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Ireland since the repeal of the Eighth Amendment

A Irlanda desde a revogação da Oitava Emenda

Irlanda desde la derogación de la Octava Enmienda

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In 2018, Ireland changed its strict anti-abortion laws. The recommendations of a national citizens assembly were central to this change [1].

A referendum took place in May 2018. Campaigning for and against with the hashtag Repeal the Eighth (#Repealthe8th). A cross-society campaign called *Together for Yes* resulted in the incorporating doctors, lawyers, parents, grandparents. The result was an overwhelming majority of 67% versus 33% in the voting.

Politicians worked hard to ensure the popularity of this law among households. Some people criticized the speed of the movement which left little time to debate nuances about the subject.

Medical opinion cautioned on specific issues such as a mandatory three-day-wait which was not evidence-based and such mandatory wait was considered as a concession supporting conservative groups. Other areas of discussion included the gestational limit of 12 weeks of pregnancy (with no restriction until this time) and how this limit would be estimated. Doctors were worried that the law did not mention whether the feticide were legal or not, which is a normal practice in terminations for fetal abnormality in other countries.

The published law enables termination without restriction for pregnancies up to 12 completed weeks as the first circumstance. However, the law also establishes a mandatory three-day-wait for the first appointment to offer medical or surgical treatment.

The second circumstance, a lawful termination, may occur when the fetus has a significant anomaly expected to be fatal or cause death within 28 days. This lawful termination was created to include cases of trisomy 13 and 18 but it does not include trisomy 21, anencephaly, and encephalocele. Ireland has presented in the recent years the NIPT (non-invasive prenatal testing) which is widely available but incurs an out-of-pocket fee. A note was required to clarify if the feticide was actually legal.

The third circumstance occurs when the woman's life or health is at risk both by medical condition or by risk of suicide. In those circumstances, there is no gestational limit for the termination.

The Department of Health asked the Institute of Obstetricians and Gynaecologists and the Royal College of General Practitioners (RCGP) to produce clinical guidelines [2,3,4] in line with the proposed legislation. The Department provided a strong administrative support evidencing the commitment with the process. Doctors worked tirelessly to produce the guide in accordance with the law. Despite the doctors' effort, the guideline creation faced some resistance, for example, both the Institute and the

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RCGP had internal discord with the leading to EGMs (Extraordinary General Meeting). A part of the general practitioners (GP) refused to provide abortion services and they were quite entitled to refuse it, but they also proposed that community care was not the appropriate service for such procedure.

On the other hand, some obstetricians/gynecologists perceived the whole procedure introduction as too rapid, also affirming that funding and training were required and that political interests were overriding the reasonable phased implementation [5]. A significant number of professionals believed that with the law implementation, they had a moral and professional obligation to provide such services as soon as reasonably possible.

The Institute of Obstetricians and Gynaecologists prepared abortion training courses, collaborating with GP colleagues and others to produce the guidelines. Some individuals pledged to provide abortion care in their hospitals. Furthermore, the Health and Safety Executive (HSE) arranged collaborative group meetings to help produce leaflets on patient information and model of care for abortion services.

Collaboration between professionals and the HSE led to an invitation to the World Health Organization (WHO) to run a course on values and professionalism to enable discussion regarding matters of conscience and law.

Approximately 200 health professionals including nurses, doctors and allied health professionals attended over a week. This course was important to challenge traditional beliefs and myths about abortion.

Model of care

The model of care enabled women to access termination in the community without restriction up to 9 weeks of pregnancy [6]. Medical abortion can be provided by the GP three-days after the termination request as long as the practitioner is certified of the up to 9 weeks of pregnancy.

Furthermore, a national phone line was created, with non-directive counselling [7], thus, the woman is directed to the most appropriate and closest care provider. This procedure avoids a patient being attended by a conscientious objector and possibly rebuffed. When a scan is necessary, an ultrasound can be provided.

For pregnancies over 9 weeks, the GP refers the patient to the local maternity service, places where medical termination or surgical termination can be arranged. Complications like hemorrhage, suspected ectopic pregnancy or patients with more complex needs are referred to hospitals.

Problems

Some protests occurred outside GP offices, which did not receive public support.

A right-wing anti-choice group set up a fake website mimicking the national website. This act deceived women into attending for scans (by non-medically trained personnel) and these women also received anti-abortion propaganda and suffered abuse. This website was quickly shut down.

