

# POSITION PAPER

on

## The Updated General Scheme of the Health (Regulation of Termination of Pregnancy) Bill 2018

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<sup>1</sup> All Authors are writing in their personal capacity.

## Executive Summary

This position paper makes a number of recommendations for (i) improvements to the General Scheme (ii) designing clinical guidance to avoid unintended ‘chilling effects’ which inhibit meaningful access to abortion care (iii) policy and resource commitments (iv) regulation of the medical profession.

### Improvements to the Bill

- **Decriminalisation:**
  - Residual criminalisation of abortion should be removed.
  - If it is not removed (i) penalties should be reduced (ii) those who assist pregnant people in consensually ending a pregnancy should not be criminalised.
- **Interpretation:** Head 1 should include interpretative principles providing that the legislation “shall be interpreted in the manner most favourable to achieving positive health outcomes for the pregnant person, and to the protection of her rights”.
- **Trans\* inclusion:** ‘Woman’ should be replaced with ‘pregnant person’ or ‘woman or pregnant person’ throughout.
- **Health**
  - The law should adopt the WHO definition of ‘health’ in Head 1.
  - Heads 4-6 should require certifying practitioners to take account of the pregnant person’s own assessment of relevant risks to her life/health, or of the severity of a foetal diagnosis.
- **Abortion in Early Pregnancy**
  - **Certification:** Nurse practitioners, midwives, nurses and other qualified healthcare professionals should be authorised to certify gestation under Head 7.
  - **Time limits:** Head 7(5) should be removed, so that abortion is available up to 12 weeks gestation (14 weeks LMP).
  - **Waiting period:** this should be removed.
- **Accountability**
  - **Refusals of abortion care** including on grounds of conscientious objection should be formally notified to the Minister.
  - Time limits for **review** of refusals under Head 13 should be reduced.
  - **Lawyers or other appropriately qualified persons** should be included in panels for Head 13 reviews.
  - The legislation should provide for an **independent, human-rights-oriented review** of its operation, similar to that in the Gender Recognition Act 2015.
  - The legislation should stipulate **remedies** in cases of wrongful delay or denial of abortion care.
- **Exclusion zones** should be introduced outside premises where abortion care is provided.
- **Distribution of misleading abortion information**, including by ‘rogue’ counsellors should be regulated.
- **Display of graphic abortion imagery** should be regulated.

- **Head 18** should be removed.

## Clinical Guidance

- **Drafting and Scrutiny**
  - Draft clinical guidance should be prepared, made publicly available for scrutiny by the Oireachtas and amended if necessary before the legislation comes into force.
  - Service users, including representatives of marginalised groups should participate in drafting and scrutinising the guidance.
  - Scrutiny processes should pay particular attention to issues of human rights, and to the World Health Organisation’s guidance on safe abortion.
- **Guidance should clarify interpretation of the law, in particular:**
  - How the law will affect **miscarriage management**.
  - How the law interacts with conflicting aspects of **Catholic medical ethics**, particularly, but not exclusively, in hospital settings.
  - When and how a doctor who holds a **conscientious objection** to abortion should disclose it.
  - **Head 4**
    - That **‘serious harm’** is not a synonym for ‘permanent’, ‘protracted’ or ‘life-threatening’.
    - How **‘extraordinary life-sustaining measures’** and **‘appropriate’** are to be interpreted.
    - That a pregnant person refused access to abortion care in later pregnancy may not be subjected to alternative treatment which violates their constitutional **rights to bodily integrity or freedom from inhuman and degrading treatment**.
  - **Head 6**
    - That where the test under Head 6 is not satisfied but there is an independent risk of serious harm to the pregnant person’s health, termination under **Head 4 may be lawfully permitted and should be considered**.
  - **Head 7**
    - That all suitably qualified healthcare professionals, including nurse practitioners and midwives, can provide abortion care.
    - That multiple appointments are not mandated.
    - That onerous examinations to date pregnancy are not mandated.
    - That self-administration of pills is permitted.
    - That ‘as soon as may be’ should be understood as ‘as soon as practicable’.
    - That , except where necessary in the interests of the pregnant person’s health, Head 7 abortion care should be provided locally.
- **Guidance should detail care pathways for persons requiring special provision including** people with physical and psychosocial disabilities, minors, people living in direct provision, survivors of sexual violence and people whose capacity to make medical decisions is in question.

- **Capacity:** Guidance should clarify how the law interacts with the law on consent for minors and for adults with diminished capacity. Updates to the National Consent Policy may also be required.
- **Interlegal issues:** Guidance should clarify care pathways for pregnant people whose circumstances are also governed by other specialised legislation.

**The Minister should clarify:**

- How public information about the new law will be disseminated.
- What training will be provided for doctors implementing the legislation, and how that training will ensure rights-oriented interpretation of the legislation.
- What systems (including disclosure protocols) will be put in place for managing conscientious objection.
- What support will be available for those who still need to travel for abortion care in circumstances where Irish law does not permit it.
- What information and training will be made available to others involved in abortion decision-making; for example, those involved in assisted decision-making where a pregnant person's capacity is in issue.
- How universal access to abortion care will be guaranteed, whether under the Mother and Infant Care scheme, the new Regulation of Termination of Pregnancy Act, or an alternative scheme.

