

Briefing Paper on the Health (Regulation of Termination of Pregnancy) Bill 2018: Making the Legislation Work, Delivering on the Referendum

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¹ This briefing should be read in conjunction with Enright, Fletcher, de Londras and Conway, “Position Paper on the General Scheme of the Health (Regulation of Termination of Pregnancy) Bill 2018” (15 August 2018), available at <https://lawyers4choice.files.wordpress.com/2018/08/position-paper-1.pdf>

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Recommendations

All recommendations refer to section numbers as per the version of the Health (Regulation of Termination of Pregnancy) Bill 2018 as initiated.

1. Legislative purposes and definitions: general principles

Recommendation 1a: Open the legislation with a statement that the purpose of the legislation is to ensure rights-respecting access to abortion care.

Recommendation 1b: Amend the long title of the Bill to reflect its character as a more enabling, rather than limiting provision. Specifically, rephrase the long title as: "An Act to ensure that pregnant people may have equitable access to abortion care in a safe and timely manner, and at no cost, and for that purpose to amend [relevant legislation as currently listed]."

Recommendation 1c: Define termination of pregnancy as "induced abortion to end a pregnancy using a medical or surgical procedure".

2. Patient safety: general requirements

Recommendation 2a: Provide that abortion be delivered in a 'safe' manner by 'competent' individuals rather than specifying where, and by what specific categories of healthcare practitioners, abortion can be performed. The specific details of these requirements should be contained in implementation guidance.

Recommendation 2b: Remove or at least reduce unnecessary requirements that risk obstructing best clinical practice. In particular, amend sections 10, 12, and 13 to remove any requirement that the same medical practitioner examines, certifies, and carries out the abortion.

Recommendation 2c: Throughout the Bill, use the term "competently trained healthcare practitioner" instead of "medical practitioner".

Recommendation 2d: The definition of "competently trained healthcare practitioner" should clearly include those with the necessary level of skill, training and qualification to legitimately participate in certifying, making arrangements for and carrying out abortions.

3. Regulating access: specific requirements for early pregnancy: section 13

Recommendation 3a: Amend section 13(1) to replace 'having examined' with 'having consulted with.'

Recommendation 3b: In clinical guidance clarify and explain the different modes of consultation and examination that may be appropriate in different concrete contexts.

Recommendation 3c: Amend section 13 to remove the 3-day mandatory waiting period by deleting section 13(2)(b)

Or

Recommendation 3d: If agreement cannot be secured to remove this clause, clarify that the mandatory waiting period will not apply where its application would contribute to undue hardship and compromise pregnant people's rights including by risking exceeding the 12-week limit for access to abortion in early pregnancy:

- At the end of section 13(2)(b) add the following: 'unless the application of the 3 day period is overly burdensome to a woman or pregnant person, including because it may contribute to them exceeding the 12 week limit referred to in subsection (1).'

4. Regulating access: specific requirements after 12 weeks of pregnancy: in cases of risk to life or health under section 10

Recommendation 4a: Amend section 10 so as to reflect its objective (protecting a pregnant person's health or life and respecting their rights) more clearly:

- Section 10(1)(c): Replace 'avert' with 'reduce', in order to avoid the possibility that too high a threshold of risk prevention would be adopted in practice.
- Section 10(1)(c): Add 'and to give effect to the pregnant person's wishes' after 'reduce the risk referred to in paragraph (a)'
- Section 10(1)(a): Replace 'serious harm' with 'harm'

Recommendation 4b: Remove Section 10(1)(b) so as to remove foetal viability as a limitation on access to abortion where pregnancy poses a risk to the life or of serious harm to the health of the pregnant person, *Or*

Recommendation 4c: Remove the reference to 'extraordinary life-sustaining measures' in the definition of viability in section 9.

5. Regulating access: specific requirements after 12 weeks of pregnancy in cases of conditions likely to lead to death of the foetus under section 12

Recommendation 5: Amend section 12(1) to replace "that is likely to lead to the death of the foetus either before, or within 28 days of, birth" with "that is likely to lead to the death of the foetus before or shortly after birth"

6. Punishing unlawful abortion: specifying criminal offences under section 5

Recommendation 6a: Delete section 5(4).

Recommendation 6b: Amend section 5 in order to meet legal standards of clarity and necessity. Specifically, adopt the following new language:

- Section 5(1): It shall be an offence for a person intentionally or recklessly
 - (a) to cause injury or death to a pregnant person such as to cause their pregnancy to end; or
 - (b) without consent to administer any drug or substance to a pregnant person such as to cause their pregnancy to end.
- Section 5(2): It shall be an offence for a person intentionally to coerce or deceive a pregnant person into having an abortion against their will or without their knowledge.

Recommendation 6c: Add a new subsection to section 5: "Subsections (1) and (2) shall not apply to a healthcare practitioner acting in good faith".

Recommendation 6d: In clinical guidance provide examples of the kinds of evidence that medical practitioners may take into account in forming reasonable, good faith opinions about whether the legal criteria under sections 10, 11, 12 and 13 are met.

Introduction: The gap between the Health (Regulation of Termination of Pregnancy) Bill 2018 and post-repeal expectations

In repealing the Eighth Amendment³ on the 25th May 2018, the public provided a mandate to pass a law that would decriminalise abortion, show respect for pregnant people's wishes, and enable provision of compassionate healthcare, especially for the most vulnerable. If the Health (Regulation of Termination of Pregnancy) Bill 2018 is enacted in its current form it will fail to reflect the ethos of the repeal mandate. It will give rise to a legal framework that does not facilitate appropriate abortion care and requires compliance with suboptimal clinical protocols.⁴ This briefing proposes that the Oireachtas continue the good legal practice of the Citizens' Assembly and the Joint Oireachtas Committee on the Eighth Amendment by building on available good will and expertise to scrutinise the proposed legislation, amending it as appropriate, and delivering on the people's vote.

Some of the Bill's provisions have not been published or scrutinised before, and others have been published but not scrutinised. The Joint Oireachtas Committee on the Eighth Amendment and the Citizens' Assembly contributed significantly to the quality of public debate about what an abortion law should look like if the referendum passed. Now that the amendment has passed and the Eighth Amendment has been replaced by the Thirty-Sixth Amendment, the Oireachtas has an important opportunity to build on the internationally recognised deliberative processes that facilitated the repeal vote, and consider the specific terms by which access to abortion care will be made lawful. In this briefing, we draw on our collective legal expertise to raise particular questions about proposed statutory provisions that carry legal risks because they are likely to (1) generate unnecessary barriers to lawful abortion access, and (2) stigmatise and punish activities that have beneficial motivations and effects. By way of introduction we identify two examples to illustrate problems 1 and 2 and clarify how the recommendations would cure the problems.

