Early Medical Abortion Care in Ireland: Conscientious Provision and the Role of Law

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Key Findings

- Those providing abortion care are doing so based on a belief that it is the 'right' thing to do and because it aligns with their professional identity and their understanding of the duty to provide appropriate care to patients
- Providers are often motivated by conscience, including respect for autonomy and women's rights, and by experience in clinical practice from pre-2019
- Legally mandated 3-day wait is problematic for most providers
    - Principled reasons
    - Practical difficulties (although these are mitigated to a degree by telemedicine)
- View that where someone presents for the first consultation who is not clear on the best course of action, this can be managed through good clinical practice rather than through legal regulation
- Inflexibility of 12-week limit is problematic in situations of failed abortion/later presentation
- Criminalisation of clinicians recognised as stigmatising but not seen as a factor that impacts on day-to-day practice
- Providers were supportive of the principle of conscientious objection but very critical of obstructive practices and identified the need for more clarification and education on the limitations of legal protection for conscientious objection
- Telemedicine generally viewed as effective within the current model of care but not suitable for everybody
- Mixed experiences of interactions with secondary care. Seen as personality dependent – most very positive but some less positive interactions
- Strong support for more extensive roll-out of free contraception scheme – especially LARCs for over 30s
- While a move towards normalisation of the service is evident, some providers felt that there was still residual stigma attached to the provision of abortion
- Pride in the clinician led establishment and roll-out of EMA in the community
- All respondents spoke about the positive and rewarding experience of providing abortion care

1 Introduction

1.1 Background

Access to sexual and reproductive health is recognised as essential to the United Nations Sustainable Development Goals (in particular SDG3 on health and wellbeing and SDG5 on gender equality) (Kim et al, the Lancet 2022). The WHO Abortion Care Guidelines set out the core elements for quality abortion care to include the availability and accessibility of information; a supportive, universally accessible, affordable, and well-functioning health system; and respect for human rights within a supportive framework of law and policy (2022).

Until 2019, abortion in Ireland was banned under all but the most extreme circumstances. This was required because the Eighth Amendment to the Constitution of Ireland provided explicit protection for the 'right to life of the unborn'. Women[1] who needed abortion care often travelled to the UK (and to a much lesser extent the Netherlands or other European countries) or self-administered abortion pills bought online. Following a lengthy campaign of advocacy by a wide range of bodies which included civil society, third sector organisations and human rights bodies, as well as healthcare providers, and a grassroots reform movement (Fletcher, 2018; Taylor et al, 2019), a constitutional referendum was held in May 2018. A decisive majority of Irish citizens (66.4%) voted to replace the Eighth Amendment with the Thirty-Sixth Amendment to the Constitution which states that '[p]rovision may be made by law for the regulation of termination of pregnancy'.

Notwithstanding the resounding endorsement by the electorate, the 2018 Act remains in essence the same as the draft General Scheme drawn up by a cautious government in advance of the referendum (Donnelly and Murray, 2020). This means the 2018 Act reinforces the law's 'extraordinary treatment' of abortion (Jackson, 2001) and the view that abortion care is fundamentally different from other forms of clinical practice.

1.2 The Legal Framework following Repeal

The Health (Termination of Pregnancy) Act 2018 (the 2018 Act), which came into force on 1 January 2019, makes abortion care lawful in four situations:

- Where 2 medical practitioners certify that there is a risk to the pregnant woman's life or serious harm to her health and the foetus has not reached viability (2018 Act, s. 9)
- Where a medical practitioner certifies that there is an immediate risk to the life or serious harm to the health of the pregnant woman and the termination is immediately necessary to avert this risk (2018 Act, s. 10)
- Where 2 medical practitioners certify that the foetus is likely to die before birth or within 28 days of birth (2018 Act, s. 11)
- Where a medical practitioner certifies that the pregnancy has not exceeded 12 weeks (2018 Act, s. 12)

The fourth of these grounds is directly relevant to Early Medical Abortion (EMA). The aspects of the 2018 Act which impact directly on providers of EMA are:

[1] We use 'women/woman' here to include pregnant people/person.

- The requirement that a medical practitioner, having examined the pregnant woman, is of the reasonable opinion formed in good faith that the pregnancy in question has not exceeded 12 weeks (s. 12(1)) (the 12-week limit)
- The requirement that a medical practitioner must certify that the pregnancy has not exceeded 12 weeks (s. 12(2)) in the manner prescribed by regulations (s.19(1)) and must notify the Minster for Health of all terminations performed, including providing their Medical Council number, section of the Act under which the termination was carried out, the woman's county of residence or her place of residence if she resides outside the State and the date the termination was carried out (s. 20(2)) (the certification/notification requirement)
- The requirement that a termination shall not be carried out unless a period of not less than 3 days has elapsed between the first and second certification by the medical practitioner (s. 12(3) (the 3-day wait)
- The provision that nothing in the Act shall be construed as obliging any medical practitioner, nurse or midwife to carry out, or to participate in carrying out a termination of pregnancy to which s/he has a conscientious objection (s. 22(1)) (the conscientious objection provision)
- The provision that it is an offence for a person by any means whatsoever to intentionally end the life of a foetus other than in accordance with the Act (s. 23(1)) (the criminalisation provision).

1.3 Operationalising a New Service

Termination of pregnancy services became available in Ireland on the 1st of January 2019. The development of the model of care and the roll-out of the service would not have been possible without the work of committed clinical providers. Many of those involved in the initial stages of operationalisation had also been very involved with the referendum campaign and were drawn from Doctors for Choice Ireland (DfC) and the Southern Task-Force on Abortion and Reproductive Topics (START). The Irish Family Planning Association which has long-standing expertise in sexual and reproductive health and a strong track record in advocacy and policy development in relation to contraception and abortion, was also important in ensuring that the change in the constitutional position in relation to abortion led to accessible and quality abortion care in Ireland (Taylor, 2019). Following repeal of the 8th amendment finalisation of the legislation and the development of the model of care occurred in parallel (Mishtal et al., 2022). The HSE and the Department of Health aimed for a collaborative approach and engaged with the ICGP, representative bodies, and stakeholders (Mishtal et al., 2022).

The model of care for EMA is set out in Clinical Guidance provided by the Institute of Obstetricians and Gynaecologists (Interim Guidance: Termination of Pregnancy under 12 Weeks, 2018) and by the ICGP Clinical Support for Termination of Pregnancy in General Practice (July 2021). These contain important additional elements in setting the parameters of EMA. In the Interim Guidance, 12 weeks is defined (following interpretation by the Department of Health) as 12 weeks + 0 days. This is determined by data from the woman's menstrual history combined with an ultrasound assessment of the foetal crown-rump length. The Interim Guidance sets a crown-rump length of 63 mm as the upper limit for termination of pregnancy at 12 weeks + 0 days gestation.

The ICGP Clinical Guidance sets out the model of care for termination of pregnancy in primary care settings. This model of care involves three consultations. There is a mandatory waiting period of three days between the first and second consultation. The third consultation is a follow up, and can take the form of phone call (UnPAC, 2022, p.72). Community care providers only provide medical abortion. The ICGP Clinical Guidance sets out the model of care for termination of pregnancy in primary care settings

and provides that abortion care can be provided in a community setting up until 69 days gestation (ICGP QRG, 2021; Horgan et al, 2021). Where a pregnancy is between 10 and 12 weeks or where there is a clinical indication that makes the person unsuitable for home self-management of medical abortion they are referred to hospital. There was significant work done to ensure an emphasis on a community provided model of care with the majority of early medical abortion (EMA) being provided by general practitioners (GPs) alongside a small number of specialist women's health clinics.