**The Medical Council, and other relevant professional bodies, should clarify:**

- What disciplinary measures will be taken where a doctor who holds a conscientious objection to abortion refuses to refer patients as required by Head 15(3).
- What steps will be taken to discourage abuses of conscientious objection.
- What disciplinary measures will be taken where a doctor wrongfully refuses abortion care under the Act.

## Introduction

One goal of the Repeal movement was to ensure equitable and agency-respecting access to abortion care in Ireland. The Updated General Scheme of the Health (Regulation of Termination of Pregnancy) Bill 2018 ('General Scheme') represents significant progress towards that goal.<sup>2</sup> However, further work is necessary. In this paper we identify:

- Some potential amendments to the General Scheme
- Some strategies for ensuring that the General Scheme is implemented and interpreted in ways which support meaningful access and the best possible health outcomes for pregnant people in Ireland.

In suggesting amendments and strategies for implementation and interpretation, we draw on lessons from other jurisdictions. European legislative models have been influential in the Irish debate so far. However, important lessons can also be learned from jurisdictions in the Global South which have faced similar challenges to Ireland in reforming abortion legislation.

### 1. Residual Criminalisation

The General Scheme is designed for a post-repeal Constitution in which women's full rights must be taken into account.<sup>3</sup> Abortion legislation must be drafted and interpreted to give effect, not only to pregnant people's right to life, but to their rights to privacy, bodily integrity, freedom of conscience, liberty, equality, and freedom from inhuman and degrading treatment.

However, the General Scheme does not make a sufficient break from the legal regime shaped and dominated by the 8th Amendment, which insisted on legal equivalence between a pregnant person and a foetus.

In particular, the General Scheme states that it is generally a crime for a doctor to carry out an abortion. This remains a serious offence carrying a penalty of up to 14 years imprisonment, ensuring Ireland maintains one of the most punitive abortion laws in the world. This offence will be subject to a small number of narrow exceptions:

- (i) Where the pregnancy has not exceeded 12 weeks (Head 7)

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<sup>2</sup> Available at

<https://health.gov.ie/wp-content/uploads/2018/07/Updated-General-Scheme-of-the-Health-Regulation-of-Termination-of-Pregnancy-Bill-2018.pdf>. Alternative 'model' legislation based on the Citizens' Assembly recommendations is in de Londras and Enright, *Repealing the 8th: Reforming Irish Abortion Law* (Policy Press, 2018).

<sup>3</sup> For a preliminary discussion of relevant constitutional rights see de Londras and Enright, *Repealing the 8th: Reforming Irish Abortion Law* (Policy Press, 2018) Ch. 2.

- (ii) Where two medical practitioners are satisfied that there is a risk to the pregnant person's life, the pregnancy is not yet viable and abortion is appropriate (Head 4)
- (iii) Where two medical practitioners are satisfied that there is a risk of serious harm to the pregnant person's health, the pregnancy is not yet viable and abortion is appropriate (Head 4)
- (iv) In an emergency where there is an immediate risk to the pregnant person's life, or an immediate risk of serious harm to her health, and termination is immediately necessary to avoid that risk (Head 5)
- (v) Where two medical practitioners are satisfied that there is present a condition affecting the foetus which is likely to lead to its death before birth or within 28 days of birth (Head 6)

The 14-year penalty is carried over from the Protection of Life During Pregnancy Act 2013. While the General Scheme also provides for a new summary offence with a maximum penalty of 12 months, the preservation of the 14 year penalty signals continuity rather than change and fails to recognise the significance of the vote to repeal the Eighth Amendment.

Moreover, much of the language of the legislation frames abortion in criminal terms, which suggests that abortion remains an unusual and stigmatised procedure under Irish law. Head 1 uses language describing termination of pregnancy as 'a medical procedure which is intended to end the life of the foetus'; this is stigmatising, and arguably is not justified in a post-repeal legal landscape in which the foetus is no longer a rights-bearing individual.<sup>4</sup> Heads 4 - 7, in setting standards for medical diagnosis, use language of 'good faith' which is unusual in a medical context, and marks these Heads out as statements of criminal defences to some offences in Head 19 rather than as statements of pregnant people's healthcare entitlements.<sup>5</sup>

The residual criminalisation of doctors under the legislation may generate 'chilling effects'; some doctors may interpret the legislation more conservatively than the Oireachtas intends, for fear of prosecution. Criminalisation also raises the prospect of 'stings' by anti-abortion activists, which may make service providers feel vulnerable to prosecution, even where they are working within the letter of the law. This fear may be a deterrent to reasonable service provision.

Because criminalisation, in this way, may inhibit legal abortion access, it is advisable to **remove specific abortion offences from the legislation**, leaving regulation of illegal, 'backstreet' or non-consensual abortion to ordinary medical regulation (including disciplinary proceedings) and the ordinary criminal law (including assault). In any case, **the 14-year maximum sentence should be reduced** to bring the law more in line with European comparators.

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<sup>4</sup> In *M v. MJELR* [2018] IESC 14, the Supreme Court confirmed that the only right of the 'unborn' was the right to life of the foetus under Article 40.3.3.

<sup>5</sup> 'Good faith' here is most likely traceable to the defence in *R v. Bourne* [1939] 1 KB 687, which was never law in Ireland.