Example One: One of the Bill's new requirements, that was not published or scrutinised before now, is that the medical professional who certifies that an abortion is lawful, must also be the medical professional who carries out or makes arrangements for the abortion. As we explain below, this is unnecessary, contradicts normal clinical practice of task-sharing, and risks becoming a legal requirement that delays or even inhibits access to an abortion. Abortions that would be lawful under the Bill may not be accessible in practice as a result of these procedural requirements. For example, a person who has had a section 13 abortion certified by doctor A, could become legally unable to have that abortion in a timely fashion if doctor A becomes ill and is not able to transfer care of their patient to doctor B as would normally happen, because of procedural requirements (mandatory waiting period, non handover of care etc) under the proposed new law. These requirements are inconsistent

³ Throughout this Briefing 'the 8th Amendment' is used as shorthand to refer to the totality of Article 40.3.3 as it existed prior to repeal and replacement by the 36th Amendment to the Constitution.

⁴ Here the government is failing to learn from how provision of abortion has developed in other countries. For example, research in Great Britain found "[s]ome clinics now offer treatment protocols (including same day or near simultaneous administration of mifepristone and misoprostol) that are known to be clinically less effective" in order to avoid a woman having to travel back to the clinic. See Sally Sheldon 'How can the state control swallowing: Medical Abortion and the Law (2016) https://www.kent.ac.uk/law/mabal/Medical%20Abortion%20and%20the%20Law_web.pdf

with good medical practice. Unless the Bill is amended to resolve this problem, an unnecessary legal provision risks letting pregnant people down and leaving them unable to access abortion care in Ireland, even though the Eighth Amendment has been repealed. Recommendations 1 and 3, in particular, propose amendments in this regard.

Example Two: Another of the Bill's new aspects is that section 5(4) makes acts of aiding, abetting, counselling or procuring a pregnant woman to access abortion other than in accordance with the law a criminal offence punishable by up to 14 years in prison. This may criminalise acts of friendship, assistance and good will, and inadvertently exacerbate vulnerabilities experienced by some pregnant people. Consider the example of a 15-year-old girl who lives in a small village in rural Ireland. She becomes pregnant and finds the pregnancy unsupportable. She does not have access to public transportation and her GP is a family friend. Her parents are extremely strict and are not aware that she is sexually active. She does not believe that she can access abortion care from her GP in confidence, and she has no way to access an alternative provider given her lack of transportation. She detects her pregnancy at 8 weeks LMP. She confides in an older sister who is attending university and living away from home, and whom she asks to help her to access abortion care. The older sister does so by ordering abortion pills online and providing them to her sister, and by staying with her while she induces an abortion using these pills. The younger sister who had the abortion has not committed a crime because of the exemption under section 5(3). The older sister, however, who has acted here from care and to give effect to the wishes of her sister, has aided "a pregnant woman to intentionally end, or attempt to end, the life of the foetus of that pregnant woman otherwise than in accordance with the provisions of this Act" in contravention of section 5(4). The abortion is "otherwise than in accordance with the provisions of this Act" because it has not been certified as being in relation to a pregnancy of less than 12 weeks LMP as required by section 13. The older sister has committed a serious crime under section 5(4) and could be prosecuted, and subject to a maximum sentence of 14 years. This effect of section 5(4) does not honour the ethos of the repeal vote, over-criminalises activities relating to abortion, and imposes a disproportionate punishment.

The recommendations that we make in this briefing are intended to assist with the task of scrutinising the Bill, including by proposing amendments that address objectives of and definitions in the Bill, remove unnecessary barriers to abortion care, and address over-criminalisation.

1. Legislative purposes and definitions: General principles in enabling access to safe, compassionate and lawful abortion

1.1 Clarifying and affirming the legal objective of providing access to abortion care

The legal objective of the legislation should be consistent with the repeal of the 8th Amendment and focused on enabling access to abortion care, rather than restricting abortion. The legislation should thus include a statutory commitment to take all practical steps to ensure that the new abortion law vindicates the full range of pregnant people's rights. This is particularly important because it is a well-recognised aspect of legal reform that, even with the best of intentions, old legal habits die hard. The people's decision to bring about constitutional change should be given statutory effect by explicitly providing for a

guarantee of access. Such legal provisions would help to minimise the risk of restrictive interpretation of the legislation, which may inhibit the will of the Oireachtas in practice.

Abortion is an issue both of human rights and of necessary medical care. Abortion legislation must be drafted and interpreted to give effect to the full range of pregnant people's rights, including rights to life, privacy, bodily integrity, freedom of conscience, liberty, equality, and freedom from inhuman and degrading treatment. In addition, legislation should be designed to facilitate provision of abortion care in accordance with international best practice. The Health (Regulation of Termination of Pregnancy) Bill 2018 is a regulatory scheme that will shape how medical care is provided, and its rights-respecting purposes should be transparent.

Recommendation 1a: Open the legislation with a statement that the purpose of the legislation is to ensure rights-respecting access to abortion care. For example:

Guarantee of access

(a) The Minister for Health shall ensure that pregnant people may access abortion care in accordance with the terms of this Act in a safe and timely manner. The Minister shall be responsible for the provision and regulation of abortion care to the highest attainable standards.

(b) Access to abortion care, including to related sexual and reproductive healthcare before and after an abortion, shall not be impeded on discriminatory grounds, including on grounds of race, sex, religion, national or ethnic origin, marital or family status, immigration status, sexual orientation, age, or other social status.

(c) In making any decision under the Act, or in providing medical care and services under this Act, the provisions shall be interpreted in the manner most favourable to achieving positive health outcomes for the pregnant person, and to the protection of their rights.⁵

And/or Recommendation 1b: Amend the long title of the Bill to reflect its character as a more enabling, rather than limiting provision. Specifically, rephrase the long title as: "An Act to ensure that pregnant people may have equitable access to abortion care in a safe and timely manner, and at no cost, and for that purpose to amend [relevant legislation as currently listed]."