While this model enabled the service to be rolled out relatively swiftly, it does mean there is very limited availability of surgical early abortion in Ireland, even for those who may prefer that option. (Spillane et al., 2021; O'Shea, 2023). Since its introduction abortion care is free for those "ordinarily resident in Ireland." However, the HSE only reimburses medical practitioners for abortion services if a PPSN number is provided, thus denying free care or delaying care to some vulnerable groups, including "newly arrived asylum seekers, students and others who are experiencing delays in being issued PPSNs." (IFPA, 2022). Access to service providers is coordinated through an HSE funded 24/7 helpline and website called 'My Options' which signposts women to local service providers. The MyOptions service also provides information in relation to pregnancy counselling and clinical nursing supports (Mishtal et al., 2022).

Section 20 of the 2018 Act requires clinicians to notify the Minister for Health of all terminations that are carried out to enable the Minister to prepare an annual report. To the end of December 2022, there were 17,820 notifications to the Minister. The vast majority of these (17,510) were provided under s. 12 (O'Shea, 2023). The data does not break down how many of the terminations carried out under section 12 took place in the community (under 9+6 weeks) and how many took place in secondary care.

Available data relates only to the number of contracts with providers of EMA (with one contract per practice) and not to the number of providers who actually provide such care. As of 16 February 2023, there were 422 contracts between the HSE and abortion care providers (O'Shea, 2023). This was a year-on-year increase in providers: from 373 contracts in April 2020 to 404 contracts in December 2021 and 413 in July 2022. It is estimated that approximately one in every ten GPs is providing abortion care (NWC, 2021, p.23). However, there remain areas of the country where there is very limited access to abortion care. Service provision is not mandatory and GPs opt-in to provide the service. The legislation also makes provision for conscientious objection, which may account for some gaps in provision, although most GPs who do not provide refer to workload pressures rather than conscientious objection as their reason for not providing (O'Shea, 2023).

There are very significant geographical variations in service provision (O'Shea, 2023). Urban centres are generally well served. In contrast, two counties (Monaghan and Longford) have just one provider contract each while seven other counties have fewer than five provider contracts (O'Shea, 2023).

1.4 Reviewing the operation of the Act

The legislation contains a statutory commitment to review the operation of the Act "not later than 3 years after the commencement" of the relevant section. The Department of Health divided the review into two phases. The first phase was to gather information from service users, service providers, and the public. This has several elements: the Unplanned Pregnancy and Abortion Care (UnPAC) Study (HSE, 2022) which was commissioned by the HSE and which focuses on service users' experiences; a public consultation which ran from December 2021 to April 2022; and research on the experiences of service providers which was commissioned by the Department of Health and was carried out by Dr Deirdre Duffy. The findings of that research have not yet been published, although it has been

submitted to the Minister for Health. The second phase was led by an independent chair, Ms Marie O'Shea BL, who was charged with assessing the extent to which the objectives of the Act have been achieved and looking at the three strands of research. This Review was published in April 2023 and makes detailed findings and recommendations about many aspects of abortion care provision.

Key relevant findings of the Review for this WP are:

- Early termination of pregnancy has been successfully implemented although some challenges remain
- Uneven distribution of provision is a problem
- Telemedicine has been helpful and is generally regarded as safe
- Some non-providing GPs are obstructive and do not fulfil their legal and ethical obligation to arrange transfer of care
- My Options is a critical infrastructure but not all women/providers are aware of its existence
- The legally mandated 3-day waiting period is especially problematic for vulnerable and marginalised women and can lead to women timing out of care
- Pathways for ultrasounds and secondary care are unreliable
- Not all GPs have engaged in education and training about abortion care
- Linkage of free of charge care to PPS Number is problematic
- Conscientious objection is a significant factor in uneven geographical distribution of care
- Criminalisation of abortion *per se* is stigmatising for women and may deter doctors from providing the service

Key relevant recommendations of the Review for this WP are:

- DoH should consider extending the category of HCPs who can provide abortion care
- The mandatory 3-day wait period should be replaced with a mandatory obligation to advise the pregnant woman that she has a statutory right to a reflection period, which she may exercise, at her own discretion
- The 12-week limit should be extended for a specified period in circumstances where it intersects with the 3-day wait and/or inability to make arrangements for the woman to access care and to allow a failed termination to be completed
- Medical providers should not be subject to criminal liability
- Safe zone legislation and criminalisation of conduct which intentionally or would reasonably be regarded as influencing the decision to have a termination or provide the service
- Ministerial guidance should be developed on obligations of conscientious objectors
- Free contraception should be extended to all women of reproductive age

While the above-mentioned studies and reports form the official statutory review of the 2018 Act, there are also a number of other published studies looking at the operation of termination of pregnancy services in Ireland. Mishtal et al conducted a study funded by the World Health Organisation, which "set out to analyse the implementation and sustainability of an expanded abortion service, examine the barriers and facilitators to the implementation process, and identify policy implementation gaps" (Grimes et al., 2023, p. 2). There are studies on abortion care before 12 weeks (Mullally et al., 2020; Horgan et al., 2021; Mishtal et al., 2022), on access to abortion in the context of fatal foetal anomalies (Power et al., 2020, 2021; O'Shaughnessy et al., 2021), on termination of pregnancy services in hospital settings (ARC & Grimes, 2021; Stifani et al., 2022; O'Shaughnessy et

al., 2021) and on providers' experience of stigma (Dempsey et al, 2021). The CPAC study contributes to this growing body of research on the operation of abortion services in Ireland, focusing in particular on the impact of the legal framework on EMA abortion care providers in the community.

2. The CPAC Study

Research from other jurisdictions indicates that 'abortion exceptionalism' (Corbin, 2014) in legal frameworks has the effect of stigmatising abortion care providers (Cook, 2014; Harris, 2014; Nejaime and Siegel, 2015; Sheldon, 2015; McGuinness and Thompson, 2020). It has been argued that, in these jurisdictions, the decision to provide abortion care requires in itself an act of conscience (Dickens and Cook, 2011; Harris, 2014; McCarthy and McGuinness, 2020).

Examples of 'abortion exceptionalism' in the Irish legal framework include the retention of criminal sanctions for clinicians who provide abortions outside the strict terms of the legislation, and the legal protection of conscientious objection in relation to termination of pregnancy. This study explores how this legal framework impacts on providers of EMA. A key objective of the research is to contribute to an evidence base which can support those engaged in service provision, and advocacy work and education, to deliver quality and accessible abortion services in Ireland.

This study was funded by the IRC New Foundations scheme under Strand 1a, Enhancing Civic Society, with the Irish Family Planning Association (IFPA) as civic society partners on the project. Ethics approval was obtained from the Social Research Ethics Committee, University College Cork to conduct semi-structured interviews with community-based providers of early medical abortion care. The participant information sheet identified the objectives of the study, and all participants gave informed consent. No remuneration was provided for taking part. All research data were saved on a secure drive at University College Cork and in line with the University's Code of Research Conduct (2021).

2.1 Methods

The study uses data from semi-structured interviews with a range of EMA service providers alongside a review of the existing literature on conscientious provision of abortion care. Semi-structured interviews were chosen as they enabled the researchers to guide the conversation towards the research questions while also increasing the likelihood of generating "rich and complex insights" from the participants (Braun and Clarke, 2006). This is because the process "is designed to bring out how the interviewees themselves interpret and make sense of issues and events." (Bryman et al. 2019). We adopted a contextualist method of thematic analysis, which "acknowledges the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings" (Braun and Clarke, 2006).

In the one-to-one interviews participants were asked about their motivation to provide early medical abortion care – when and why did they decide to provide, and did they have any concerns about the decision. They were also asked about the impact of the legal framework on the day-to-day provision of early medical abortion; and about their experience of providing the service, including questions about stigma, consequences arising from their decision to provide, and about positive and negative aspects of providing the service. The interview guide was developed by the research team and piloted prior to commencing the interviews.