Although it is clear that it will not be an offence for a pregnant woman to access abortion through importation and use of pills, the lack of clarity around inchoate offences (such as collusion) should be addressed. The government should **clarify whether someone who assists or encourages a pregnant person to terminate a pregnancy illegally using pills will be open to prosecution under Head 19**. For example, would a mother who obtains abortion pills for her daughter in early pregnancy be charged with inchoate offences? The possible prosecution of a friend or family member might deter vulnerable people from seeking abortion aftercare.

## **2. Definition of ‘Termination of Pregnancy’**

The definition of abortion in the General Scheme is novel in referring to intentional ending of the ‘life of the foetus’, rather than to intentional ‘termination of a pregnancy’ or ‘procuring a miscarriage.’ This is a further mark of residual criminalisation and the language itself is arguably stigmatising. It is also unclear whether some forms of miscarriage management fall within this definition. **Clinical guidelines should clarify the impact the legislation will have on care pathways for pregnant people undergoing inevitable miscarriage.**

## **3. Trans\* Inclusive Language**

The General Scheme uses ‘woman’ throughout. A pregnant trans man who has applied for a Gender Recognition Certificate is a man in Irish law.<sup>6</sup> Non-binary people have no means of legally affirming their gender under Irish law. While the Interpretation Act 2005 *may* mean that the definition of woman used in the General Scheme includes pregnant men and non-binary people, this is by no means clear. The current language is insufficient to address the needs of non-binary people. It is inconsistent with the policy commitment to trans\* inclusive healthcare, and likely to cause excluding, traumatising and stigmatising medical care experiences for trans\* people.

**The language of the Bill should be changed to ensure full trans\* inclusivity.** A possible solution is to use gender neutral language throughout, replacing ‘woman’ with ‘pregnant person’. Gender neutral language is less ambiguous. It is also more respectful of trans\* and non-binary identity, ensuring that nobody needs to accept misgendering as a condition of access to medical care. Alternatively, if there is a policy commitment to recognising that access to abortion care predominantly impacts the rights and healthcare of women, ‘woman’ could be replaced by ‘woman or pregnant person’ throughout.

## **4. Head 7 - Access to Abortion in Early Pregnancy**

Under the Scheme, before 12 weeks, doctors have no role in assessing a pregnant person’s reasons for terminating the pregnancy. The doctor’s role is to certify that in their ‘reasonable opinion formed in good faith’ the pregnancy has not exceeded 12 weeks. It is not clear why only a doctor can perform this role, and **we propose that**

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<sup>6</sup> See s.18 Gender Recognition Act, 2015

**nurse practitioners, midwives or other healthcare professionals with appropriate expertise to date pregnancies should be empowered to certify under Head 7.**

Abortion is accessible under Head 7 up to 12 weeks LMP, rather than 12 weeks' gestation. Using LMP, rather than conception or implantation, as the starting point of pregnancy has advantages in reflecting pregnancy experience and common medical practice. However, it has the restrictive practical effect of reducing the relevant period of pregnancy by approximately two weeks. Pregnant people need adequate time for reflection and decision-making after discovering that they are pregnant. Under the current draft, many pregnant people would have only a few weeks, or in some cases days, in which to make their decision. For example, some people who experience irregular menstrual cycles may not realise that they are pregnant until almost 12 weeks LMP. **Consideration should be given to removing Head 7(5), so that abortion would be available up to 12 weeks gestation.**

Head 7 does not prevent qualified healthcare professionals other than doctors from carrying out abortion procedures. This should not be amended, or contradicted in clinical guidelines. In accordance with best international practice, appropriately qualified practitioners such as **midwives, nurse practitioners and nurses should also be permitted to provide abortion care**, particularly as this helps to ensure local access.<sup>7</sup>

Head 7 does not make clear whether the person seeking an abortion must make two contacts with a doctor or doctors in order to obtain an abortion. A requirement to attend multiple appointments (one for certification, one for termination of pregnancy, and possibly others for aftercare) would be unduly burdensome for many pregnant people; for example those who struggle to access childcare, those living in controlling relationships, those whose mobility is affected by disability or those travelling from Northern Ireland. Clinical guidelines should clarify that **multiple appointments are not required.**

The doctor is required to certify that in their 'reasonable opinion formed in good faith' the pregnancy has not exceeded 12 weeks LMP. It is not clear that this standard requires in-person examination of the patient; however, the residual criminalisation of doctors under the legislation may mean that doctors feel obliged to conduct an in-person examination. Arguably, use of blood tests and ultrasounds to confirm dating of the pregnancy exceeds what is required by a 'reasonable opinion formed in good faith'. These procedures might also delay access to abortion in some circumstances. **Clinical guidelines should clarify that onerous examinations are not required in order to date the pregnancy.**

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<sup>7</sup> World Health Organisation, *Safe Abortion: Technical and Policy Guidelines for Health Systems* (2012), para 3.4.2.1: "Comparative studies have shown no difference in complication rates between women who had first-trimester abortions with MVA performed by midlevel health-care providers and those who had the procedure performed by a physician"; see further Sheldon and Fletcher 'Vacuum aspiration for induced abortion could be safely and legally performed by nurses and midwives' *Journal of Family Planning and Reproductive Health Care* (2017) 43: 260-264; available here <https://srh.bmj.com/content/43/4/260>

Head 7(3) requires the doctor to wait 3 days to make arrangements for terminating the pregnancy. Presumably, this would include waiting to prescribe necessary pills. Where pills are used to terminate the pregnancy, consideration should be given to allowing the pregnant person to take them at home; there is no good medical reason for requiring in-person supervision of use of the pills, and self-administration is common practice in several jurisdictions including France and Scotland.<sup>8</sup> **Clinical guidelines should clarify that in-person supervision of pill consumption is not required.** International evidence is clear that it is safe to take abortion pills at all points in the first trimester and they should be licensed accordingly.