1.2. Defining termination of pregnancy consistently with the objective of providing lawful, destigmatised compassionate abortion care

The 36th Amendment allows for provision to be made "for the regulation of the termination of pregnancy". "Termination of pregnancy" includes but is not limited to abortion. The Health (Regulation of Termination of Pregnancy) Bill 2018 is specifically aimed at regulating

⁵ This is as recommended in 'IFPA response to Health (Regulation of Termination of Pregnancy) Bill 2018 (Irish Family Planning Association, 2 October 2018), drawing on Mairead Enright, Vicky Conway, Fiona de Londras, Mary Donnelly, Ruth Fletcher, Natalie McDonnell, Sheelagh McGuinness, Claire Murray, Sinead Ring, Sorcha ui Chonnachtaigh, "General Scheme of the Access to Abortion Bill 2015" (2015) 5(1) *feminists@law*.

abortion. Its exclusive focus on abortion, rather than other forms of termination of pregnancy, ought to be made clear.

The current definition of termination of pregnancy in section 2 provides that “termination of pregnancy, in relation to a pregnant woman, means a medical procedure which is intended to end the life of a foetus.” Particularly when read in light of its use in the criminal offences in section 5, the definition implies that the foetus has independent legal status to be protected by criminal law. This position has no constitutional basis in the absence of the 8th Amendment,⁶ and the definition fails to recognise the significance of the new constitutional arrangements. This language stigmatises and misrepresents the actions of those who are ending a pregnancy in good faith and in order to achieve constitutionally endorsed objectives. An alternative definition, which describes a termination of pregnancy in more neutral terms, while recognising that foetal life ends through induced abortion, would be more appropriate.

Recommendation 1c: Define termination of pregnancy as "induced abortion to end a pregnancy using a medical or surgical procedure". In clinical guidance, clarify the different modalities of inducing abortion and ending foetal life.

2. Regulating for patient safety and eliminating or reducing unnecessary requirements that obstruct best clinical practice: General requirements

Generally, medical practice is regulated through the lens of patient safety. In order to be safe, pregnant people must not be exposed to non-consensual treatment, risky delays, or avoidable injuries. As we outline here, certain provisions in the current Bill are individually problematic, and taken as a whole give rise to an unworkable structure that is likely to lead to unsafe clinical care.

2.1 Providing that abortion be delivered in a ‘safe’ manner by ‘competent’ individuals

At present the Bill specifies where, and by what specific categories of healthcare practitioners, abortion can be performed. These provisions are both unduly specific for primary legislation, and unduly restrictive of which healthcare professionals can provide abortion care. They thus risk over burdening some categories of healthcare professional, over-medicalising the provision of abortion including in early pregnancy, and becoming quickly out dated. Specific requirements on who can provide abortion care and where should instead be contained in implementation guidance.

Unnecessarily restricting abortion provision to a small pool of personnel and locations has clear potential to obstruct delivery of legislative objectives and may hinder best clinical practice. Ireland has an important opportunity to learn from other jurisdictions, which are moving away from an approach that imposes restriction by limiting provision to particular people or places.⁷ Best clinical practice evolves over time and relevant legislative provisions

⁶ Rather, following the Supreme Court in *M*, any legal interest in foetal life ought to be understood as an aspect of the common good, which is to be respected consistently with pregnant people’s rights.

⁷ For example, in a 2008 evaluation of Early Medical Abortion, Ingham and Lee found that “Some staff respondents stressed that the quality and training of the staff involved were more important factors than the physical location, subject to certain basic requirements being met”. See R Ingham and E Lee

may become out-dated very quickly if they do not facilitate the provision of safe and competent care.

Minister Harris has stated his intention to require General Practitioners to refer people who are between 9 and 12 weeks pregnant to 'a consultant obstetrician in a hospital environment'. This could create a clear hurdle to accessing care and may lead to unnecessary delay or obstruction.⁸ This is particularly problematic given the restrictions placed on abortion after 12 weeks gestation.

Recommendation 2a: Provide that abortion be delivered in a 'safe' manner by 'competent' individuals rather than specifying where, and by what specific categories of healthcare practitioners, abortion can be performed. The specific details of these requirements should be contained in implementation guidance.

2.2 Removing the unnecessary linkage between certification and carrying out an abortion in order to enable normal task sharing between professional colleagues

The provisions on certification in sections 10, 12, and 13 are (1) difficult to understand, and (2) out of step with the usual approach to collegial/team management of a patient's needs in a community or hospital setting. In making certification practically unworkable, the legislation risks setting delivery of abortion care up for failure. We note that these arrangements were not scrutinised by the Joint Oireachtas Committee on the 8th Amendment or during the referendum campaign. They should therefore now be subjected to close scrutiny for their impact on effective access to abortion care, and on the practicalities of the provision of medical care.

Section 13: Section 13(2)(a) of the Bill states that the medical practitioner who carries out the termination of pregnancy must also have examined the pregnant person and certified

(2008) *Evaluation of Early Medical Abortion (EMA) pilot sites* Department of Health http://webarchive.nationalarchives.gov.uk/20130123193543/http://www.dh.gov.uk/en/PublicationsandStatistics/Publications/PublicationsPolicyAndGuidance/DH_084618_p.104 ; see also 'Health worker roles in providing safe abortion care and post-abortion contraception' (WHO, 2015) http://apps.who.int/iris/bitstream/handle/10665/181043/WHO_RHR_15.15_eng.pdf?sequence=1 which breaks abortion care down into its component tasks and assesses who can should be able to perform these tasks on basis of by reference to patient safety.

⁸ The US Supreme Court decision in the case of *Whole Woman's Health v. Hellerstedt* 579 U.S (2016) is instructive here. This case was a challenge to several legal restrictions placed on providing abortion care, including that the providing clinic should have admitting privileges at a hospital not more than 30 miles away. Restrictions of this sort are, known as TRAP (Targeted Regulation of Abortion Providers) laws, have been successful advocated for by anti-abortion activists in order to restrict access to abortion services in the USA. We are not suggesting that the motivations for restrictions on place or personnel in the draft Irish legislation are the same as those which underpin USA TRAP laws. However, it is clear that a consequence of over-regulation of abortion care, through restrictions such as those on place or personnel found in this Bill, make provision of care burdensome. The requirement that a hospital be involved directly in care (as opposed to available if complications arise) is analogous to a TRAP law. It inhibits access by increasing travel times and risk of overcrowding, but there is no health risk to justify it, given how rarely complications arise. Restrictions on place and personnel may also create unnecessary competition for resources between those being referred to hospital care/ ultrasonography for an abortion and those who require hospital care/ ultrasonography as part of their standard maternity care; see further Dr Noirin Russell 'First trimester termination of pregnancy – challenges in secondary care' <http://startireland.ie/resources/UCC%20talk%2006102018%202322%20Noirin.pptx>

that the pregnancy has not exceeded 12 weeks (dated from first day of last menstrual period) under section 13(1)). The abortion may not be performed by, for example, a colleague in the same practice. There is no medical rationale for requiring the person who certified gestation to provide the abortion. Furthermore, section 13(3) adds unnecessary confusion by requiring that the medical practitioner “shall make such arrangements as he or she shall deem to be necessary for the carrying out of the termination of pregnancy” once the mandatory waiting period has expired.

