes these essential conversations as 'dangertalk' [10] (p. 200) because they do not sit comfortably with some pro-choice rhetoric. Yet they are necessary in developing ethical guidance for conscientious provision. This guidance can play an important role in expressing the values that underpin conscientious provision, which include concern for women's agency, health and rights. By recognising these values, ethical guidance can provide a normative context for clinician engagement and a way to address the complex ethical situations that inevitable arise.

3. The new Irish legal and ethical framework

The 2018 Act establishes the foundations for abortion care in Ireland. In broad terms, the 2018 Act allows pregnant women to access abortion care in four situations. First, where the pregnancy has not exceeded 12 weeks. Second, where there is a risk to the life, or of serious harm to the health of the pregnant woman and the foetus has not reached viability. Third, where there is an immediate risk to the life or of serious harm to the health of the pregnant woman. Finally, where there is present a condition that is likely to lead to the death of the foetus either before or within 28 days of birth. In each situation, clinicians play a gatekeeper role, deciding when and whether the statutory criteria for access to care have been met. Depending on the applicable circumstances, one or two clinicians must certify that the requirements of the 2018 Act have been met.

The 2018 Act is a peculiar piece of legislation, which must be understood in its political context. The General Scheme of the Bill had been published in advance of the referendum [23], and this provided the basis for the presentation of the political choice to the electorate during the referendum campaign. The overwhelming public support for the removal of the Eighth Amendment left it unclear whether citizens had voted on the basis of the published General Scheme or whether they supported a broader reform agenda. Whichever was in fact the case, the Irish Government chose to align closely the post-referendum legislation with the original proposal, which had been formulated when the scale of the public appetite for change had not yet become apparent [24].

The political context is also reflected in the very short time (and correspondingly limited opportunity for critical reflection) between the publication of the full Bill (27 September 2018), the 2018 Act being signed into law (21 December 2018), and the 2018 Act coming into force on 1 January 2019. Although some Regulations (subordinate legislation) have been introduced, these deal only with the technical certification requirements and do not provide additional clarity on several important gaps and uncertainties in the legislation.

During the short lead-in time before commencement of the 2018 Act, the Medical Council's Ethics Working Group launched a public consultation on the amendments required to the *Guide to Professional Conduct and Ethics* (8th edn). This had been published in 2016 prior to the repeal of the Eighth Amendment and reflected the legal context of that time. The updated *Guide* was finally published on August 30, 2019 [25]. Significantly, the amended *Guide* expands the equality and diversity provision. The *Guide* requires clinicians to try to understand patients' cultures and respond to their individual needs (para. 8.1) and continues '[y]ou should not discriminate against patients or colleagues on any grounds' (para. 8.1). Unlike the *Guide*'s previous statement on non-discrimination, this prohibition on discrimination is not restricted as regards grounds and clearly can be seen to prohibit discrimination on the basis of either the request for or the provision of abortion care. In this way, the Guide provides a first building block in grounding conscientious provision in Irish ethical discourse. On the specifics of abortion, the *Guide* affirms that termination of pregnancy is legally permissible within the provisions of the 2018 Act (para. 48.1). It sets out a duty to provide care, support and follow-up for women who have had a termination (para. 48.2).

The *Guide* also updates its guidance regarding conscientious objection. This aspect of the *Guide* is not restricted to abortion care but is stated in more general terms (although the location of conscientious objection in the paragraph immediately succeeding the *Guide*'s discussion of abortion is hardly an accident). The *Guide* affirms clinicians' ethical entitlement to refuse to provide or to participate in the carrying out of a procedure, lawful treatment or form of care which conflicts with the clinician's 'sincerely held ethical or moral values' (para. 49.1). It then sets out what clinicians who have a conscientious objection must do. This includes informing patients, colleagues and employers as soon as possible (para. 49.2); informing the patient that s/he has a right to seek treatment from another doctor and giving the patient enough information to enable him or her to transfer care (para. 49.3). Clinicians are also required to make the transfer of care as easy as possible for the patient, including being sensitive and respectful and minimising any distress for the patient. Reinforcing this requirement, paragraph 49.4 of the *Guide* explicitly cross-references the non-discrimination requirement which is set out in para. 8 of the *Guide*. Clinicians are also required to arrange the transfer of care for the patient if s/he cannot make the arrangements on his or her own behalf (para. 49.6) The *Guide* also prohibits the provision of false or misleading information by clinicians as well as the wilful obstruction of access to treatment based on the clinician's conscientious objection (para 49.5). Finally, the *Guide* is clear that in an emergency situation, clinicians must provide 'as a matter of priority' the care and treatment which the patient needs (para. 49. 7).