There is no good reason for imposing a three-day waiting period post-certification, particularly as the General Scheme makes no provision for waiving this waiting period where applying it might lead to hardship, or might cause a pregnant person to exceed the 12-week limit for access to abortion in early pregnancy. Waiting periods do not necessarily function as periods for reflection, but exacerbate stress in abortion decision-making. **Consideration should be given to removing the waiting period in Head 7(3).**<sup>9</sup>

“As soon as may be” after the three-day waiting period has elapsed, the doctor must make arrangements for the termination. **Clinical guidelines should clarify that “as soon as may be” means “as soon as practicable”, and should set a reasonable upper time limit.**

Pregnant people should be able to access abortions from local healthcare providers in early pregnancy. A requirement that early abortions be performed in centres where ultrasound is available is likely to inhibit meaningful access to abortion, particularly in rural areas.<sup>10</sup> For this reason, **any proposal that all or some abortions in the first trimester should be performed in hospitals should be resisted.**

## **5. Head 4 – Serious Harm to Health**

This ground will provide the only viable care pathway for the majority of pregnant people who are unable to access abortion care within the 12-week limit under Head 7. These may include victims of sexual violence, minors, people living in coercive relationships, or people who have recently experienced a crisis such as bereavement.

**The WHO definition of ‘health’ should be adopted,**<sup>11</sup> to clarify that ‘health’ must be interpreted contextually, to take account of the person’s wider circumstances and social well-being, and of their own perceptions of the risks to their health. Health

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<sup>8</sup> See further Ngo et al ‘Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: a systematic review’ *Bulletin of the World Health Organization* 2011;89:360-370. doi: 10.2471/BLT.10.084046

<sup>9</sup> Until 2015, French law imposed a 7 day ‘cooling off period’, which could be reduced to 2 days if the pregnancy was approaching 12 weeks.

<sup>10</sup> In 2017, 13% of abortions in England and Wales took place between 10 and 12 weeks gestation (12 and 14 weeks LMP). This has fallen gradually from 20% in 2007.

<sup>11</sup> Constitution of the World Health Organisation, 1946

must be understood, not only as an independent right, but as interacting with other constitutional rights e.g. to autonomy, privacy and bodily integrity.

**Clinical guidelines should clarify that ‘serious’ is not a synonym for ‘permanent’, ‘protracted’ or ‘life-threatening’.** Temporary suffering or debility should also meet the statutory threshold. It is not necessary, in order for this ground to be satisfied, that doctors should foresee some risk to the pregnant person’s life.

## 6. Head 4 – Interpretation and Medical Discretion

The following elements of Head 4 are unclear, and their meaning will need to be fleshed out in clinical guidelines.

- Viability, defined as the capacity to survive outside the uterus without ‘extraordinary life-sustaining measures’.
- Appropriate.

Arguably **questions of viability and appropriateness should be dealt with under clinical guidelines** rather than in abortion legislation. If they remain in legislation, they essentially form part of a defence to some offences in Head 19, and this is likely to lead to further chilling effects.

Doctors may differ as to what constitutes an ‘extraordinary life-sustaining measure’ or ‘appropriate’ treatment. The reference to the duty to ‘have regard to the need to preserve unborn human life as far as practicable’ in s. 7 (1) (a)(ii) of the Protection of Life During Pregnancy Act 2013 is not mirrored in the General Scheme, because this duty has its origins in the Eighth Amendment. Nevertheless, if Head 4 is read conservatively, it is possible that people whose lives or health are at risk due to pregnancy will be refused access to abortion under this ground in favour of demanding interventions designed to ensure live birth. In the wake of the *Ms. Y* case, **clinical guidelines must clarify that a pregnant person refused access to an abortion in later pregnancy may not be subjected to any treatment which violates their constitutional rights to bodily integrity or freedom from inhuman and degrading treatment.**<sup>12</sup>

## 7. Head 6 - Severe and Fatal Foetal Anomaly

**The 28-day time limit in definition of ‘condition likely to lead to the death of the foetus’ may be problematic.** The March draft of the General Scheme did not include this time limit. It creates two difficulties:

- In some cases of fatal anomaly it will be possible to predict death soon after birth, but not the time-frame within which it will occur.
- The legislation clearly excludes cases where the foetus’ life expectancy after birth is short – a matter of months or years – but not as short as 28 days.

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<sup>12</sup> See further Fletcher ‘Contesting the Cruel Treatment of Abortion-seeking women’ *Reproductive Health Matters* (2014) 22:10-21.

**Clinical guidelines should clarify that, in cases of severe foetal diagnosis, where the test under Head 6 is not satisfied, but there is an independent risk of serious harm to the pregnant person's health, termination under Head 4 may be lawfully permitted and should be considered.**

**The potential interactions of the definition of viability and the definition of 'condition likely to lead to the death of the foetus' in Head 6 are unclear.** It may be implicit in the legislation that, in order to be considered viable, a foetus must be considered likely to be capable of survival outside the uterus, without extraordinary life-saving measures, for longer than 28 days. This issue might affect access to an abortion under Head 4 in cases where a pregnant person, whose own health is at risk of serious harm, has received a diagnosis of foetal anomaly where the prognosis is unclear. In particular, a harmful pregnancy might be prolonged, or treatment delayed in such cases.