Sections 10 and 12: The certification processes outlined in sections 10 and 12 are similarly problematic. Section 10(1) and section 12(1) each require that “2 medical practitioners, having examined the pregnant person, are of the reasonable opinion formed in good faith” that specified grounds making an abortion permissible are met. Section 10(2) and section 12(2) require that at least one of the examining physicians is of a particular medical specialism. Section 10(4) and section 12(4) then require that the specialist physicians in 10(2) and 12(2) carry out the abortion.

Thus, across the Bill, the same doctor(s) must perform three separate functions: (1) examine the pregnant person, (2) certify their entitlement to access abortion, and (3) terminate the pregnancy.

It is not medically necessary for the same doctor to perform these three different aspects of providing abortion care. Indeed, this requirement flies in the face of good medical practice. As with any health service, managing a sustainable and timely abortion service requires the possibility of distribution and handover of care to accommodate working patterns and the possibilities of justifiable staff absence due to illness, holidays, care responsibilities or other needs. These provisions are poorly drafted and do not appear to be informed by a proper understanding of how clinical practice, including in multi-disciplinary teams, normally works. It is particularly important to amend section 13 given the impact of the mandatory waiting period.

Finally, requiring that the practitioner who certifies legal eligibility is also the person who makes arrangements for the carrying out the termination could cause problems for the accommodation of conscientious objection (section 23) within the health service. These two sections, read together, could create a binary structure whereby clinicians either must sign up for all aspects of abortion care or none. This is problematic because some practitioners may be content to certify that a procedure is necessary or permissible under the law but, for reasons of conscience, may object to any further involvement in treatment. The Bill in its current form does not facilitate this.⁹

Recommendation 2b: Remove or reduce unnecessary requirements that risk obstructing best clinical practice. In particular, amend sections 10, 12, and 13 to remove any requirement that the same medical practitioner examines, certifies, and carries out the abortion.

⁹ Dr Jayne Kavanagh 'Conscientious Objection in Practice', Presentation at MVA Training, Dublin (27 September 2018)

2.3 Ensuring internal consistency and enabling future implementation of best practice

The Bill's provisions in relation to the roles of medical practitioners in participating in abortion care are (1) internally inconsistent and (2) out of step with international best practice.

Sections 10, 12, and 13 of the Bill only permit medical practitioners (i.e. doctors as defined by the Medical Practitioners Act 2007 as amended) to certify, make arrangements for, or carry out terminations of pregnancy. It is well recognised, including by the WHO, that nurses, midwives, and other competently trained individuals can have a significant role to play in delivering abortion care, and that they should receive appropriate training and support in that regard.¹⁰ The requirement of medical practitioner involvement in every case is overly specific. Instead the Bill should ensure that whoever provides care is competently trained and qualified. We note, in addition, that, although sections 10, 12, and 13 confine participation in abortion care to doctors, section 23 on conscientious objection refers to medical practitioners, midwives and nurses, suggesting that midwives and nurses will be participating in abortion care. Their exclusion from sections 10, 12, and 13 thus introduces internal inconsistency into the Bill.

Recommendation 2c: Throughout the Bill, use the term “competently trained healthcare practitioner” instead of “medical practitioner”.

Recommendation 2d: The definition of “competently trained healthcare practitioner” should clearly include those with the necessary level of skill, training and qualification to legitimately participate in certifying, making arrangements for and carrying out abortions.¹¹

3. Regulating access: specific requirements for early pregnancy in section 13

3.1. In requiring ‘examination’ rather than consultation, section 13 adopts legal language that inhibits rather than facilitates best medical practice

Examination is commonly understood to mean in-person physical examination of a patient. These examinations are often physically intrusive (e.g bimanual pelvic exams and transvaginal ultrasounds) and should not be mandated where they are not required and medically justified. In the context of early medical abortion, consultation with the patient should be sufficient for certifying that an abortion is permissible. While this *may* entail examination in some circumstances, it would be more appropriate for clinical guidelines to specify these than for legislation to mandate it in all circumstances.

¹⁰ Safe Abortion: technical and policy guidance for health systems (2nd Edition) (WHO, 2012), p. 65: “Abortion care can be safely provided by any properly trained health-care provider, including midlevel (i.e. non-physician) providers. The term “midlevel providers” in the context of this document refers to a range of non-physician clinicians (e.g. midwives, nurse practitioners, clinical officers, physician assistants, family welfare visitors, and others) who are trained to provide basic clinical procedures related to reproductive health, including bimanual pelvic examination to determine age of pregnancy and positioning of the uterus, uterine sounding and other transcervical procedures, and who can be trained to provide safe abortion care” (available at http://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf;jsessionid=4CF1FDA64212A7644483F7AB2B16C2D9?sequence=1).

¹¹ See also ‘IFPA response to Health (Regulation of Termination of Pregnancy) Bill 2018 (Irish Family Planning Association, 2 October 2018)

The requirement under section 13 to ‘examine’, rather than ‘consult with’, a patient as part of the certification process risks infringement of bodily integrity, and potentially places an obligation on the treating doctor to undertake a clinically unnecessary procedure. It also prevents ‘future proofing’ of the legislation so that it can accommodate developments in telemedicine. Requiring examination by law when it is not clinically necessary, erects a legal barrier to access and puts those with less access to, or do not wish to be treated by,¹² a local medical practitioner at particular disadvantage. The proposed law therefore has potentially harmful consequences, is disproportionate to its legal objective, and may give rise to unnecessary and overly intrusive medical procedures.