Clinical guidelines regarding the practicalities of delivering the service were also developed in the short time available. At the request of the Department of Health, the Institute of Obstetricians and Gynaecologists published three sets of interim clinical guidance, covering each of the circumstances in which abortion care may lawfully be provided [26-28]. The Irish College of General Practitioners also produced interim clinical guidance for its members, who are the primary providers of early abortion [29]. These clinical guidelines provide further detail on some of the core standards established in the 2018 Act. These include guidance as to how the 12 week limit should be determined (requiring an ultrasound scan where the woman's dates indicate the pregnancy may exceed 9 weeks), and regarding what is required to establish the existence of a

risk/immediate risk to life or serious harm to the woman and of a condition which is likely to lead to the death of the foetus before birth or within 28 days of birth.

In these last two complex clinical contexts (except in an emergency), the interim guidelines recommend the use of multidisciplinary team (MDT) discussions in reaching conclusions. The Interim Clinical Guidance recommends that the MDT be a formally constituted committee which should include a range of medical and allied specialities and that attendance and participation at the MDT should be open to all relevant consultants in the hospital group. It also recommends that decisions of the MDT should be made by majority consensus. This creates a tension with the 2018 Act, which places legal responsibility for certification on two individual clinicians. It also is out of line with the WHO *Safe Abortion* guidance [30]. This recognises that access to care can be unduly delayed by 'burdensome procedures of medical authorization' and is clear that 'third party authorization should not be required for women to obtain abortion services' (p.95) [30].

4. Barriers to conscientious provision of abortion care in Ireland

From a conscientious provision perspective, the 2018 Act is clearly an enormous improvement on the legislative position prior to the repeal of the Eighth Amendment [2,31]. As described above, the 2018 Act significantly expands access to abortion care, including allowing automatic access to abortion care up to 12 weeks of gestation. The Act also removes any criminal sanction for women seeking abortion care. However, aspects of the 2018 Act constitute a continuing barrier to conscientious provision which, because of the unusually compressed legislative processes employed, were not subject to the normal degree of pre-legislative scrutiny.

First, there are technical elements of the 2018 Act which impede the delivery of care. One example relates to early term pregnancies (less than 12 weeks), which are likely to constitute the substantial majority of terminations. The 2018 Act imposes a 3-day waiting period after the request for termination is made (s. 12 (3)). This was presented during the referendum campaign and in subsequent political debates as providing the pregnant woman with an opportunity for reflection. However it is difficult to find this justification convincing given that this reflection is scheduled to begin only after the woman has had a consultation with her doctor and sought the termination. There is no health rationale for

the waiting period, and it is contrary to WHO *Safe Abortion* Guidance (p. 78) [30]. The effect in practice is to fragment and delay the delivery of care. This is especially felt by women whose local provision of care is inadequate and who have twice to travel long distances to access care, and also by women who come for care towards the end of the 12-week limit (interpreted as 12 weeks + 0 days) and who may be denied a termination of pregnancy simply because of the waiting period. The 12-week limit (as it is legally formulated) also denies care to women who present and are given care within the required time limit but for whom the termination fails. In such cases, if the post-termination pregnancy exceeds 12 weeks, additional abortion care cannot be provided (on pain of criminal sanction). The women most likely to be affected by these denials of care are women who are otherwise vulnerable: minors, women living in domestic violence refuges, homeless women, and women living in direct provision centres (institutional accommodation provided by the State to those seeking asylum).