2.1.1 Participant selection and recruitment

This working paper is based on a qualitative study of 15 EMA providers located throughout the country. We utilised a purposive approach to sampling and targeted our recruitment to community providers of early medical abortion – GPs in community practices and clinicians working in specialist women's health clinics. This call was circulated by the co-founder of the START group, and by the project partners in the IFPA, to their networks of service providers and included an information sheet on the project. Because one of the objectives of the study was to understand the motivation of those who choose to provide abortion care while it remains stigmatised it was determined that a broader recruitment strategy circulated to all GPs, which would include non-providers, would not be the most effective sampling strategy. Clinicians who were willing to participate in the study were invited to contact the research team by email and once they did so they were asked to complete a consent form and interviews of approximately 1 hour were arranged with each participant. Participants were offered a choice of being interviewed in person or online. At the start of each interview the participants were again advised of the purpose and nature of the research and asked for oral consent to participate in the research. The interviews were all conducted online using Microsoft Teams.

The level of experience of providing EMA services among the clinicians who took part in the study ranged from those who commenced providing at the very start of the service in January 2019 and those who were newer registered providers. The timeframe under discussion during the interviews included the period when Covid-19 regulations meant that there was an amended model of care in operation with more options for remote access to services, etc. The *COVID-19 Public Health Emergency Termination of Pregnancy – Temporary Provisions for Early Pregnancy Model of Care* was introduced on 6 April 2020. This amended model of care, which provides for telemedicine, remains in place, although an updated model of care is currently being developed.

2.1.2 Data analysis

Interviews were conducted on Microsoft Teams from April – September 2022 and were carried out by one of the two researchers on the project. The interviews were recorded and automatically transcribed using Microsoft Teams software. The transcription was then checked back against the recordings by the Project Manager to ensure accuracy in the auto-transcription. All recordings were then deleted. The transcripts were reviewed after each interview to ensure that any points or insights that arose could be followed up in subsequent interviews. Following this first phase of analysis the transcripts were subjected to qualitative analysis (Creswell, 2018) and coded using a theoretical thematic analysis (Braun and Clarke, 2006).

As is required for a theoretical thematic analysis the researchers had engaged with existing literature on conscientious objection and conscientious provision of abortion, stigma, and the journey to legalisation of abortion in Ireland in advance of conducting the semi-structured interviews. Following familiarisation with the data, whereby each researcher actively read all the transcripts in detail, coding was agreed by consensus. Each researcher took two initial transcripts and coded them in NVIVO. This was followed by a team meeting which reviewed the coding of these initial transcripts, and all codes were discussed and developed before agreeing on a final coding framework. The transcripts were then divided between the researchers and coded in NVIVO. Once the coding was completed and collated the researchers worked together to identify, review, and refine themes.

2.2 Participants

The gender breakdown of those who participated in the study was 11 female providers and 4 male providers. Thirteen of the participants were in general practice and two were clinicians working in specialist sexual health clinics. Of those working in general practice there was a range of practice profiles, from sole practitioners to multiple partner practices, to practices with a specialism in women's health. There was a geographical spread of providers between urban and rural locations.

Provider type: (n = 15)	
General Practitioner	13
Sexual Health Provider	2
Gender:	
Female	11
Male	4
Location:	
Urban (Dublin)	7
Other Urban	2
Rural / Town	6

Among the interviewees were clinicians who had various levels of involvement with the repeal movement prior to the introduction of the legislation and those who did not participate in the campaign to repeal the eighth. Some participants had very strong and well-established peer support networks, others were just beginning to find their place within the network of providers.

2.3 Limitations

This study has several limitations and its findings should be read in light of these.

First, the study focuses only on a discrete aspect of abortion care in Ireland, specifically the provision of EMA in community settings. Secondly, the sample size is small (n = 15) and while there is geographical variation and a reasonable mix between urban and rural providers, some areas of the country are not represented. Notwithstanding this, the research team were satisfied that we had reached saturation in respect of the research questions. Third, the findings of the study are not triangulated with evidence from service users or from any of the ancillary services/secondary care

providers. Finally, the recruitment process employed means that respondents were entirely self-selecting and that there is a heavy representation of doctors involved in some way with the START Doctors network.

3. Findings

The provision of EMA is clearly not just about the law. This means that the impact of the legal framework must be understood in the broader context in which providers operate. For this reason, our findings relate to issues of motivation and the broader experience of providing EMA as well as providers' engagement with the law.

3.1 Motivations for providing EMA

While there was some variation in providers' stated motivations for providing EMA, a majority identified respect for human rights and meeting women's needs as motivating factors. Provider 10 encapsulated a commonly stated position in the following quote: 'I'm a very great believer in bodily autonomy and the rights of the individual and stuff like that. So I would really, that would be my biggest motivation around this, you know.'

Some providers had been active in political campaigns, in some cases going back to the 1983 abortion referendum (which inserted the 8th Amendment into the Constitution), and a number had been involved the 2018 referendum to repeal the 8th Amendment. For these providers, the decision to provide EMA was a natural and inevitable progression from their political involvement. Provider 1 stated 'I felt absolutely compelled to provide the service' while Provider 11 identified the link between political campaigning and their decision to provide:

> I was very struck by if I didn't become a provider, what had it all been about? What had it all been for? But really, how could I look anybody else in the eye? How could I look anybody else in the eye and say, be brave, have courage. It'll be OK. Just do it anyway. You owe this service to your patients. It's the right thing to do. If I didn't actually live that myself, I just would be a big fraud.

However, not all providers had this kind of political involvement and made the decision to provide after the service became lawful. Provider 15 had not campaigned 'yay or nay' and described themself as a 'pragmatic' rather than an 'ideological provider'. For this provider, the focus was on providing 'good clinical care' for women. This theme of providing good clinical care was frequently identified by providers (both those who had had political involvement and those who had not).

Past experiences played a significant motivating role in many provider responses. Provider 1 described their experience:

> I've been working for a long time in practice before the repeal of the 8th Amendment, and just saw the appalling situations that women were in and the cruelty of it, the absolute unfairness of it, the discrimination against women who didn't have the means to travel, like the only people I saw were the women who couldn't get themselves on the boat and get sorted.

Almost all providers recounted experiences of women who had been unable to access abortion care under the previous legal regime. Many identified women they knew professionally (and in some cases personally) who had had to travel to England to access abortion care (as well as situations in which

women were unable for financial reasons or who, because of their legal status, could not travel). Others told quite harrowing stories of physical harms to women by attempts to cause miscarriages and women who had ended up in unhappy 'forced marriages' as a result of pregnancy.

The potential to provide a high-quality service and deliver comprehensive patient care was also identified as a motivating factor. Provider 2 described this motivation:

> I suppose when we learned about how community provision could be the gold standard and GPs would have the obvious role of family planning, and ... I just felt professionally and morally obliged to kind of step up and start providing, you know, if I could at all.

3.2 Legal factors identified by Providers

We began with an open question for all providers on the impact of the law on their practice. There was a remarkable degree of uniformity in responses. Provider 1's response summarises the unanimously held view across all providers: 'I mean, the three day wait is the main, that's the main thing.' The second legal factor identified in response to this open question was the 12-week limit.

3.2.1: Provider Views on the 3-Day Wait

A substantial majority of providers found the 2 consultations/3-day wait to be problematic (although as discussed below, many providers saw value in a flexible model which allowed for a wait in some circumstances). Providers varied in the reasons they considered the mandatory 3-day wait to be problematic. Several noted the inherent unfairness and paternalism of the requirement. Provider 1 explained this viewpoint as follows:

> [I]f you look at it purely from a feminist point of view, if you want to put it that way, on the rights of the woman, you know, if a woman is sure, she should not have to wait three days.

Several providers also identified the disproportionate impact of the 3-day wait on poorer women. Referring to the pre-Covid position, Provider 15 described the impact:

> You had to see them for visit 1 and they have to come back again three days later, you know, and that was a big deal for some people, especially coming long distances or, you know, paying for bus fares or, you know, the way, trying to, you know, juggle childcare and other commitments and all that.