Recommendation 3a: Amend section 13(1) to replace ‘having examined’ with ‘having consulted with.’

Recommendation 3b: In clinical guidance clarify and explain the different modes of consultation and examination that may be appropriate in different concrete contexts.

3.2. The imposition of a 3-day mandatory waiting period is not evidence-based and may result in inability to access abortion care

The difficulties already noted with section 13 are exacerbated by the mandatory 3-day waiting period required between certification and performance of an abortion. Such waiting periods are problematic,¹³ particularly where they may result in inability to access abortion care. This may happen where the waiting period causes the pregnant person to exceed the time limit for lawful abortion, or where living in coercive or abusive circumstances may make it impossible for a pregnant person to access medical professionals on multiple occasions within a short time period. As noted by the WHO,

Mandatory waiting periods can have the effect of delaying care, which can jeopardize women’s ability to access safe, legal abortion services and demeans women as competent decision-makers.¹⁴

The interaction of the mandatory waiting period with the requirements made of a medical practitioner in sections 13(1) and 13(3) make it even more problematic. If the practitioner who certified the abortion is not available to perform the termination after a period of three days the pregnant person could potentially have to restart the whole process.

Recommendation 3.c: Amend section 13 to remove the 3-day mandatory waiting period by deleting section 13(2)(b)

Or

¹² See for example the reasons for travel identified by Christabelle Sethna and Marion Doull in ‘Spatial disparities and travel to freestanding abortion clinics in Canada’ (2013) 38 Women’s Studies International Forum 52–62

¹³ Enright, Fletcher, de Londras and Conway, “Position Paper on the General Scheme of the Health (Regulation of Termination of Pregnancy) Bill 2018 (15 August 2018), available at <https://lawyers4choice.files.wordpress.com/2018/08/position-paper-1.pdf>

¹⁴ Safe Abortion: technical and policy guidance for health systems (2nd Edition) (WHO, 2012) http://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf;jsessionid=4CF1FDA64212A7644483F7AB2B16C2D9?sequence=1 p.96

Recommendation 3.d: If agreement cannot be secured to remove this clause, clarify that the mandatory waiting period will not apply where its application would contribute to undue hardship and compromise pregnant people’s rights including by risking exceeding the 12-week limit for access to abortion in early pregnancy:

- At the end of section 13(2)(b) add the following: ‘unless the application of the 3 day period is overly burdensome to a woman or pregnant person, including because it may contribute to them exceeding the 12 week limit referred to in subsection (1).’

4 Regulating access: specific requirements after 12 weeks in cases of risk to life or of serious harm to health under section 10

Section 10 specifies the requirements for access to abortion in the context of risks to the life or of serious harm to the health of the pregnant person. Section 10(1) states that an abortion may be performed where “2 medical practitioners, having examined the pregnant person, are of the reasonable opinion formed in good faith” that certain grounds are met.

Section 10 clearly aims to do away with the harmful binary distinction between a risk to life and a risk to health that accompanied the Eighth Amendment and contributed to poor clinical treatment for women, including Savita Halappanavar. This is a welcome development. However, as currently drafted, section 10 poses serious difficulties in realising that aim.

First, the current wording sets a very high threshold for access to abortion in all circumstances after 12 weeks. Once the 12-week protected period has passed, lawful abortion will only be available for reasons related to serious health risks. This is unlikely to serve the needs of pregnant people in Ireland, some of whom will seek abortion after 12 weeks for other reasons. In a 2008 study of reasons for second trimester abortions Ingham *et al* identify several reasons why a person may request abortions at this stage including lack of knowledge or understanding of pregnancy or a change in life circumstances.¹⁵ The current wording of the legislation means that pregnant people in these scenarios may be forced to continue with their pregnancies or to continue to travel or access abortion pills online.

Second, section 10 includes terms such as ‘appropriate’ and ‘avert’ that were not scrutinised during the Citizens’ Assembly or the Joint Oireachtas Committee. These terms are amenable to restrictive interpretation that may delay the provision of treatment needed to preserve pregnant people’s health and respond appropriately to circumstances of vulnerability. Legislators, and the members of the Health Committee in particular, now have an important opportunity to scrutinise the impact of including these terms in the legislation in order to assess whether they will facilitate or obstruct the kind of abortion provision that is expected in the wake of the referendum vote.

Section 10(1)(c): Appropriateness and averting risk

¹⁵ Roger Ingham ‘Reasons for Second Trimester Abortions in England and Wales’ (2008) 16 *Reproductive Health Matters* 18-29

Section 10(1)(c) states that, in addition to agreeing that a relevant risk is present, the two certifying doctors must be satisfied that: “it is *appropriate* to carry out the termination of pregnancy in order to *avert* the risk referred to in paragraph (a)” (emphasis added).

There are a number of serious concerns with this subsection. First, the assessment of appropriateness does not focus on the wishes or best interests of the pregnant person; there is no requirement to assess whether an abortion is ‘appropriate’ by reference to whether an abortion or continuation of pregnancy and delivery is safer for the pregnant person. The only requirement seems to be to assess whether it will ‘avert’ the risk to life or health that has been identified. The legal risk is that this section could be interpreted in practice as requiring a pregnant person to continue a pregnancy or go through a very premature delivery even if an abortion is safer for them and is their preferred course of action. In order to clarify that the law does not require this rights-violating and clinically suboptimal situation, it should be amended to require respect for a pregnant person’s wishes when determining appropriateness.

Second, ‘avert’ is ordinarily understood to mean ‘prevent’. Therefore, in situations where an abortion would considerably reduce risks to life or health but not fully avert them, there is a legal risk that a pregnant person could be forced to continue with a pregnancy on the grounds that the need for aversion, rather than reduction or considerable reduction, had not been met. Placenta accreta (morbid adherence of the placenta to the wall of the uterus, usually to a C-section scar from a previous pregnancy) is an example of a condition in which abortion at an earlier post-viability gestation would undoubtedly be safer for the pregnant person. This is because the longer the pregnancy continues the more the placenta grows into the scar and the more serious the morbidity becomes. In such a case, ending a pregnancy at an earlier gestation would reduce but not completely eliminate the risk. Under the current wording of the legislation, a person who at 14 weeks gestation requires an abortion due to a condition like placenta accreta would meet the requirements of sections 10(1)(a) (risk to health) & 10(1)(b) (pregnancy has not reached viability), but may not meet the criteria of section 10(1)(c) as the abortion would not completely *avert* the risk but instead reduce it. That person may thus not be entitled to access abortion and might instead be required to travel for abortion care.