## **8. Pregnant People's Agency and Voice**

The legislation currently makes little provision for patient voice in abortion care. Head 12(2) allows that a pregnant person must be heard by the review committee if she appeals a refusal of care and wishes to be heard. However, Heads 4-6 do not require the certifying doctors to consult with the pregnant person on her own assessment of risks to health or life, or of the severity of a foetal diagnosis. **Heads 4-6 should be amended to include a specific requirement to consult with the pregnant person and take account of their views.**

**Clinical guidelines should clarify that pregnant people are entitled to a reasonable degree of choice of provider, and to a choice of methods of termination where more than one method is available.** For example, in some cases a choice of surgical or non-surgical methods should be available, or a pregnant person should be entitled to refuse induction of labour.

The government bears the responsibility of ensuring that everyone living in Ireland is aware of the new law on abortion, and that pregnant people receive all necessary information to enable them to access care under the new legislation. **Appropriate information and education campaigns should be supported.** As part of this, consideration should also be given to **regulating 'rogue' abortion counsellors and other agencies involved in distributing misleading or fraudulent abortion information.**

## **9. Consent and Capacity**

Head 14 states that the ordinary law of consent to medical treatment shall apply to abortion. However, the government has not clarified whether repeal of the Eighth

Amendment, in its view, means that current legal limitations on pregnant people's right to refuse consent to medical treatment are stripped of effect.<sup>13</sup>

Head 14 makes no reference to issues of capacity as these relate to minors, in particular to so-called 'mature' or *Gillick*-competent minors; children under the age of 16 who can demonstrate competence to make their own medical decisions. It is not clear whether such children will be permitted to make abortion decisions for themselves.

Head 14 makes no reference to adults whose decision-making capacity is in question. Until commencement of the Assisted Decision-Making Capacity Act 2015, a person whose decision-making ability has been legally removed will be a ward of court, and a court or committee of the ward will make abortion decisions on the person's behalf.<sup>14</sup> When that Act is commenced, abortion decisions will be taken with the support of a decision-making assistant, or co-decision-maker if one has been appointed. In some circumstances, a declaration of lack of capacity will be sought, and a court will appoint a decision-making representative, or will decide for itself whether to seek an abortion on the person's behalf. The government should clarify whether expedited decision-making will be possible in these circumstances, especially where the pregnant person is accessing abortion under Head 7 and is subject to the 12-week deadline. It is also essential that courts and persons assisting in abortion decision-making receive appropriate training and information on the abortion legislation.

**These issues around consent should be fully clarified in clinical guidelines, and in updates to the National Consent Policy. Clinical guidelines should emphasise the importance of respect for the pregnant person's rights, even where decision-making capacity is perceived to be in issue.** Particular attention should be paid to circumstances where the preferences of any interlocutor in the decision (e.g. a parent or co-decision-maker) are seen to override the will and preference of a child/vulnerable adult.

## 10. Clinical guidelines

As discussed, the proposed legislation may harm some pregnant people if it is not interpreted in a manner consistent with protecting their constitutional and human rights. Clinical guidelines are an important source of reassurance for doctors in implementing the new law; they are entitled to certainty, especially because the General Scheme provides for some residual criminalisation of doctors who provide abortions which are not permitted by the legislation. However, clinical guidelines also have a role in ensuring security and certainty for people who need to terminate their pregnancies. **It is recommended that:**

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<sup>13</sup> *National Consent Policy* (HSE, 2017), 41.

<sup>14</sup> See further: The National Safeguarding Committee, *Review of current practice in the use of wardship for adults in Ireland* (December 2017) available here <http://safeguardingcommittee.ie/wp-content/uploads/2018/06/Wardship-Review-2017.pdf>

- **There is transparency in drafting clinical guidelines. Draft clinical guidelines should be published and scrutinised by the Oireachtas, and amended if necessary, before the legislation comes into force.**
- **Service users, including representatives of marginalised groups (e.g. people with physical and psychosocial disabilities, minors, people living in direct provision, survivors of sexual violence and people whose capacity to make medical decisions is in question) participate in drafting and scrutinising the guidance.**
- **Clinical guidelines reflect the World Health Organisation’s recommendations on safe abortion.<sup>15</sup>**
- **Clinical guidelines clarify care pathways for groups with distinct needs including people with physical and psychosocial disabilities, minors, people living in direct provision, survivors of sexual violence and people whose capacity to make medical decisions is in question.**
- **Clinical guidance does not put any unduly conservative ‘gloss’ on the legislation.<sup>16</sup>**
- **Consideration is given to how the clinical guidelines may interact with Catholic medical ethics.**
- **Doctors responsible for implementing the legislation receive human-rights-oriented training in interpreting and implementing it. Such training should also be incorporated into the curricula of Irish medical schools.**

In addition to clinical guidelines, other jurisdictions have benefited from initiatives designed to generate consensus between doctors, lawyers, healthcare professionals and reproductive health activists around human-rights-oriented interpretation of the legislation. An example is the Colombian organisation La Mesa por la Vida y la Salud de las Mujeres.<sup>17</sup>

To reinforce clinical guidelines, **consideration should be given to including interpretative principles in the legislation which provide that it “shall be interpreted in the manner most favourable to achieving positive health outcomes for the pregnant person, and to the protection of her rights.”**