The 3-wait also creates logistical difficulties, especially for those providers who do not work a 5-day week and are the only provider in the practice. Providers identified various steps which they take to deliver care within the legal framework. These included arrangements for terminations on their 'paperwork day' (Provider 3), coming in on a Saturday morning (Provider 6) or phoning to do the first consultation even though it is late in the evening 'because it sets the clock on that day' (Provider 11). In spite of efforts by providers the challenge of finding two appointments can sometimes mean that the woman's wait between consultations may extend beyond 3 days, something which, as Provider 4 identified, can be very stressful for the woman.

These logistical difficulties become more intense if the pregnancy is coming to the end of the 9-week period (when provision moves to secondary care) and even more so where the pregnancy is towards the 12-week limit. The logistical problems created by the 3-day wait in the first of these situations was described by Provider 1:

> [T]hat young girl I just spoke about a while ago, she presented to me at 9 weeks and five days and if there wasn't a three day wait, she could have had a medical termination in the community, but she didn't. She had to have a surgical termination as a result of the three day wait, which, you know, and she might have needed that anyway, given that she was up against the dates, but she might not have.

The more serious problem created when the 12-week limit is approaching was explained by Provider 4:

> [I]f I was to get somebody calling me tomorrow and I said, OK, this person is 11 weeks I'd be saying, OK, X Hospital and Y Hospital have now both had their clinics for the week, so they're not going to be on again until Monday. Z Hospital is tomorrow, but that's too soon for this woman. So they can't see her until Tuesday. And sometimes you'd be looking and going she's going to be 11 + 5, 11 + 6 if they can't see her at the next clinic, she's not going to make it.

For these providers (and for the majority of providers we interviewed), the problem was the inflexibility and rigidity of the system and exacerbation of difficulties because of the interaction between the 3-day wait and other aspects of the system.

Notwithstanding that there were ongoing problems with the 3-day wait, most providers recognised that the logistical problems caused had been improved by the introduction of phone consultations during the Covid-19 pandemic. As described by Provider 2:

> Telemedicine is excellent and you know the way it gets the, the three day wait clock ticking and all of that.

Most of the providers held the first consultation over the phone (although they were happy to have an in-person consultation if this was the woman's preference) although most also expressed a strong preference to have at least one consultation in person.

Although most providers found the legally mandated 3-day wait to be problematic, two of the fifteen providers indicated support for the legal position. Provider 8 stated:

> Personally, I'm in favour of it and I think it gives a chance, I mean, I think it does what it's supposed to do, I think. I think it gives a chance to maybe talk to a counsellor. It's a chance to organize a scan.

This provider also noted the benefits of being able to refer to the legal obligation as a way to avoid being pressured to provide medication immediately:

> I think if we didn't have that three day wait, I think the doctor, it's probably quite selfish of me, but I think the doctor would be under a lot more pressure to just, yeah, here you are – just take the pill.

Provider 12 outlined some practical benefits of the 2 consultation requirement, including that first consultation can be used to check out dates and decide whether a scan is needed and also to chat with the woman and give them a chance to ask questions and discuss worries.

Even those providers who found the mandatory 3-day wait to be problematic recognised it is sometimes appropriate to wait before providing the medication. Provider 1 described this:

> There have been lots of times where I've been really glad of the three day wait where I've seen a woman who I know is making a knee jerk reaction, not to be paternalistic about it, but you, you know, the women who are really distressed.

Several providers had encountered a small number of women who had not come back for the second consultation. This may have been because they had changed their minds about proceeding with the termination although it may also have been because of a spontaneous miscarriage. Provider 9's description of women's uncertainty is representative: 'One or two where I've I have felt that they definitely need to have more counselling. But yeah, it's literally one or two. It's very it's very rare. Most women are very, very sure.' In situations of uncertainty, most providers would favour having a second consultation. However, they felt that this was better addressed through good clinical practice rather than a hard and fast legal rule. Provider 3 sums up a commonly held view as follows:

> [Y]ou have a feeling yourself if the woman is certain or not and I think I'd rather if we were given that sort of clinical ability to make that decision.

3.2.2 Provider Views on the 12-week Limit

The second legal impact identified by all but one of the providers in response to our open question was the 12-week limit. Some providers felt the gestational limit was set too low, with these providers generally favouring a gestational limit of 14 weeks. Provider 5 describes: 'you'll catch most women under 14. I think. And I think if you had it up to there, I think you wouldn't have this wild panic kind of thing.' Most providers did not have an issue with the limit as such, with Provider 15 seeing this as a political rather than a medical decision: 'I think that is a matter for the government and for the people of Ireland to decide when that limit is.'

Regardless of their position on the appropriateness of the 12- week limit in principle, most providers expressed concern regarding inflexibility of the limit. This was especially the case given the restrictive interpretation of 12 weeks in the Interim Clinical Guidance (2018) (following direction from the Department of Health) as being 12 weeks + 0 days (or 63mm head to rump). Provider 5 describes their frustration at the operation of the hard limit as follows:

> I mean, it's so it's so black and white in a thing that's grey. You know what I mean? And like it's dependent on a measurement. And a guess you know, like they they're measuring that crown rump length and if somebody measures it, you know a millimetre more or less, that's the difference between 11 + 5 and 12 + 1. And it's, it's 2 millimetres. It's just a ruler.

Provider 9 identified safety reasons in favour of a more flexible approach:

> And I think there should be some kind of clinical flexibility around it that the hospitals you know, could use to, you know, to be a bit you know, it's always gonna be safer to terminate a pregnancy here at 12 weeks plus 5 minutes, than it is to put them on an airplane and have to have it at 20 weeks, by the time they got organised.

3.2.2.1 12 Week Limit and Failed Abortion

The inflexibility of the system was seen to be especially problematic in cases of failed abortion –i.e. situations when medication is administered but does not work. Provider 10 sets out a view shared by several participants as follows:

> But my real concern around it is the woman who has had a failed termination; she needs to be able to complete, she must be able to complete, you know, it's just so wrong that she's not. The idea that somebody, you know in the extreme circumstance, somebody who doesn't realize that they've had a failed termination and they don't realize until 12 1/2

> weeks, and then suddenly they're carrying a baby, but they have taken a highly teratogenic medication - that's really, really bad.

Providers expressed serious concerns about the harms caused by the medication to the foetus in such circumstances as well as the impact of this on the woman who has been unable to access the termination. Provider 9 describes one such case:

> I have a case which is ongoing at the moment, and that's exactly what happened to her. And she's recently delivered a baby that hasn't done well at all, you know. Yeah, very, very problematic. So that's why I've got an issue with it, like, this lady's life has been ruined because of what happened, and it was simply that, there's the she started the abortion, the abortion failed. And then when she attended the hospital, she was over the dates.

The woman in question did not have a visa and so was unable to travel once the 12-week limit was reached.

The risk that a failed termination may not be completed within the 12-week period also impacts on the informed consent process. As described by Provider 4:

> I suppose the other part of it is just the very fact that every single consultation and the consent process, you have to be warning somebody about this 12-week limit and saying to them, and if we only find out that it hasn't worked after 12 weeks, we can't do anything.

Provider concerns about failure become more acute when the woman presents at or around 9 weeks gestation. A number of providers described how, with terminations at this stage, they will use blood tests to track the effectiveness of the medication so as to allow for a speedy referral to secondary care if necessary.

