Thank you for the invitation to discuss the matter of “Clinical Guidelines” being prepared in light of the impending introduction of abortion services in Ireland. The Institute of Obstetricians and Gynaecologists of Ireland (IOG) is the national professional and training body for obstetrics and gynaecology in Ireland. Members of the Institute are drawn from all 19 maternity hospitals and units across the country.

In April this year the IOG set up a number of working groups to establish principles to underpin the development of guidelines for legislation for abortion services in Ireland in the event of successful repeal of the Eighth Amendment. More than 50 members of the Institute volunteered to participate in the development of guidelines. Members have visited units in Scotland, England, and Norway where abortion care is integrated into the health system.

Clearly the legislative process is not yet completed, therefore the IOG working groups are drafting guidelines on the basis of what has been proposed to date by the Minister of Health. Guidelines will be completed when the final legislation is passed by the Houses of the Oireachtas.

The following workstreams have been established and I will comment below on the some of the general principles that we are following:

1. Early Pregnancy
2. Threat to life and health of the mother
3. Fetal Medicine
4. Conscientious objection
5. Staff Training

In order to deliver fit-for-purpose services for termination of pregnancy in Ireland, the Institute recommends that:

a) Services should be free to all at the point of delivery
b) Funding for the service, as with all women’s health care, should be appropriately resourced and ringfenced. International experience, supported by data, is that following legalization of abortion services numbers decline with the passage of time for a variety of reasons including the removal of barriers to access and when the service includes advice on and provision of contraception. The IOG therefore strongly supports the proposal of the Oireachtas Committee on the Eighth Amendment and the Minister for Health’s proposal that every effort should be made to reduce crisis pregnancies, including by the provision of free contraception.

1. **Early pregnancy**

Early pregnancy is defined as the first 12 weeks of pregnancy, i.e. 12 weeks after the woman’s last menstrual period and on average 10 weeks post-conception.

We have looked to the example of Scotland, a country with a similar population to Ireland for data on TOP services. In Scotland around 75% of TOPs are at less than 9 weeks and 91% of these are medically induced. Approximately 10% require hospital attendance because of complications. We believe that Irish figures should be in line with those of Scotland.

In line with international best practice it is proposed that early medical abortion (EMA), less than 9 weeks pregnancy takes place in the community.

Although routine pre-termination ultrasound scanning is not recommended as mandatory in international guidelines, it is performed in most circumstances where it is readily available, and always if there are concerns about dates or ectopic pregnancy, or if the woman chooses. In Ireland, however, we are only too well aware of the well-documented infrastructural deficits in access to ultrasound in pregnancy. Introduction of a TOP service without adequate scanning facilities is fraught with risk, and IOG therefore recommends that appropriate and immediate investment in ultrasound is an integral element of TOP services.

After 9 weeks, and before 12 completed weeks, it is recommended that medical TOP takes place in the hospital setting due to the increased risk of complications such as bleeding. It is likely that a proportion of women will choose a surgical option for practical reasons. Risks and benefits of both methods will be explained.

The IOG recommends that a 24 hour, 7 days a week, helpline be established to help with appointments, provide reassurance, and provide information if a woman is concerned about any aspect of her care, e.g. where to go in the case of a complication.

The proposed 3-day interval between the first consultation and initiating the TOP is not supported by evidence, it may act as a barrier and it makes unwarranted assumptions about
women’s ability to make their own decisions. There is evidence that those who request termination remain satisfied with their decision. A waiting time, if any, should be from the time of first contact with the service.

Contraceptive advice and services, including long acting options, should be available at the time of the TOP.

Blood tests for anemia, blood group, and HCG, if appropriate, should be taken at the time of first consultation. It may also be appropriate to test for sexually transmitted infections (STIs).

2. Threat to life or health of the pregnant woman

Any woman whose life is at risk, or where there is a serious risk to her health, will be in hospital already. Since the introduction of the Protection of Life in Pregnancy Act in 2013 experience has been gained in the performance of TOP in hospitals and so current practice need not alter.

3. Fetal Medicine - TOP for fetal abnormality

All of these will take place in hospitals. The medical procedures will be the same as for those performed for the risk to life or health. It is envisaged that medical management with mifepristone and misoprostol will treat the majority of cases.

Currently TOP for fetal abnormality takes place outside the State. Diagnosis in Ireland is almost exclusively based on ultrasound. In the USA and Europe, Magnetic Resonance Imaging (MRI) is the standard of care. MRI is useful in complex anomalies to confirm or exclude pathology suggested by ultrasound. MRI results can change diagnosis from fatal to life limiting and vice versa. The overall diagnostic accuracy of MRI is 93% as compared with 68% for ultrasound. Thus when MRI is used further to initial ultrasound:

- Additional information is provided in 50% of cases
- The diagnosis is changed in 35% of cases
- Medical management is changed in 33% of cases
- Prognosis is changed in 20% of cases

However, MRI is currently only available in one maternity hospital in the country (the National Maternity Hospital). Thus, the IOG recommends funding to expand access to fetal MRI.

4. Service delivery implications; Conscientious objection
The Medical Council has clear guidelines on conscientious objection in Section 49 of the current *Guide to Professional Conduct and Ethics*, quoted below:

**Conscientious objection**

49.1 You may refuse to provide or to take part in the provision of lawful treatments or forms of care which conflict with your sincerely held ethical or moral values.

49.2 If you have a conscientious objection to a treatment or form of care, you should inform patients, colleagues and your employer as early as possible.

49.3 When discussing these issues with patients, you should be sensitive and considerate so as to minimise any distress your decision may cause. You should make sure that patients’ care is not interrupted and their access to care is not impeded.

49.4 If you hold a conscientious objection to a treatment, you must:

- inform the patient that they have a right to seek treatment from another doctor; and
- give the patient enough information to enable them to transfer to another doctor to get the treatment they want.

49.5 If the patient is unable to arrange their own transfer of care, you should make these arrangements on their behalf.

49.6 In an emergency, you must make your patient’s care a priority and give necessary treatment.

The IOG sees no reason to change these guidelines.

Section 50 of the Medical Council Guidelines deals with the current TOP services in Ireland and will need to be updated once the legislative process relating to abortion is completed.

We draw attention to the document “Professional’ refusal to Provide Abortion Care on Grounds of Conscientious Objection” published by European Human Rights Jurisprudence on State Obligations to Guarantee Women’s Access to Legal Reproductive Health Care, which states at a minimum that they must:

1. Ensure the adequate availability and dispersal of willing providers
2. Prohibit institutional refusals of care
3. Establish effective referral systems
4. Disseminate information on legal entitlements to abortion care
5. Impose clear limits on the legality of refusals
6. Implement adequate monitoring, oversight, and enforcement mechanisms to ensure compliance with relevant regulations.
5. **Staff training**

The IOG has already begun organizing courses for staff training on techniques not currently performed in Ireland.

Education in abortion care is being introduced into postgraduate training programs for doctors.

A separate educational program based on conscience and values is recommended for all whether directly involved in abortion care or not.

Staff Support: Abortion care in Ireland will be a significant change for all health care professionals. In view of this we recommend the establishment of an abortion providers network to include nurses and midwives who will be integral to delivery of woman centred care.

Ends.