Thus, the current wording of this subsection does not do enough to prevent the unworkable framework that was imposed by the 8th Amendment from having residual effects in some scenarios where abortion is requested and recommended after 12 weeks gestation. The attempt to balance the rights of the pregnant person and those of the foetus under the 8th Amendment contributed to poor clinical outcomes, including death, for pregnant women. This kind of treatment-compromising balancing is exactly what repeal of the 8th amendment sought to remove from clinical decision-making, but seems to be reinscribed in s. 10(1).

Finally, this subsection is particularly problematic given that it is currently unclear whether repeal of the 8th Amendment means that pregnant people will have the same right to refuse medical treatment as any other competent adult. Section 10 does not require the treating doctor to show that s/he has taken account of the pregnant person’s assessment of risks to their life or health, or to have meaningfully consulted with her. This omission in itself tends to

suggest that, as under the 8th Amendment, seriously ill women may be subjected to burdensome treatment against their will.¹⁶

Recommendation 4a: Amend section 10 so as to reflect its objective (protecting a pregnant person's health or life and respecting their rights) more clearly::

- Section 10(1)(c): Replace 'avert' with 'reduce', in order to avoid the possibility that too high a threshold of risk prevention would be adopted in practice.
- Section 10(1)(c): Add 'and to give effect to the pregnant person's wishes' after 'reduce the risk referred to in paragraph (a)'
- Section 10(1)(a): Replace 'serious harm' with 'harm'

Section 10(1)(b): Viability

Section 10(1)(b) states that the 2 certifying doctors must be satisfied that: "the foetus has not reached viability". Section 9 defines viability as the point of pregnancy at which "the foetus is capable of survival outside the uterus without extraordinary life-sustaining measures". The words "without extraordinary life-sustaining measures" were not included in the March version of the General Scheme and have not been scrutinised. The March version of the General Scheme defined viability as "the point in pregnancy at which, in the reasonable opinion of a medical practitioner, the foetus is capable of sustained survival outside the uterus". Although that original wording has not been scrutinised, it is closer to the usual clinical understanding of viability.

Defining viability by reference to extraordinary treatment is problematic, vague, and gives rise to a ground that may be subject to a range of interpretations. Deirdre Madden suggests that:

The distinction between ordinary and extraordinary or heroic measures in Ireland and elsewhere was probably influenced by the theology of the Roman Catholic Church where extraordinary treatment is regarded as treatment which is excessively burdensome or without benefit for the patient. It is possible to classify different treatments, such as nutrition and hydration, as always either ordinary or extraordinary, and so as always obligatory or optional.¹⁷

For example a clinician may form the view that all treatment is 'ordinary' if the alternative is the ending of foetal life. The ambiguity as to what constitutes 'extraordinary' in the context of neonatal treatment is even harder to resolve, as summarised by Margaret Brazier and David Archard:

Neonatal intensive care is invasive and burdensome. A baby may be subjected to 200 or so intrusive and painful procedures in one fortnight.¹⁸

Given that invasive and intensive treatments of neonates may be construed as 'ordinary' treatment in some clinical contexts, this legal standard is too difficult and unclear to apply in

¹⁶ See, by contrast, de Londras and Enright, *Repealing the 8th*, (Policy Press, 2018) 113

¹⁷ Deirdre Madden *Medicine, Ethics, and the Law* (3rd Edition) (Bloomsbury Publishing, 2011) p.579

¹⁸ Margaret Brazier and David Archard 'Letting babies die' (2007) 33 *Journal of Medical Ethics* 125-126

practice. As a result, access to abortion could be denied on grounds that the foetus could be viable via invasive and intensive treatment, even when there is a clear case that a pregnant person's life or health is at risk. This is even more problematic given that the provision does not currently specify that the pregnant person's consent is required before any measures are taken to ensure the foetus attains neonatal viability. The interaction of this section's approach to viability with the definition of a fatal foetal anomaly in section 12 is also unclear and worrisome.

Furthermore, no satisfactory scrutiny has been undertaken of the proposal that 'foetal viability' should determine the lawfulness of the provision of abortion in situations where there is a risk to a pregnant person's life or a serious risk of harm to their health. While normal clinical practice would be for a viable foetus to be delivered early, and for all appropriate steps to be taken to try to maintain neonatal life in these circumstances, the imposition of a statutory provision requiring early delivery in situations even of risk to the life of a pregnant person may have the effect of delaying decision-making or medical treatment where the foetus is at the cusp of viability, thus potentially exacerbating the risk to a pregnant person's life or health. Continuing criminalisation may further hinder medical decision making in such circumstances. The fact that the pregnant person cannot choose to end their pregnancy through termination in such circumstances, even where it may be considerably safer for them and foetal viability may not be clear, further compounds the difficulties such a provision may cause. Serious consideration should thus be given to removing foetal viability as a limitation to access to abortion where there is a risk to the life, or a risk of serious harm to the health, of a pregnant person.

Recommendation 4b: Remove Section 10(1)(b) so as to remove foetal viability as a limitation on access to abortion where pregnancy poses a risk to the life or of serious harm to the health of the pregnant person

Or

Recommendation 4c: Remove the reference to 'extraordinary life-sustaining measures' in the definition of viability in section 9.

5. Regulating access: specific requirements after 12 weeks of pregnancy in cases of conditions likely to lead to death of the foetus under section 12

This section is intended to enable access to abortion for those people who find themselves in the distressing circumstances of having received a diagnosis that their pregnancy is not likely to lead to a positive birth outcome. In contrast to the wording of the General Scheme published in March 2018, the section now specifies that the foetus must have a condition likely to lead to death *within 28 days of birth*. While diagnosis of foetal anomaly involves high levels of certainty, prognosis does not. While it may be possible to predict that death soon after birth is likely, it is not usually possible to set out the exact time frame within which it will occur. Timelines of this sort are not currently used in clinical practice as part of the prognosis for a particular condition. The legislation clearly excludes cases where life expectancy after birth is short, and potentially burdensome and painful for the neonate. This means that parents who receive diagnoses of serious and fatal anomalies, but where a life expectancy

of less than 28 days cannot confidently be predicted, will still be required to travel abroad for abortion care if they decide they cannot continue with the pregnancy.