3.2.2.2 Impact of 12-week Limit on Clinical Practice

While, as several providers recognised, the 12-week limit has a more direct impact on providers of abortion in secondary care, a number described some direct experiences of women presenting either very close to or past the 12-week limit. For all of these providers, these were relatively rare occurrences. For women past the 12-week limit, there is nothing that the provider can do other than identifying the possibility of travelling abroad to access the service. Where the pregnancy is close to the 12-week limit, providers describe the scramble involved in trying to get access to secondary care. The problem here is that secondary care providers typically operate on a clinic model, with clinics running only on certain days. Where a scan is needed, this can further delay the provision of care. The impact of all of these factors, when combined with the 12-week limit, is described by Provider 5 as follows:

> You know, like that's the wall you come upon because you're kind of going, you know, you're like, I can do nothing. What's worse is if you, just say, if somebody who's unsure their dates and ... because they're not really sure so you get scanned and then they're 11 plus 2. But like the scan was done on Thursday and you don't get the report until Monday. Then you're like kind of gonna ahh, you know, they were 11 + 2 on Friday. I could have done something about it. Now you're 12. I can do nothing.

Almost all providers interviewed (13/15) identified the role of ultrasound/scanning in discussing the 12-week limit. Scans may be used for various reasons, including for clinical and safety reasons. They are used in a legal context to ensure compliance with the 12-week limit. Most providers indicated that they typically scan for legal reasons only where there is a doubt about dates or where the woman's

menstrual cycle is erratic or she is taking oral contraception or is breastfeeding. Provider 3 summarises the more commonly held position as follows:

> I don't send everybody for an ultrasound. I know some people are worried about that legally, so they do. ... I tend to trust the woman and so if she's certain of her dates, I accept that.

Several providers were more cautious. Provider 12 described themself as being quicker to order a scan for legal reasons compared to some colleagues and speculated 'That may be because I'm older. Maybe I'm more suspicious of younger people than they are – they're of a generation with them.... But I think people tell fibs.' The possibility of misleading information about dates was also raised by Provider 15 who identified a situation they had encountered in which a woman had given a date which indicated that the pregnancy was 9-weeks gestation but the scan showed it to be at 24 weeks.

3.3 Other aspects of the legal framework

We identified three other aspects of the legal framework as relevant to EMA: the potential criminal liability of providers; the specific legislative protection for conscientious objection; and the certification and reporting requirements. For the most part, these were not identified by providers in response to the open question and provider responses were elicited following direct inquiry by the researchers.

3.3.1 Potential for Criminal Liability

Most providers felt that the potential for criminal liability was inappropriate although most also indicated that this was not something that they were personally worried about. Provider 12's description is typical:

> Yeah, I mean it's I don't go into work terrified of the guards, but, you know, you just have to be so much more careful. And there's no harm being careful. But we can be careful without being threatened. I think it's also very nasty to doctors, to threaten them with sending them to jail if they make an honest mistake. They do say if you make an honest mistake, you won't go to jail, but you could be in the in the dock.

In general, providers were comfortable that their own practice could not give rise to criminal liability, identifying ways in which they ensured that their practice was strictly in accordance with the law. As explained by Provider 1:

> I think I you know the legislation is clear enough that I have to act in good faith and I feel that I document that carefully that you know, if I make a decision that a woman is under 10 weeks gestation and suitable for abortion in the community, it's very clear why am I thinking that. And I feel that's definitely defensible. So I don't feel I'm criminalising, potentially criminalising myself in the way I conduct the service.

Notwithstanding their confidence in their own practices, several providers identified more general problems for the service associated with the potential for criminal liability. Provider 10 identified the impact on the choice to provide (or continue providing):

> But, you know, these kind of things scare people off. You know, and somebody who is criminalised or something, they're going to leave. You know, they're probably gonna retire early.

Provider 12 talked about the general impact on quality, stating

> All they're doing is making everybody nervous, and if you're nervous, you're not going to work as well as if you're not nervous.

The impact on the quality of the service was taken up in some detail by Provider 11. They suggested that the potential of provider criminalisation had a chilling effect on practice, making providers 'hypervigilant' in ways that they were not in other areas. The problem with this is that

> We become much more doctor centric. And a lot less patient focused and patient centred and the decision making then is made very much to facilitate and protect the doctor or the provider than the patient, because we are very concerned about getting it wrong and the strong arm of the law

3.3.2 Legislative Protection of Conscientious Objection

When asked about their views on the specific statutory protection of conscientious objection, the vast majority of providers were clear that no-one should be required to provide abortion care. Providers' reasons for this were both practical and principled. At a practical level, several providers noted that a conscientious objector would not provide the best service for women. At a level of principle, providers identified the importance of tolerance and respect for different views. Provider 15 explained:

> Like I do understand that abortion is different and I think people have the right to feel that it is wrong and I think anyone who does not want to be involved should never ever be forced to be involved.

Providers also recognised that even if a doctor did not have a conscientious objection as such, they might still not wish to take on the additional burden of providing the service. Provider 9 explained that they didn't know any conscientious objectors although not all the doctors they knew were providers:

> I think the majority of doctors that I know who don't provide abortions would say it's because they couldn't be bothered or they're too busy or they don't want to have to do the training or, or they might have a bit of a yuck factor about it.

While providers were strongly supportive of choice regarding the decision about whether to provide, several providers questioned the need for inclusion of a specific provision to this effect in the 2018 Act. These providers identified the way in which conscientious objection was addressed in the Medical Council Guide to Professional Conduct and Ethics (8th Ed) (rev'd 2019) which they considered to be adequate. Provider 4 also identified the stigmatising impact of the inclusion of the specific protection in the Act:

> I suppose, what it can continue to do in a lot of ways, is it does continue to stigmatize people who do provide you know,

Along similar lines, Provider 11 identified that while they did not have a problem with conscientious objection, they considered that

> [I]t gets overstated and it gets given undue importance and there's no equivalent commitment to conscientious, you know, provision.

This provider also identified that conscientious objection is framed by the law in a binary way and continued:

> When of course, in reality it's not. You will have people who will, for instance, quite happily do all the everything except the procedure, or you'll have people quite happy to do everything, including giving tablets rather than it's not a procedure.

Provider 11 found the binary legal construction to be insensitive and lacking in nuance and that is creates polarisation and allows people to hide behind it.

While accepting of colleagues' decision not to provide, some providers identified the importance of recognising the scope and limits of conscientious objection protected under the 2018 Act. Provider 14 identified:

> you know the nurse still has to do a pregnancy test and check your blood pressure, you know. They can't – it's the actual procedure itself, the dispensing or the aspiration not doing the check up afterwards, you know?

Several providers were critical of doctors they had heard of who used their conscientious objection to make women feel uncomfortable or who were obstructive or who refused to comply with the legal and ethical obligation to refer the woman to a provider. Provider 1 described:

> I think I've seen women who've been impacted by the issue of conscientious objectors who felt very belittled or dismissed by other doctors. And I think that's wrong.

This provider also identified examples of obstruction by scanning services:

> I've definitely had women who ended up getting scanned by services that were obstructive, genuinely obstructive and in kind of spinning her along until she was over the 12 weeks.

Provider 2 was clear on the difference between conscientious objection and obstruction:

> You can't tell a patient you can't have an abortion. You can tell the patient I don't provide termination care, but the duty is very much on you to say look, this is direction you go if that's what you need and yeah conscientious obstruction is different - it's when you say no you can't have an abortion because that's wrong.

Although several providers identified examples of obstruction, a clear majority expressed satisfaction with the way in which non-providing colleagues, including colleagues who were conscientious objectors, operated the system in practice. This description by Provider 10 is typical:

> So there is another practice in town who were very, very much; you know they were very against the repeal of the 8th and then they were very strongly against, you know, provision as it was introduced. But they now, certainly one of them now refers to me on a regular basis. And you know, she doesn't provide herself, but she's very comfortable, and she will ring me up and say I'm referring so-and-so to you.

3.3.3 Certification/Notification Requirements

Providers had mixed views on the certification/notification requirements. While some found it to be a nuisance or additional burden, for others, it was 'not a big deal' (Provider 14) or even positive. Several providers considered that the certification requirement was helpful because of the way it reinforced (both for the woman and for the provider) the significance of the decision being made. Provider 7 described:

> I like the legal framework and structure and limits around it because it's not, there's no sense that it's like a free for all do what you want to kind of thing.