## 11. Interlegal Issues

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<sup>15</sup> WHO, *Safe Abortion: Technical and Policy Guidelines for Health Systems* (2012)

<sup>16</sup> For an example of guidelines which encourage restrictive interpretation of the law see discussion of Northern Ireland in Whitaker and Horgan, ‘Abortion Governance in the New Northern Ireland’ in De Zordo et al (ed), *Abortion: A Fragmented Landscape* (Berghahn, 2016) 252-254. The United Kingdom Supreme Court has recently given the view that the current law in Northern Ireland is disproportionate and incompatible with Art 8 ECHR insofar as that law prohibits abortion in cases of (a) fatal foetal abnormality, (b) pregnancy as a result of rape and (c) pregnancy as a result of incest; see *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27; available here <https://www.supremecourt.uk/cases/uksc-2017-0131.html>. This shows how restrictive interpretations contribute to rights non-compliance.

<sup>17</sup> See further Gonzalez-Velez and Jaramillo, ‘Legal Knowledge as a Tool for Social Change’ (2017) 19(1) *Health and Human Rights* 109

Some patients will be subject to more than one legislative regime when they request an abortion under the new legislation. For example, some cases may fall under the Mental Health Act and abortion legislation;<sup>18</sup> under immigration and abortion legislation, or under the mandatory reporting provisions of Children First and abortion legislation. Ambiguity about the interaction of separate Acts may lead to delays in access to treatment. **Clinical guidelines should spell out clear care pathways for pregnant people whose circumstances are also governed by other legislation.** In particular, it should be made clear that obligations under reporting protocols such as *Children First* operate parallel to the Act and do not require interruption or delay in the provision of abortion care.

## 12. Conscientious Objection

The General Scheme makes provision for conscientious objection on the same basis as the Protection of Life During Pregnancy Act 2013. Medical professionals may refuse care on the basis of a conscientious objection under Head 15. Only those participating in carrying out the termination of pregnancy are entitled to withhold care in this way – other staff such as porters, administrators, and those providing aftercare are not. Under Head 15(3) those asserting a conscientious objection owe a duty of referral: they are obliged to make such arrangements for timely transfer of the pregnant person’s care as may be necessary to enable her to terminate the pregnancy.<sup>19</sup> The medical professional’s constitutional right to freedom of religion and conscience under Article 44.2.1 is ‘subject to public order and morality’, including the need to vindicate the rights of others, and the duty of referral protects the pregnant person’s rights to bodily integrity, freedom of conscience, privacy and freedom from inhuman and degrading treatment.

**Clinical guidelines should clarify when and how a doctor who holds a conscientious objection to abortion should disclose it.** Particular care should be taken in disclosure of conscientious objection to patients:

- A doctor refusing to certify an abortion under Heads 4-7 for reasons of conscientious objection should notify the pregnant person of his objection in writing.
- Hospitals and general practitioners should be required to publish information making patients aware of the fact that personnel hold a conscientious objection e.g. on websites, in practice leaflets, and on posters in public areas.

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<sup>18</sup> See e.g. *HSE v. BS* [2017] IEDC 18

<sup>19</sup> The so-called ‘New Zealand option’ is sometimes suggested as a substitute for Head 15(3). In *Hallagan v Medical Council of New Zealand*, 2 December 2010, the New Zealand High Court held that a doctor if approached by an abortion-seeking woman, may refuse to consider her case at all. Then the doctor does not owe a duty of referral, but must inform the woman of her right to have her case considered by a different doctor. However, the Court also held that, if the doctor has evaluated the woman’s entitlement to access an abortion, and only then decides to exercise a conscientious objection, a duty of referral and non-abandonment applies. By analogy, arguably, once a woman requests an abortion under Head 7, the doctor has already begun to consider her case and the duty of referral applies. It is also worth bearing in mind that in New Zealand, under the Contraception, Sterilisation and Abortion Act 1977, abortion is available on health grounds up to 20 weeks, and so the risks of delay are not as great as under the Irish scheme. For these reasons the ‘New Zealand option’ is not relevant to the Irish case.

- Consideration should be given to requiring doctors who hold a conscientious objection to declare this (in advance of commencement of the legislation) to the Department of Health; to enable the Department to identify areas of unmet abortion need.

**The Medical Council should clarify what disciplinary measures will be taken where a doctor who holds a conscientious objection to abortion refuses to refer patients as required by Head 15(3).**

**The Medical Council should also clarify what steps it will take to discourage abuses of conscientious objection.** It is unacceptable for a doctor who holds a conscientious objection to abortion to participate in assessment of a pregnant person under Heads 4-6 in an effort to obstruct access to legal abortion care. It would also be unacceptable for a doctor to disclose a conscientious objection which is not sincerely held simply because he prefers not to participate in abortion care for other reasons.<sup>20</sup>

The Catholic Bishops' Code of Ethics<sup>21</sup> suggests that hospitals should be entitled to assert 'institutional conscience' as a justification for prohibiting provision of legal abortion care on their premises. Institutional conscience is not recognised as a right under international human rights law.<sup>22</sup> Under Article 44.2.5 of the Constitution, the church enjoys denominational autonomy; 'the right to manage its own affairs'. It is doubtful whether reproductive healthcare comes squarely within a denomination's 'own affairs'. Article 44.2.5 may not apply to the secular functions of publicly funded hospitals in the first place.<sup>23</sup> Even if Article 44.2.5 does apply, its protections are not absolute – protection for denominational autonomy must be balanced against protection for the rights of pregnant people who need to access abortion care and of hospital employees who are willing to provide it. Arguably, by providing for a statutory right of individual conscientious objection, while restricting institutional assertions of conscientious objection, the General Scheme imposes only a proportionate burden on publicly-funded hospitals which subscribe to a religious ethos.