There is nothing to suggest that the 28-day time limit excludes invasive and intrusive measures to keep the neonate artificially alive, but possibly in great pain and with little or no prospect of independent, pain-free survival. The 28-day time limit has not been scrutinised and the Health Committee should consider whether it is an appropriate statutory provision. There is no need to specify a timeline for foetal death in the legislation; instead the wording as proposed in the March 2018 General Scheme could be restored. This clearly limits access to lawful abortion to situations of fatal diagnosis for the foetus, but better supports parents who decide it would best to access abortion care in Ireland where an exact life expectancy cannot be clinically predicted.

Recommendation 5: Amend section 12(1) so as to replace “that is likely to lead to the death of the foetus either before, or within 28 days of, birth” with “that is likely to lead to the death of the foetus either before or shortly after birth”.

6. Punishing unlawful abortion: Specifying criminal offences under section 5

The continued criminalisation of abortion gives rise to a problematic legal framework that is inconsistent with the objective of providing rights-respecting access to reproductive healthcare. Section 5 with its three separate abortion-related offences involving the ‘intentional ending of the life of the foetus’ gives the impression that the legislation is primarily criminal. This contradicts one of the clear messages associated with the vote to repeal the Eighth Amendment, which was to destigmatise and decriminalise abortion care.

International human rights organisations have condemned the use of criminal law in the regulation of abortion care.¹⁹ Specifically with regard to Ireland, the European Court of Human Rights (ECtHR) has accepted that the threat of criminal sanction has the potential to have a ‘chilling effect’ on clinical practice.²⁰ The wording of these offences (particularly ‘intentional ending of the life of the foetus’) closely resembles the punitive tone of the Protection of Life During Pregnancy Act 2013, (‘intentional destruction of unborn human life’). The offences carry with them a maximum sentence of 14 years. All of this is particularly problematic given the legacy of criminalisation consequent to the 8th Amendment.

Ideally, abortion should be completely decriminalised. Any residual offences related to non-consensual acts causing a pregnancy to end either intentionally or recklessly should be much narrower than those currently contained in the Bill. They should be tailored specifically to the harms that the law seeks to avoid. Any offences should come at the end of the Bill rather than clouding the legislation’s key objective: providing rights-respecting access to abortion care. It would be more appropriate to begin the Bill with a statement that outlines

¹⁹ For example ‘She is not a criminal: The impact of Ireland’s Abortion Law’ (Amnesty International, 2015) pp 104-106. https://www.amnesty.org.uk/files/she_is_not_a_criminal_report_-_embargoed_09_june.pdf

²⁰ A, B and C v. Ireland (2010) ECHR 2032, Application no 25579/05

the government's commitment to ensuring access to abortion care in accordance with principles of international best practice (Recommendation 1, above).

6.1 Reducing the chilling effects of the criminal law

It is well established that criminalisation of abortion does not reduce the incidence of abortion.²¹ Indeed, a recent study indicates that there is often a higher incidence of abortion in countries where restrictions are tighter.²² Therefore, the best way to reduce the need for medically unsupervised abortions is to ensure accessible abortion care, not to criminalise people, effectively shutting them out of the healthcare system. While the Bill decriminalises access to abortion for pregnant people, which is important, its criminal provisions are designed in such a way as to impose a serious chilling effect on medical practice and to criminalise acts of friendship, care and support where someone seeks abortion outside of the provisions of the new law.

The potential for criminal sanction places medical practitioners in a vulnerable position. In particular, and as experienced in other jurisdictions, the generation of 'sting operations' in order to pursue both public and private prosecutions is an established tactic of anti-abortion activism.²³ Such tactics have the effect of making practitioners cautious in their interpretation and implementation of law.²⁴ This caution can mean, in practice, that treatment protocols are hyper-cautious,²⁵ and abortion is not effectively available even where it is legally permitted. Although prosecutions are in fact rare as medical professionals generally apply abortion law in good faith, criminal provisions can be manipulated to generate a fearful, stigmatising environment, potentially decreasing the number of health care practitioners willing to provide abortion care. Furthermore, such an environment can mean that those who do provide abortion care are more conservative in how they interpret the law, leading to a negative impact on provision.²⁶ Thus, any residual criminalisation must be closely scrutinised to ensure that it provides sufficient legal security within which medical professionals can provide abortion care consistent with the law.

6.2 Specifying criminal offences in order to meet legal tests for clarity and necessity

Residual criminalisation has a negative impact on those who seek to assist persons seeking abortion. This is so where the law seeks to criminalise those who aid, abet, counsel or procure abortion, as in this Bill. Section 5(4) specifically provides that someone who acts

²¹ 'Highly restrictive laws do not eliminate abortion'

<https://www.gutmacher.org/infographic/2018/highly-restrictive-laws-do-not-eliminate-abortion>

²² 'Highly restrictive laws do not eliminate abortion'

<https://www.gutmacher.org/infographic/2018/highly-restrictive-laws-do-not-eliminate-abortion>

²³ See further Sheelagh McGuinness 'A Guerrilla Strategy for a Pro-life England' (2015) 7 *Law, Innovation and Technology* 283-314.

²⁴ See Deirdre Duffy et al, "Abortion, emotions and health provision: Explaining health care professionals' willingness to provide abortion care using affect theory" (2018) 71 *Women's Studies International Forum* 12-18.

²⁵ This is in evidence in some hospital trusts in England and Wales. See, Ellie Lee et al 'The 1967 Abortion Act fifty years on: Abortion, medical authority and the law revisited' (2018) 212 *Social Science and Medicine* 26-32.

²⁶ See for example 'Doctors 'afraid to sanction abortions' amid sharp rise in prosecutions' (25 January 2017) <https://www.irishnews.com/news/healthcarenews/2017/01/25/news/doctors-afraid-to-sanction-abortions-amid-sharp-rise-in-prosecutions-904522/>

with the consent of the pregnant person in order to assist them in accessing abortion (by, for example, ordering pills for them online), is committing a serious criminal offence and liable for up to 14 years imprisonment upon conviction. While the intention may be to protect pregnant people from coerced abortion, section 5(4) as currently drafted clearly goes beyond this. It creates a new offence of aiding, abetting, counselling or procuring a pregnant person to end their pregnancy otherwise than in accordance with the provisions of the Bill. This provision was not included in the March 2018 General Scheme and has not been scrutinised.