All of the providers interviewed had worked out systems to deal with the legislative requirements. Provider 11 provides a detailed description of the process they use:

> I prepare a folder pack of all the paperwork on any particular, you know, for any particular patient which includes the HSE booklet, the consent forms, patient information leaflets, leaflets on how to take the tablets. But it also includes the certification form, the notification form, the STC claim forms. These are all my bits. And so then when I've it all done I do the paperwork on the day and I hand what's left of my paperwork out to the practice manager and she processes that. She makes sure it's sent in, she claims, that she sends the notification and then she knows two weeks after I've cleared it that I'm happy that this pregnancy is over because this pregnancy test is back and she closes the file.

Things become a little more complicated where the two consultations have involved two different practices (as might happen where the first doctor is going on leave and asks a colleague at another practice to step in) although as Provider 3 described, there are systems to deal with this:

> I'll always scan a copy. They have to give it to the patient to give to the GP. So they've proof that they've been certified or whatever it's called certification.

While all providers were able to work with the certification/notification requirements, several questioned the value of the notification requirement. Provider 4 was clear:

> The notification is just like a total waste of time - if they were using it to collect good information, nobody would mind. But like just to get the Medical Council number off the doctor, that's like, that's the only information they collect. I mean, the county of the person, in some ways, you can say yes, it identifies that it's all counties, but also that suggests, mistakenly, I think, that it's available in all counties, because it's not actually recording the county that it took place in.

For some, the lack of useful information captured by the notification process was especially annoying because of the urgent need for good data to help improve the service. Provider 11 noted:

> [W]e have absolutely no information whatsoever of who's seen, what gestation they are, where they come from, how far they travel, what their complication rate is and so on and so forth.

3.4 Delivering the Service

While the main focus of the research was on providers' engagement with the legal aspects of abortion provision, the research also provided rich data on providers' broader experience of delivering the service. Sometimes these were in response to a specific question but at other times, the themes identified below emerged from the discussion.

3.4.1 Impact of Telemedicine

In April 2020, as part of emergency responses to Covid-19, the model of care for EMA changed to allow for remote consultation (by phone or video) (typically described as telemedicine) (Spillane et al, 2021). No legal changes were required to allow this to happen.

We asked providers about their experience of telemedicine in EMA and whether they would like to see this model of care continue post-Covid.

All the providers were happy to facilitate telemedicine (typically a phone call) for one of the two legally required consultations, with some routinely conducting the first consultation in this way, unless there is a reason not to, eg. the women wants an in-person consultation or is not sure about dates. Provider 5 described their process as follows:

> I'll do it on the phone and they're fine. And then if there's an element of not sureness about them, so if they say they're like, I don't know when my dates are or I can't remember when I had a period, I'm going sorry, can you just come down and I'll do a pregnancy test and just poke you a little, but if they're solid on their dates and you're kind of going OK that's fine, then you can do all that kind of on the next day.

The third consultation required under the ICGP model of care almost inevitably takes place by phone.

As identified above, providers found that telemedicine reduced the inconvenience of the 3-day waiting period for women, especially for women who had to travel longer distances or had childcare or other responsibilities. Provider 15 describes:

> The two face-to-face visits was difficult for the more rural women. Certainly the women coming up on the bus from X now that was difficult for them. I remember one woman and she had a 3-year old and a 1-year old with her and she'd come up on the bus and it was, it was heartbreaking.

While recognising the increased convenience of telemedicine for the woman, a clear majority of providers expressed a strong preference to have one in-person consultation. Provider 10's response is typical:

> I'm OK provided they come and visit me for one. ... I just think it's quite useful to be able to put a face on somebody. And so I think that's, you know, and I think as well as that they just have a better idea about you if they've met you as well. They, you know, a long time on a phone call, people don't get to know you and they don't get any body language and stuff.

A number of providers also identified the limitations of telemedicine where the woman does not speak English, with Provider 2 describing telemedicine in such circumstances as 'just absolutely pointless because you can't really manage'.

3.4.2 Interactions with Ancillary Services: My Options/Ultrasound providers

Most providers we spoke to were registered with My Options and for these, most of their referrals came through My Options. The typical process is described by Provider 14:

> We actually call it an MO. A My Options. And it's coded differently and they're given half an hour and it's all fine and, you know, and the girls kind of know if someone rings, fit them in.

Sometimes, too, providers use My Options as a form of protection when they receive a phone inquiry from someone who is not one of their own patients. Provider 5 explained:

> I remember getting phoned by the guards to say that my name was on a list that have been made public as a provider, so that there might be people prosecuting - not prosecuting, protesting. So since then, we just were, everything just gets deferred back to My Options.

In general, providers were happy with My Options, although most had relatively limited dealings with this service beyond receiving referrals from it. Some providers appreciated that they could call My Options and ask to come off the list for a period, for example, if they were on leave or under unusual pressure. Providers also appreciated being able to refer women to My Options for post-termination counselling and also where women needed advice while taking the medication. Provider 8 explained 'you know it's nice to be able to give these women a number to ring if it's three or four in the morning, and just to be able to at least give them something'. However, it is important that the medical advice given to the woman in this situation is appropriate and one provider recounted an experience of incorrect advice being given (although they also acknowledged that these were 'teething problems' in the early stages of the service).

Providers' experience of ultrasound providers was somewhat more mixed. For some providers, the service worked smoothly, with minimal delays and fitted neatly with the 3-day waiting period. Others recounted that women sometimes had to travel distances and wait for appointments, although this tended to be less of a problem if a woman could pay for private ultrasound. Where a woman is up against dates, providers will typically contact ultrasound providers looking for early appointments and, in this situation, providers found that the ultrasound provider will usually try to fit in an appointment.

In general, providers did not identify any issues about the sonographer's conduct. However, one provider expressed concern about an issue that had arisen shortly before our interview and which they brought up unprompted. The sonographer had made a point of phoning the provider to let them know that this was the second time that a particular woman had come for a scan in relation to termination. The provider who had inquired of the patient and was aware of this fact was uncomfortable with the communication, explaining 'I just thought it's smacked of judgment of the patient very much so to me, and yeah, so I thought that was a real concern for the ultrasound provider company.'

3.4.3 Interactions with Secondary Care Providers

Given that only 11/19 hospitals provide abortion care, depending on location, the issue of referral to secondary care is much more challenging for some EMA providers. Two of the providers we spoke to had to make referrals to hospitals other than the woman's nearest hospital because the nearest hospital did not provide. One of these providers also identified that they did not feel that they could refer women to the nearest hospital if they experienced medical complications following a termination. They described:

> we're finding like if people are, you know, haemorrhaging following a termination, they have to go to X hospital in any sense, they might be 1/2 an hour from Y hospital and an hour and a half from X hospital. But that's what we've been told.

Providers reported mixed experiences of secondary care. Provider 10 summarised a commonly held perspective in describing the quality of secondary interactions as 'very personality dependent'. Most providers were very positive about their interactions with their secondary care facilities. Language used by providers in this regard included terms like 'brilliant'; 'very very good'; 'fantastic'; 'excellent';

'extremely helpful and supportive'. Providers identified some consultants as highly supportive. Provider 2 described the consultant in their local hospital:

> [They are] just excellent. [They] give a really personal kind of wrap around service you know. So we're very, very lucky and I would say that lots of other parts of the country are very jealous of that. I would say that would be probably the gold standard really.

Several providers also identified the important role played by midwife TOP co-ordinators in those hospitals which had such a position. Provider 11 described the TOP co-ordinators in their local hospital as 'absolute heroes' and continued 'They've been heroes everywhere. They're the people who've kept the whole service together.'