**In the event that mass conscientious objection makes abortion inaccessible across a particular geographic area, or hospital, the state should take steps to fulfil its positive obligation to ensure alternative provision for pregnant people.** The government should clarify what provision is being made to manage this risk. Would the state, for example, fund abortion travel between counties?

Conflicts between law and Catholic medical ethics may manifest, not only in conscientious objection, but in interpretation of the legislation. For example, under Head 4 (1)(c), Catholic medical ethics may direct a doctor to prefer to prolong a pregnancy which is near viability, on grounds that abortion is not 'appropriate'. What

<sup>20</sup> See further Fletcher, Conscientious Objection, Harm Reduction and Abortion Care, in Donnelly and Murray eds. *Ethical and Legal Debates in Irish Healthcare* (Manchester University Press, 2016)

<sup>21</sup> Irish Catholic Bishops Conference, *Code of Ethics for Healthcare* (Veritas, 2018)

<sup>22</sup> See discussion in O'Neill Institute and Women's Link, *Conscientious Objection: A Global Perspective on the Colombian Experience* (Georgetown University, 2014)

<sup>23</sup> Article 44.2.5 has previously been invoked in respect of employees who were under the direction of a religious superior. See e.g. *McGrath and O'Ruairc v. Maynooth College* [1979] ILRM 166

a doctor considers ‘appropriate’ may be influenced by religious values. Catholic medical ethics might also be relevant to the provision of ancillary services; for example a conscientious objector might be reluctant to share the results of a scan which disclose a foetal anomaly, if they suspect the pregnant person will choose to terminate the pregnancy.

The Bishops’ code of medical ethics does not always prescribe concrete rules for Catholic doctors; rather, doctors must manage the interaction of religious and secular law in accordance with their own conscience. Accordingly, pregnant people may have very different experiences of the law, depending on their doctors’ religious commitments.

**Clinical guidelines should address the intersection of the General Scheme with Catholic medical ethics, to ensure equality of abortion access for all pregnant people.** Additional research, or public hearings, may be required to identify likely areas of conflict.

### 13. Exclusion Zones

The Minister for Health has suggested that it may be necessary to use exclusion zones to manage anti-abortion activity outside locations where abortion care is provided. An exclusion zone is a designated space within which any protest, or interference with service users, or with employees providing abortion services, is an offence. **Exclusion zones should be introduced to protect healthcare providers and pregnant people in their provision of and access to abortion care.** Such zones are necessary to prevent conduct outside abortion care facilities which cannot reasonably be managed using injunctions, or existing powers under criminal law. Unwanted conduct might include protest, display of disturbing images, public prayer, or activities designed to dissuade the pregnant person from entering the healthcare facility. This is a breach of service-users’ right to privacy because it exposes them to public scrutiny while they are making an intimate and sometimes stigmatised medical decision. It further infringes on the lives of workers in those facilities who should be able to enter and exit their workplace without harassment.

Exclusion zones are an infringement on protestors’ rights to freedom of expression and assembly. However, those rights are not absolute. Exclusion zones may be a proportionate measure to achieve the legitimate aim of protecting the privacy rights of service users and health service employees. In order to strike an appropriate balance, consideration should be given to:<sup>24</sup>

- The size of the zone (e.g. 150m from facility entrance)
- The specific activities to be prohibited within the zone.<sup>25</sup> These should not be confined to efforts to directly obstruct access to a healthcare facility by impeding free movement, but should also include any behaviour likely to intimidate service users or disrupt employees’ working conditions.
- Whether the operation of the zone will be reviewed regularly.

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<sup>24</sup> See further *Dulgheriu v. Ealing* [2018] EWHC 1667

<sup>25</sup> This is why the blanket exclusion zone in the U.S. Supreme Court case of *McCullen v. Coakley* 134 S. Ct. 2518 was struck down.

- Whether those who would wish to engage in protest, or in conversation with service users will have an alternative means of exercising their freedom of expression.
- The powers of an Garda Síochána and other security personnel to enforce those zones (e.g. arrest as a last resort).

An exclusion zone will not prevent all illegitimate attempts to dissuade pregnant people from accessing facilities where abortions are provided. **Some consideration should be given to regulating distribution of misleading abortion information,<sup>26</sup> and to the display of graphic materials even outside of exclusion zones.<sup>27</sup>**

#### **14. Remedies, Reviews,<sup>28</sup> and Accountability**

Serious questions arise around accountability for refusals of care (leading to ‘wrongful births’), or delays in access to care under the General Scheme:

- Head 17 provides that all terminations of pregnancy shall be notified to the Minister, but says nothing about refusals. Although reviews of refusals are reported under Head 13, not all refusals will lead to a review. In particular where a doctor refuses to certify an abortion under Head 7 (before 12 weeks), the pregnant person is not entitled to a review under Head 8.
- Before 12 weeks, presumably the pregnant person refused care (for reasons other than conscientious objection as regulated by Head 15) is expected to approach another doctor. After 12 weeks, if a doctor refuses to certify, or refuses to offer any opinion on whether a pregnant person is entitled to an abortion, the pregnant person may apply for a review under Head 8. The review appears from Head 11 to be a fresh decision, rather than an inquiry into whether the first decision to refuse certification was correct, or taken properly. Head 8 does not require a doctor to provide written reasons for refusal.
- Head 15 makes no provision for recording refusals on the basis of conscientious objection.