Given that the referendum was premised on legislation that promised decriminalisation of the pregnant person it is difficult to interpret the vote as giving a mandate to criminalise those who help and support a pregnant person in doing something that is not in itself a crime.

The offences in section 5(4) are framed in terms of secondary liability, and seem to model those found in section 7(1) of the Criminal Law Act 1997 (“Penalties for assisting offenders”). Secondary liability arises where someone has aided, abetted, counselled or procured an act that is criminal to be done by another. However, in this case it is not a crime for the pregnant person to undertake the conduct in question (i.e. the abortion other than in accordance with the Act). Thus, there is no crime attracting primary liability. As a result, an offence modelled on secondary liability is difficult to justify, this is even more so when one considers that the wording used here is extremely broad. For example, in England and Wales the term ‘counsel’ has been broadly defined to include ‘encourage’. Should such an interpretation be adopted here innocuous behaviour might well be criminalised. For example, if a person were to muse aloud in the company of another about whether to end their pregnancy outside the terms of the law, the other’s silence might be interpreted as encouragement and thus criminalised. Thus, in this context, secondary liability is too broad and undefined a concept to underpin an offence, and creates the possibility that genuine acts of friendship and support will be criminalised.

We can identify only one other example in Irish law where similar wording is used to criminalise behaviour said to be secondary to a decriminalised activity: assisted suicide in section 2(2) of the Criminal Law (Suicide) Act 1993. It is troubling that the same approach would be taken to abortion now that it is to be decriminalised, not least because abortion does not involve the ending of a life that has constitutional rights. These are not equivalent scenarios and should not be treated as equivalent by the criminal law.

Finally, there is no justification for imposing a 14-year sentence for such an offence.

Recommendation 6a: Delete section 5(4).

6.3 Non-consensual ending of pregnancy & coerced abortion

Section 5(4) may have been intended to address harms related to coercion or undue influence to have an abortion. Such activities are harmful and criminal regulation may be appropriate, however it is possible to frame an offence more specifically and appropriately than is done in the current wording of section 5(4). Specific offences regarding non-consensual ending of a pregnancy and coerced abortion should be framed in a way that centres the rights and interests of the pregnant person. The creation of an offence of causing

a pregnancy to end without the consent of the pregnant person could be taken as an opportunity to acknowledge the particular harms experienced by those who are caused to lose a pregnancy in this way. The Bill currently fails to do this.

Recommendation 6b: Amend section 5 in order to meet legal standards of clarity and necessity. Specifically, adopt the following new language:

- Section 5(1): It shall be an offence for a person intentionally or recklessly
 - (a) to cause injury or death to a pregnant person such as to cause their pregnancy to end; or
 - (b) without consent to administer any drug or substance to a pregnant person such as to cause their pregnancy to end.
- Section 5(2): It shall be an offence for a person intentionally to coerce or deceive a pregnant person into having an abortion against their will or without their knowledge.

6.4. Protecting and defending medical practitioners who provide good faith abortion care and contribute to the development of good standards of clinical care

At present, the Bill requires that relevant medical practitioners form ‘a reasonable opinion in good faith’ that the criteria for lawful access have been met, as provided for across sections 10, 11, 12 and 13. This means that medical practitioners will be able to defend themselves against criminalisation and stigmatisation by reference to their reasonable, good faith opinions that the pregnancy was less than 12 weeks gestation, or that there was a risk of serious harm to the health of the pregnant person. In order to make it clearer to medical practitioners that no criminal offence takes place where a medical practitioner is acting in good faith and in accordance with the law, a specific defence of good faith should be included for medical professionals in section 5.

Recommendation 6c: Add a subsection to section 5 that provides: “Subsections (1) and (2) shall not apply to a healthcare practitioner acting in good faith”

Requiring reasonable, good faith provision as a component of the criteria for lawful access also means that the development of good legal standards for rights-respecting abortion care will rely on medical practitioners being able to exercise their clinical judgment in forming such reasonable opinions in good faith. Criminalisation may inhibit them in doing so.

For example, dating a pregnancy is not an exact process, and even where ultrasound is appropriately used it has “an error margin of up to six days”.²⁷ Therefore a ‘reasonable opinion’ that the pregnancy has not exceeded 12 weeks would allow pregnancies of 12 weeks + 6 days to be accommodated if ultrasound is used, given the relevant margin of error. However, uncertainty around and fear of criminal prosecution in cases of error may encourage doctors to use tests that are not medically necessary to date a pregnancy (e.g. requiring an ultrasound as a precondition to referring for secondary care), or even to refuse access at 11-12 weeks because they cannot be absolutely certain that the pregnancy is not

²⁷ If undertaken in the first trimester ultrasound “has an accuracy of approximately 95%, with an error margin of up to 6 days. There is an increasing error margin of up to 2 weeks the later the dating scan is performed.”

[https://www.figo.org/sites/default/files/uploads/IJGO/papers/Contemporary%20Issues%20in%20Women%E2%80%99s%20Health%20\(December%202013\).pdf](https://www.figo.org/sites/default/files/uploads/IJGO/papers/Contemporary%20Issues%20in%20Women%E2%80%99s%20Health%20(December%202013).pdf)

too advanced. This would have clear implications for the fulfilment of pregnant people's rights.

Therefore, implementation guidelines should reassure doctors that there is no risk of prosecution where the pregnancy is dated in good faith, using ordinary dating methods. Similar reassurance will be necessary in a range of other contexts.

Recommendation 6d: Clinical guidelines should provide examples of the kinds of evidence that medical practitioners may take into account in forming reasonable, good faith opinions about whether the legal criteria under sections 10, 11, 12 and 13 are met.

Conclusion: Towards better legal practice

Repeal of the 8th amendment and insertion of the 36th Amendment clearly provided a mandate to the Oireachtas to regulate abortion by law. While the electorate may have reasonably expected this law to reflect the principles of the General Scheme published in March 2018, there is no requirement that the legislation as passed would be a carbon copy of that Scheme or be unduly limited by it where best medical and legal evidence suggest that it would lead to poor outcomes for pregnant people.

This Briefing provides both illustrations of the potentially negative effects of the Bill as initiated and practical suggestions for its improvement. It is intended to support members of the Health Committee and the Oireachtas in developing what was mandated on the 25th of May 2018: workable, rights-respecting legislation that puts the needs of pregnant people at the centre, supports best medical practice, and breaks decisively with the damaging structures of the 8th Amendment.