However, some providers had had less positive interactions. Provider 9 identified the inconsistencies in how different hospitals approach abortion care. They described one (large) hospital where they were unable to get through directly to a midwife but had to leave a message with a secretary:

> I'm going no, no, I don't need to pass the message to the team. I need to talk to somebody who will tell me when the lady can come in, you know, and it's like as if they didn't respect the fact or they didn't understand the fact that I am a GP, I have actually seen the patient, I know what I'm doing here, I do understand that, you know, she needs to be seen quickly and it was as if they assumed that I probably hadn't a clue and therefore get in line.

Provider 3 contrasted the more rigid approach of their local hospital with their own efforts to respond quickly where a woman is close to the 12-week limit:

> They are actually, they don't squeeze things in now so like so I'll kind of always trying fit someone in but they definitely don't. So they have specialist clinics kind of once or twice a week where they'll provide sort of the terminations if needs be, and it doesn't always fit with the time scheduling, that's the problem you know so, that can be an issue if you're kind of right up against a deadline to you know.

3.4.4 Contraception

Although we did not directly ask providers about contraception, the issue was brought up by 2/3^{rds} of the providers we spoke to. Most of these providers saw part of their role to involve initiating a conversation about contraception although some acknowledged that this can be embarrassing for the woman. Provider 6 explained:

> I don't like asking them what contraception they were on because a lot of the time, they're embarrassed to say, well, I'm on none, or whatever like and there is a bit of it, a guilt complex.

However, this provider confirmed that they always do ask although they also say to the woman that that they are not putting pressure on the woman to make an immediate decision to use contraception. This provider was also critical of providers that they know that insist that if they are to provide abortion care, the woman has to leave with some sort of contraception.

Provider 12 took a more robust approach to contraception:

> They often go, I don't want to think about it at the moment and I you have time to say no you must because fertility comes back almost immediately.

This provider indicated that, in their experience, significant numbers of women seeking terminations had not been using contraception.

Most of the providers who brought up contraception expressed very strong support for the broader roll-out of free contraception. Provider 13's perspective on this was widely shared:

> I do think it's a kind of madness to provide termination of pregnancy service without having contraception - effective, reliable, affordable contraception as a backup - free contraception. I think it's, personally I think it's a nonsense to provide free contraception up to the age of 25, like women who are 45, have terminations and can go on to have pregnancy.

Providers identified the particular needs of women whose families were complete and who would benefit from long-acting reversible contraception (LARC) such as the Mirena coil but for whom the cost was prohibitive. Provider 5 describes:

> our main barrier with the with the take up of long acting contraception was the cost of us for the patients who were private, because it is like the cost of Mirenas like there's 100 and something to buy the damn thing. And it's 180 to have it fitted.

This provider continued 'I've had women coming and going, you know, I just don't have the money for it this month. I'm saving and you're like oh, you shouldn't have to save for contraception'.

3.5 Personal Experiences of Provision

While the provision of abortion care is a professional function, the decision to provide has personal implications for providers. To try to elicit these, we asked providers about their personal experience of providing abortion care. While this was an open question, we did include subsequent prompts asking providers specifically about negative and positive aspects/consequences of their decision to provide.

3.5.1 Reactions of Others

Several GP providers recounted a degree of nervousness at the initial roll-out of the service. Sometimes this had to do with the possible responses of other people working in the practice (whether as GPs or in other roles, for example as nurses or receptionists). Most GP providers found that the response had been positive. Provider 10 described:

> So, I suppose it's been really useful that all of them have been really supportive of this throughout, OK. And that's been a very important thing in the practice. I thought it might be an issue of having to bring them along initially. But as it turned out, it wasn't at all. It was very much they were telling me what to do.

This was not always the case, however. Two providers recounted significant problems with practice colleagues. One ended up leaving the original practice to set up on their own while the second came close to doing so. For Provider 11, a compromise was found to allow them to provide within their practice:

> So how I provide then in the context is that I'm the only provider in the practice, although that's changing a little bit with time and I provide sort of outside of practice time in the sense of, in my own time. So I see people, you know early in the morning, across lunchtime, tea time, and the practice doesn't take the income from it.

Sometimes, providers (and their GP colleagues) were concerned about how other patients of the practice might respond to their decision to provide. Provider 1's description is fairly typical:

> there was a lot of anxiety I think in the practice beforehand about whether there would be objections or, you know, whether patients would be upset or there'd be protests. And so definitely I had to respect that aspect of it within the practice and therefore not go on the public list initially.

For most, there had not been a negative reaction from patients. Some providers had received letters from patients complaining about their decision to provide and some had lost patients. However, these numbers were small and by and large, patients had either not been concerned or were pleased that their GP was providing. Provider 15's account is typical:

> I was very pleasantly surprised at how supportive people were and interestingly, it was the older women were more supportive. I remember one woman saying to me in a very sad voice, she said I'd like my daughter to have more choices than I did.

This support from older women was mentioned by several providers.

Finally, several providers identified their concerns about the possibility of protests. For most, these had not materialised. However, some providers had been targeted by protesters. Sometimes this involved in-person protests, such as those described by Provider 6: 'we have protesters every third Friday, I think, or every second Friday outside; you know they go to Mass, and then they rock up outside the surgery' and Provider 13: 'I had the white crosses. I used to say to a ... colleague hers were properly made. Mine were twigs, and the paint was wet by the time somebody took them down.' Other providers had been targeted by attempts at phone 'stings.' Provider 5 described some of these calls: 'these two were just men and the situation was kind of weird. Like it was like oh, they're young and their parents don't know. And I was like, no, that's some sort of weird pro-life group going.'

Other providers had not been personally affected but were aware of protests in other practices. Provider 2 recounted accounts of surgeries in another part of the country:

> we've seen, you know, up in County Longford, I think wasn't it, you know, one of the surgeries being daubed with graffiti and we've seen people getting awful threats and you know, these people coming out with placards and praying and white coffins and all of this outside GP surgery, very upsetting, you know.

This provider identified the chilling effect of protests of these kinds which 'does hamper, or dampen at least, people's enthusiasm providing the service you know.'

Some providers had found these protests disturbing, especially for their other patients. Provider 2 described:

> it's upsetting because, like, I mean, you know, I'd have patients coming in, that have like you know, dementia, or they're on a bereavement visit, their wife just died or their kid just died, or they've had a couple of miscarriages or you know, something awful has happened and they'd to pass those pickets and you know, that's awful. I think, you know, it's ridiculous.

Providers described various responses to these protests. Provider 13 described:

> when they put the crosses up first I went around and told the guards and showed them the photographs and they said if they give you any trouble we're there for you. So that was a very positive experience.

3.5.2 Stigma

Two providers specifically referred to provider stigma (with two others identifying stigma or shame experienced by women accessing the service). Provider 4 explained that while their work environment was 'very safe', they were less confident about broader societal acceptance of their work:

> But I would say there's very few people who would talk openly about the fact that they provide that service in a social setting, because they just don't know who's there and what their view is going to be. And that's actually a stigma like, that is actually, you know, a stigma that you're carrying.

Provider 7 indicated that abortion care still remained contentious within the ICGP, describing abortion provision as a 'huge stigma. Yeah, yeah, I would think so. Yeah. It's not something that people talk about openly. Yeah, like even within GP's, I think there's a huge stigma, yeah.'

Several other providers did not use the word 'stigma' but indicated a reluctance to talk socially about this aspect of their work. Provider 12 recounted the experience of telling a good friend that they were a provider:

> she and her husband were over for drinks and the topic came up and I said, yeah, well we're doing abortions and I could see that they went, oh, and I didn't ask them, but I suspect they were people who voted in favour. But, yes, I'll vote in favour for abortion if it's sort of done over there and I don't have to think about it. Oh my God, she's actually doing it. Wow.

This provider (who does not bring the topic up in social situations) explained:

> I mean, I said it to that particular friend because I'm close enough. That I thought, whatever she thinks, she'll forgive me for it. And I also thought they need to know, some people need to know, because it's actually happening with real people. It's not just a myth that's happening over somewhere else.