A second and overarching problem is that a clinician who provides abortion care outside of the circumstances specified in the 2018 Act is potentially criminally liable and could be subject to a prison sentence of up to 14 years (s. 23). The possibility of a clinician actually being prosecuted is relatively slim. Irish law enforcers do not have a history of using the criminal law against clinicians and there is a statutory defence where a clinician provides abortion care on the basis of a 'reasonable opinion formed in good faith' (s. 9(1); s. 10(1); s. 11(1); s. 12(1)) that the circumstances of the 2018 Act apply. However, the retention of the criminal sanction sets abortion care apart from other forms of healthcare and suggests that healthcare professionals providing abortion care are in some way inherently less conscientious than other professionals and that the usual regulatory mechanisms of (general) criminal and civil sanctions and professional/fitness to practice oversight are insufficient for these professionals. In this way, the Irish law perpetuates the stigmatisation of both the care provider and the recipient of abortion care [32,33].

Third, the 2018 Act statutorily enshrines conscientious objection, without any countervailing reference to conscientious provision. The 2018 Act states that, other than in emergency circumstances, a medical practitioner, nurse or midwife may not be obliged to 'carry out or to participate in carrying out' a termination to which s/he has a

conscientious objection (s. 22(1)). S/he is, however, statutorily obliged to make arrangements for the transfer of care 'as may be necessary to enable the woman to avail of the termination of pregnancy' (s. 22(3)). No further guidance is provided as to what constitutes participation in carrying out a termination. Given that the term 'participate' is used in a broadly similar context in the Abortion Act 1967 (UK), the decision of the United Kingdom Supreme Court in *Greater Glasgow Healthboard v Doogan and Anor* [34] may be persuasive should this issue come before the Irish courts. The Supreme Court (UK) held that to participate means to have 'hands on' involvement. If applied in Ireland, this would mean that the legal right to conscientious objection under the 2018 Act would not extend to ancillary tasks, such as managerial and supervisory tasks. However, until this is confirmed by the Irish courts, there is still uncertainty around the scope of the legislative conscientious objection provision.

Leaving this uncertainty aside, the conscientious objection provision has other implications for service delivery. Under the 2018 Act, any health professional (within the designated categories) can, without any further action required on their part, claim conscientious objection. This means that the statutory protection can encompass genuine, such as religious, conscience-based objections; objections of 'convenience' based on a clinician's work load and the concern to avoid taking on the undeniable burden of providing a new and difficult form of care in an already overstretched service and objections based on a clinician's unarticulated biases. 'Convenient objection' has proved to be a significant impediment to delivery of lawful abortion care in some other jurisdictions, for example Italy [35]. At present, there is no Irish data available on why clinicians rely on the conscientious objection provision. It is clear, however, that clinician refusal has prevented uniform access to abortion care, especially secondary (hospital-based) care, which involves more complex cases. By July 2019, only 10 out of 19 Irish maternity units were providing access to abortion care [36]. In one notable example, all four consultant obstetricians in one rural hospital announced that the hospital was unsuited to the provision of abortion care. The effect is to deny women in this part of the country reasonable access to democratically endorsed and legally recognised care. Although the appointment of a fifth obstetrician to provide services was subsequently

announced [37], there are inevitable delays in getting this additional clinician in place (and given its history, it is not clear how attractive the post will be).