Cases of women attending for termination were apparently leaked and some protests occurred outside hospitals. The Ireland government declared that such conduct was unacceptable. A legislation has been planned to create an exclusion zone around abortion medical clinics/sites.

The model of care affirms that the service must be provided in the public system, i.e., women cannot be specifically targeted. It also protects against stigmatising providers or clinics. The previous experiences of other countries helped to build the model of care.

Community provision

In the community, GPs training was conducted by a committed voluntary group called Start (Southern Taskgroup on Abortion and Reproductive Topics). They travelled around the country, explaining protocols and paperwork, and encouraging doctors to sign up for the service. Uptake in the community was supported by government funding.

Conscientious objection

A representative stated he would appreciate to be able to not refer the patient to another provider, arguing that by this referral the doctors which addressed the pregnant woman to another provider would be inadvertently participating in abortion.

In some hospitals, porters refused to bring patients back from the operating room. Some physicians lobbied for freedom of conscience and suggested doctors were not bound by law if they deemed the law unethical. These are seen as fringe opinions and not reflective of the widespread physician body.

Inside the hospitals

While the general public believed the battle for abortion had been won, in the hospitals an undercurrent of resistance was never far from resolving the situation. Physicians who were conscientious objectors perceived as they had the right to refuse clinical cover to patients admitted on call as well as the sonographers who wished to have the right to refuse scanning women.

Particular problems arose with the surgery scheduling, with few nurses participating due to religious beliefs. Practice managers offered to act when necessary.

It was clear to those committed conscientious that for many doctors existed a difference between the vote and the ability/wish of some of them to provide abortion care.

Eight months later, less than half of the designated hospitals are providing all the legally available options of termination.

Management is not responsible in these cases but it enables the persistence of lack of provision and women must travel elsewhere. In the larger maternity hospitals, committed lead gynecologists have been appointed to supervise such care.

As positive developments, some nurses and midwives report satisfaction for being able to provide continuity of care and patients are extremely thankful for the modification of the law. In the cases not eligible for termination – such as those where the fetus presents a life limiting condition, causing disability but not death – women still have to travel for termination.

Although the HSE committed to fund this new service, no extra funds have been provided as of now, causing tension between hospital management, the HSE, and the Department of Health.

Links with other countries

Colleagues in the United Kingdom were immensely helpful in providing teaching training, advice and travelling for training courses. The Institute of Obstetricians and Gynaecologists associated with the Royal College of Obstetricians and Gynaecologists to plan for ongoing training. Gynecologists joined the British Society for Abortion Care to connect with other abortion providers.

The Irish experience has proven that medical abortion in the community is possible to be introduced even without no previous history of any abortion provision in the country. It is only necessary a small number of conscientious providers to begin with it. As health professionals become more comfortable with the process, more and more are willing to sign as providers.

Similarly to other countries, culture is hard to change; many providers reported hearing value-based judgement of patients. Some midwives expressed surprise that women undergoing terminations for fetal anomaly would want or need bereavement services. The idea was prevalent among medical professionals that early terminations were "social abortions".

In fact, many of the early appointments were attended by women with medical conditions which generated a pregnancy unsafe or dangerous and in fact should have had better support with access to contraception.

While most legislative barriers have been lifted, some obstacles to access remain due to conscientious objection and geography. More initiatives have to be done to address the needs of the marginalized women.

The government is planning to provide free contraception. A working party has been created and engagement has occurred with stakeholders. Advocacy to doctors, nurses and midwives is still required.

Conclusion

The implementation of termination of pregnancy faced many challenges in Ireland. The commitment of the political leaders, in association with the Department of Health, clerical and medical staff within the Health Service Executive was essential to the success of the project.

Professional commitment by doctors in the community has been inspiring.

Since the implementation, very few terminations have been done in hospitals. In the community, most procedures occurring under 12 weeks of pregnancy are dealt with before 9 weeks. The three-day-wait is perceived as an undue delay and barrier to women.

The idea that the medical community would not be able to handle the influx of patients seeking the procedure has proven to be false.

A more comprehensive contraception package would be ideal and ongoing training is required from medical school to specialist level so that women receive respectful holistic care regardless of the caregivers' personal beliefs.

Additional information

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