In contrast to the tensions in social situations described, most providers reported limited stigma in their work environment or in broader relations with colleagues. Provider 9 identified that non-providing GP colleagues had generally been supportive and although not providing themselves, were generally pleased to see the service being provided:

> And you know, usually you know you receive admiration from colleagues who felt like I didn't feel, you know, I had the courage or whatever, but good for you. Well done. And then in terms of friends and family and, you know, neighbours or whatever, my wider circle. Yeah. I haven't received any negative feedback from anyone. In fact, quite the opposite.

As regards public perceptions, Provider 13 pointed out that the nature of general practice is that no GP is identified simply on the basis of providing abortion care:

> So we wear many hats, you know, and I don't think there's been anything, but again I don't look at social, you know, social media and stuff like that, and some people think I might be the devil incarnate. I think when they meet me and I look after their granny, I think they'll say actually he's not too bad, you know.

3.5.3 Support and Advice

Because of the method of recruitment (through IFPA and START doctors), providers interviewed were generally integrated into some form of support network. Provider 1's response was shared by many of the GP providers interviewed:

> So the START network is my main resource, so I'm on the WhatsApp group for START and that's just a brilliant resource. And you know there's consultants, there's colleagues, there's very knowledgeable colleagues, people who were involved in drafting the protocol. So you always get your answer there and usually within about 5 minutes of putting up your query. So that would be my main resource.

The significance of START doctors for the roll-out of GP-based abortion care was described by Provider 14: 'You know, I genuinely believe without START there would be no GP led termination of pregnancy in Ireland.'

Other sources of support identified by providers included: the medical director of the clinic (for women's health clinic providers); identified colleagues; consultant obstetricians; and for legal matters, Medisec or the Medical Defence Union.

3.5.4 Normalisation of Service

Most providers spoke about how the service has become increasingly normalised. Provider 9 described the challenges of the early days of provision:

> I started at the practice in February and I was the only doctor providing abortions in the practice at the time and around the country, there still weren't many providers. People weren't dipping their toe in the water, so in the beginning when I was there on my own and I was probably doing at least one abortion every day, and I found that a little overwhelming.

However, this Provider continued 'as there are more providers who trained up and then the pressure eased up. I got better at it. I got more experienced.' This increased expertise and experience is reiterated by many providers. Provider 15 described the early days as 'fairly hairy' but continued 'But it's like all things, once you're doing it regularly, you upskill in it and that at this stage, I think I'm comfortable working within my comfort zone.'

For most providers, providing abortion care has become just one element of the general service they provide. As described by Provider 8:

> providing abortions has slipped very seamlessly into what we do. I don't have a special time, I don't have a special clinic that I see them. So anyone out in the waiting room could be coming in for anything.

Many GP providers commented on the importance of abortion care being offered in general practice for women's privacy. Provider 5 explained 'You're not having to sit in a kind of an isolated sort of room with other people who are looking for the same thing. You know, you're sitting in a room where nobody knows what's wrong with you. Like any GP office. And nobody knows what you're doing when you're leaving, so that's fine.' The value of this for women is described by Provider 11: 'And I think patients really appreciate the fact that you don't know why they are there.'

Enhanced options for training was also seen as an advantage of normalisation. Provider 2 noted the change in this respect:

> It was just so taboo and off the charts and all sorts you know whereas nowadays the trainees want to learn about it because you know - like I take students from LOCAL UNIVERSITY all the time - and they see a couple of terminations every month and they see the normalcy of the care and you know it's not like as when we went through college.

While welcoming normalisation, this is not without some difficulties. Provider 8 noted:

> I do feel maybe a little bit of complacency has settled in though, that you know people who didn't provide at first, and always thought they'd see how it went, I think maybe now they're thinking ah sure there's enough of them there and now we don't need to.

3.5.5 Overall Experience of Provision

Our last question for providers asked them to identify the most positive and satisfying elements of their work. All providers were very positive about their experience. Provider 11's response is representative:

> It's one of my favourite parts of the job and that's the response of so many GP's, they really, there's something, I don't know why, whether it's because we had so much difficulty for so long we haven't yet got to take the service for granted or we're just needy doctors because the patients are so appreciative. You know, and the patients are incredibly appreciative. Either because you didn't eat them alive and make judgements about them, or because it was easy, or because they didn't pay, or you know all the different reasons people have.

For several providers, this linked back to their reasons for providing abortion care in the first place. Provider 4 described:

> So I think that is like, that just is the reward of it, is that you know that you feel you are supporting that autonomy, that people are making the decision that is best for them. And the more times you hear it the more you realize that people really have thought about what is best in this situation, and quite often there's no win for them - they're not happy about it but they know that it's the best thing for them.

Provider 2 identified broader benefits for their practice from their decision to provide:

> I think it's made us a better practice in general... There's a lot of personal growth and professional growth and, and learning, you know.

For GP providers especially there is evident pride in what has been achieved and a concern to maintain and enhance the service. Provider 3 explained:

> But within the GP community, if it was sort of like, I'll say it to colleagues, certainly I do say it to my colleagues and I say, look, this is a great service to provide and I encourage my colleagues to do it. And some of them do take it on.

4. Conclusion

The Independent Review of the 2018 Act identified the need for ongoing research to build evidence around the operation of the 2018 Act from the perspective of service users and service providers. This Working Paper contributes to this by presenting the findings from a qualitative study of EMA providers. Most findings of this study are consistent with the findings of the Independent Review, and other research studies into the operation of the 2018 Act and provide additional support to the recommendations made by the Independent Review. These include the need for greater flexibility around both the 3-day wait and the 12-week limit; the inappropriateness of criminalisation; the need for greater clarity around the limitations on the right to conscientious objection; and the importance of a roll-out of the free contraception scheme to all women of child-bearing age.

There are however a couple of points which either do not wholly align or were not part of the Independent Review investigation. First, while the CPAC study strongly reinforces the case for removal of the mandatory 3-day wait, it does not support the replacement of this with a mandatory requirement to inform the woman of her right to a 3-day reflection period which she could exercise at her own discretion. While we did not put this question directly to providers (this way of addressing the 3-day wait had not been part of discussions prior to the Independent Review), provider responses suggested that they saw clinical guidance and the operation of the professional duty of care as the best way to address situations in which a woman is experiencing uncertainty or doubt.

Secondly, a finding of this Study which is not reflected in the Independent Review (most likely because of the scope of the empirical research which underpinned the Review) is the role of conscience in the decision to provide. All of the providers in the study identified their motivation in deciding to provide in a way which can broadly be described as conscience-based (although providers typically did not use this term). Providers identified both principled and personal reasons, including from their professional experience, as to why they made the decision to provide at a time when this was a new service and potentially fraught with significant negative consequences for providers. The role of conscience in the decision to provide helps explain why many providers make such efforts (including working out of hours, phoning around secondary care providers to find appointments etc.) to ensure the service is available to and functioning for women, in spite of the legislative hurdles that are in place. It also helps explain the significant efforts made by many secondary care providers whose efforts were identified by EMA providers. However, it also means that the burden of providing abortion care may fall disproportionately on those providers who are motivated by conscience to provide this kind of care. Ultimately, this could have implications for the sustainability of EMA care. We suggest that more attention needs to be paid to the role of conscience in provision, including in education and training, especially given the dominance of conscientious objection narratives in public discourse.

Thirdly, and again not identified in the Independent Review, is the very clear finding that EMA providers have found the experience of provision to be overwhelmingly positive. Most providers identified strong support from their colleagues, especially those in their support networks but also including non-providing colleagues, as well as from other patients in their practice and the broader community. They also note women's appreciation both for the availability of the service and for non-judgemental provision. Most EMA providers also identified instances of excellent and committed secondary care providers. This is not to deny that there have been negative experiences but the clear message from the CPAC study is positive. We suggest that this positive narrative needs to be reinforced both in public discourse and in education and training.

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