These legislation-derived impediments have assumed greater significance because the provision of abortion care has also run into some implementation challenges. This has meant that access to care is uneven across the country, both for community-based abortion care and abortion care provided in hospitals. Some of these challenges are inevitable. Because abortion care was essentially unavailable in Ireland prior to 1 January 2019, Irish primary and secondary care facilities have not been set up to provide abortion care. Irish medical schools and associated hospitals have had no history of providing abortion care training. Thus Irish healthcare providers faced a steep learning curve in establishing the required service. This in turn requires high levels of State support which, to date, has not been adequate. In a powerful critique, consultant obstetrician and maternal-foetal medicine specialist Dr Keelin O'Donoghue identified the absence of preparatory work in facilitating new services and excoriated the lack of leadership, resourcing and education as well as the failure to recognise the complexities involved in providing abortion care [38]. She states that, as a result, clinicians who provide abortion care are made to feel isolated and undermined in some hospitals. This has immediate practical implications for access to abortion care, especially where MDTs are operating on the basis of majority consensus as recommended by the Clinical Guidance discussed above. While the MDT model may work effectively in hospitals where clinicians who provide abortion care are supported and respected, in hospitals where clinicians are isolated and undermined, the operation of the MDT is likely to impede delivery of care.

Dr O'Donoghue also identified other service-level deficiencies which make clinicians' positions more difficult. For complex cases where the reason for the termination is that the foetus is likely to die before or within 28 days of birth, clinicians have to operate without a national policy on prenatal screening or national ultrasound guidelines on best practice, and without universal access to dating or anomaly scans. Inevitably in these situations, difficulties will arise. One case, which garnered significant political and media attention, concerned a termination on the ground of likely foetal death. Media reports indicate that the termination was carried out on the basis of an initial test which showed that the foetus had Edwards Syndrome and was likely to die before or shortly after birth.

However, it appears that a second test received after the termination had been carried out suggested that the foetus did not in fact have the condition in question. An independent review into the circumstances in question is currently underway [39]. This tragic case makes clear the importance of training, guidance and support for conscientious providers of abortion care.

5. Conclusion: The way forward

Irish abortion care has come a long way in a short time. Healthcare professionals played an important role in the political campaign to repeal the Eighth Amendment [4] and are central to the delivery of abortion care post-repeal. Without conscientious providers, the establishment of a legal right to abortion is essentially meaningless. For this reason, delivery on the democratic mandate for abortion care creates an imperative to develop a climate for conscientious provision. This requires political, ethical and clinical leadership. Politically, the 2018 Act needs to be amended to remove those elements which are impeding the provision of care. The 2018 Act includes a requirement that it must be reviewed before 1 January 2022 (s. 7). Although the Act does not identify the purpose of this review, the open-ended nature of the requirement can be seen to offer a relatively early opportunity to address the legislative failings and gaps in implementation, including ethical implementation. Prior to this, however, political leadership needs to extend beyond reducing the impediments to care and must also incorporate resourcing, funding for clinical and ethical training, and closer engagement with governance of hospital practices.

The question of conscientious provision must also be addressed by the provider of public health services, the Health Service Executive (HSE). Most secondary abortion care will be provided in HSE facilities and therefore the leadership provided by the HSE, in terms of clinical and ethical training and policy development, is essential in developing an effective service that is consistent with the Medical Council's 2019 Guide to Professional Conduct and Ethics. In September 2019, nine months after the introduction of termination of pregnancy services in Ireland, the HSE announced that it was seeking to recruit a

clinical lead for abortion services – this will be a part-time position, for a period of two years – and one of the key objectives is the roll out of abortion services to all 19 maternity units in Ireland [40]. While the time-lag between abortion services becoming available in the State and the appointment of a national clinical lead is regrettable, this is a positive development with the potential to address some of the implementation challenges outlined above. If this potential is to be fully realised then conscientious provision must be afforded a greater level of respect than is currently the case.

Ongoing leadership by professional bodies, in particular the Medical Council, the Institute for Obstetricians and Gynaecologists and the Irish College of General Practitioners, is necessary to ensure that ethical and clinical guidance is informed by the principle of conscientious provision of a service which a sizeable majority of Irish citizens has endorsed. Such guidance is critical to train the next generations of clinicians in both the clinical and the ethical aspects of conscientious provision. All of these steps are central to the development of an ethical framework for reproductive healthcare in Ireland, which will ultimately empower clinicians to deliver conscientious service to those who require it.

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Conflicts of Interest

The authors have no conflicts of interest.

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