**The legislation should be amended to require notification of refusals to the Minister, including refusals on the basis of conscientious objection.** The notification process should enable the Minister to identify areas of unmet need and non-provision, and reasons for refusal of care. It should also enable the Minister to assess whether grounds under the legislation are being interpreted appropriately. The notification process should not identify patients or doctors individually.

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<sup>26</sup> See de Londras and Enright, *Repealing the 8th: Reforming Irish Abortion Law* (Policy Press, 2018) 116

<sup>27</sup> s. 7 of the Criminal Justice (Public Order) Act 1994 is inadequate in this respect because breach of the peace is an element of the offence. A graphic image can be intimidating and intrusive without occasioning a breach of the peace.

<sup>28</sup> In 2017, there were 15 terminations under the PLDPA and 1 application for review, which was successful. In 2016, there were 25 terminations under the PLDPA, and 1 application for review, which was successful. In 2015, there were 26 terminations under the PLDPA and 1 application for review, which was successful.

**The legislation should make provision for an independent, human-rights-oriented review of its operation, equivalent to that in s. 7 of the Gender Recognition Act 2015.** This should take place within 2 years of commencement of the Act. This review should encompass the views and experiences of service users.

A review process under Head 11 may take up to 10 days after the pregnant person applies for a review (3 days under Head 10(1) and 7 days under Head 11(1)). Delays of this kind are obviously inappropriate in cases where the pregnant person's life is at risk, or their health is at risk of serious harm. **These time limits should be reduced.**

**Consideration should be given to including lawyers, or other appropriately qualified persons, in the review process to encourage human-rights-oriented interpretation of the legislation.**

No provision is made for remedy in situations of wrongfully denied abortion care, even where this results in a pregnant person becoming ineligible for lawful abortion by exceeding time limits. The only envisaged 'remedy' appears to be the provision of an abortion following a 'review'; however this would not provide effect relief or remedy to women denied care too late in the process to be able to access abortion in Ireland or by travelling abroad. **Clinical guidance should clarify the disciplinary implications of wrongful denial of care. The professional bodies, including the Medical Council, should clarify their position on the disciplinary measures which can be taken if a doctor wrongfully refuses care to a pregnant person entitled to access an abortion under this legislation. Consideration should be given to the remedy for a pregnant person where abortion care is wrongfully denied.**

## **15. Continued Travel**

The general constitutional right to travel is not removed by repeal of the Eighth Amendment. Some pregnant people will need to continue to travel to access abortions. These will include people who are not legally entitled to access abortions after 12 weeks in Ireland. Many of these people will face financial and other obstacles to travel, In particular, those who receive diagnoses of serious anomalies falling outside the terms of Head 6 should be considered. These families will encounter many of the same difficulties as families who receive a fatal diagnosis, including around repatriation of remains and funeral arrangements.

The General Scheme provides for repeal of the Regulation of Information (Services outside the State for the Termination of Pregnancies Act 1995). As a result, doctors will be permitted to provide information to patients on travel abroad, and refer them for treatment at foreign facilities. However, there is no legal guarantee of access to appropriate facilities abroad.

**Consideration should be given to whether and how the State will support people who need to travel for abortion care in circumstances where Irish law does not permit it.**

## 16. Universal Provision and a Statutory Right to Abortion Care

It is important that abortion is normalised within the wider healthcare system. However, abortion access triggers particular human rights concerns which mean that the public health case for universal provision is very strong. Moreover, failure to provide affordable abortion care is likely to lead to continued reliance on online abortion pill providers.

Universal primary healthcare provision is a rarity in Ireland.<sup>29</sup> We can assume that abortion care will be available free to GP visit/medical card holders up to 12 weeks. However, many pregnant people who are not entitled to GP visit/medical cards may struggle to raise the money for GP consultations and prescription fees in time to obtain an abortion under Head 7.

There is, in theory, universal access to public hospital care in Ireland. However, long waiting lists present difficulties. It is also not clear whether a person terminating a pregnancy in hospital would be required to pay if they do not hold a medical card.

Free pregnancy counselling and related medical care is currently provided by a range of human rights promoting reproductive health organisations, such as the Irish Family Planning Association and Dublin Well Woman Centre. This is publicly regulated and funded. Consideration should be given as to how to make the most of this experience and local reach.

**The Minister should clarify whether universal abortion care will be provided under the Mother and Infant Care scheme, under the new law, or under a different new legislative scheme, perhaps also providing for universal free access to contraception.**

## 17. Regulation of Providers

The practical function of Head 18 is unclear. It does not appear to prohibit commercial or employment relationships between those providing abortion counselling and information, and those willing to provide abortion care in Ireland or abroad. Its purpose seems to be to stigmatise providers by raising the spectre of unreasonable remuneration for related services. **Head 18 should be removed.**

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<sup>29</sup> Exceptions include GP care for children under six, and cervical screening