QUEEN'S UNIVERSITY BELFAST

Health law: convergence and divergence on the island of Ireland

Ó Néill, C., & Mulligan, A. (2023). Health law: convergence and divergence on the island of Ireland. *Irish Studies in International Affairs*, *34*(2), 285-329. https://doi.org/10.1353/isia.2023.a910145

Published in:
Irish Studies in International Affairs

Document Version:
Publisher's PDF, also known as Version of record

Queen's University Belfast - Research Portal:
Link to publication record in Queen's University Belfast Research Portal

Publisher rights
© 2023 The Author(s). This is an open access article licensed under a Creative Commons AttributionNonCommercial 4.0 International License. Open Access funding provided by IReL.

General rights
Copyright for the publications made accessible via the Queen's University Belfast Research Portal is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy
The Research Portal is Queen's institutional repository that provides access to Queen's research output. Every effort has been made to ensure that content in the Research Portal does not infringe any person's rights, or applicable UK laws. If you discover content in the Research Portal that you believe breaches copyright or violates any law, please contact openaccess@qub.ac.uk.

Open Access
This research has been made openly available by Queen's academics and its Open Research team. We would love to hear how access to this research benefits you. – Share your feedback with us: http://go.qub.ac.uk/oa-feedback

Download date:19. Jul. 2024

Health Law: Convergence and Divergence on the Island of Ireland

Clayton Ó Néill, Andrea Mulligan

Irish Studies in International Affairs, Volume 34, Number 2, Analysing and Researching Ireland, North and South 2023, pp. 285-329 (Article)

Published by Royal Irish Academy
DOI: https://doi.org/10.1353/isia.2023.a910145

For additional information about this article
https://muse.jhu.edu/article/910145

[Mon Nov 20 08:57:30 2023] Access provided at 20 Nov 2023 13:57 GMT from Queen's University, Belfast
This work is licensed under a Creative Commons Attribution 4.0 International License.

ARINS
Analysing and Researching
Ireland, North and South

UNIVERSITY OF NOTRE DAME | KEOUGH SCHOOL OF GLOBAL AFFAIRS
Keough-Naughton Institute for Irish Studies

Acadamh Ríoga na hÉireann
Royal Irish Academy

Health Law: Convergence and Divergence on the Island of Ireland

Clayton Ó Néill
Queen's University Belfast
Andrea Mulligan
Trinity College Dublin

ABSTRACT

This article considers how health law operates on the island of Ireland, including some of its key issues: (1) capacity, (2) abortion and (3) clinical negligence. The healthcare and political context in both jurisdictions is discussed, as well as cross-border initiatives and arrangements. In relation to capacity, the article points to new legislation that has been introduced in the two jurisdictions and considers how it reflects (or does not reflect) the UN Convention on the Rights of Persons with Disabilities. Parallels and divergences of legislative change in respect of abortion are analysed, including approaches to process

Author's email: clayton.oneill@qub.ac.uk; andrea.mulligan@tcd.ie
ORCID iD: https://orcid.org/0000-0001-9856-7598; https://orcid.org/0000-0002-9160-4875

Irish Studies in International Affairs, Vol. 34, No. 2, 285–329, *Analysing and Researching Ireland, North and South*
© 2023 The Author(s). This is an open access article licensed under a Creative Commons Attribution-NonCommercial 4.0 International License. Open Access funding provided by IReL.

and implementation of change. The law on clinical negligence is critiqued in relation to standard of care, breach of duty, causation and quantum of damages and civil procedure. The article identifies convergences and divergences in terms of administration/procedure, legislation and context, but highlights a shared movement towards more human rights-oriented change and reform.

INTRODUCTION

The purpose of this paper is to identify and analyse the similarities and differences in the field of health law on the island of Ireland. Healthcare in Northern Ireland (NI) is provided both by Health and Social Care (HSC) and privately. In the Republic of Ireland (RoI),[1] this care is provided by the Health Service Executive (HSE) and privately. Healthcare is given free at the point of use in NI, following the ethos of the National Health Service (NHS), but there is currently some disquiet about the practical functioning of aspects of healthcare in NI. In RoI, those who have a medical card have access to free medical care, and many other sectors of the population also have access to public health services. There are significant issues in both jurisdictions in terms of waiting lists, overcrowding, ambulance services and shortage of medical staff.

Obviously, in a paper such as this, it is impossible to address all the pertinent issues. At the outset, we should take a moment to consider the particular nature of health law. A relatively new field of academic study,[2] health law comprises a complex interaction of different branches of both public and private law. On the public law side, constitutional law and human rights law protect fundamental rights in the health sphere, but common law rights—such as the right to refuse treatment—are important too. Criminal law plays a limited role in health law—generally in respect of gross negligence manslaughter—but, arguably, its reach should be more extensive.[3] Healthcare professions are subject to their own bespoke branch of public law via statutory regulation of the professions. Tort law, and specifically medical negligence, was at one time considered to constitute most of medical law

[1] We are using the term 'RoI' to ensure consistency and to distinguish it from NI, although we recognise that the official name of the state is Ireland, or in the Irish language Éire.

[2] The novelty of health law is contested by some commentators. See Margaret Brazier and Jonathan Montgomery, 'Whence and whither "modern medical law"?', *Northern Ireland Legal Quarterly* 70 (2019), 5.

[3] Mary-Elizabeth Tumelty and Eimear Spain, 'Gross negligence "medical" manslaughter in Ireland: legal context and clinician concerns', *Medical Law International* 21 (4) (2021), 321–42.

(as it was then known). It remains extremely important in terms of tangible protections for patients in the healthcare sphere and is supplemented by contract law in private healthcare settings. Montgomery argues that describing the discipline as medical law instead of health (or healthcare) law has been unsatisfactory because there is a need to embrace aspects of the healthcare system that lie beyond doctors and medical interventions.[4] In RoI, there is also an important nexus between constitutional law and private law in healthcare because Bunreacht na hÉireann, the Irish Constitution, is horizontally applicable.[5] The Supreme Court has expressly acknowledged that part of the function of the tort of negligence in the clinical context is to vindicate constitutional rights.[6] Given this complex structure, it is difficult to map health law in one jurisdiction, never mind two. However, the areas we have chosen for particular consideration are ones that we feel draw out the aspects of health law that provide the most fruitful sources of comparison, and the best overall insights into health law of the two jurisdictions.

There is no credible dispute of the assertion that both systems are under-funded and fail to fully meet public needs. The concept of universal free-at-point-of-use care found in NI is laudable, but its operation has deteriorated significantly in recent years. In fact, it remains an ideal rather than a reality, a conceptual dream of what a patient would desire of her/his healthcare provider. The *Financial Times* reported that UK average unmet health needs were among the worse in Europe.[7] There is, accordingly, a growing failure to deliver high-quality healthcare in NI. While the healthcare system in RoI is not optimal, there are slow, but notable and increasing, improvements in this jurisdiction. For example, all those below average (median) income, plus all aged 70 and over and aged seven and under, are now entitled to free (and actually available) general practitioner (GP) care. The system in RoI arguably delivers better health care in almost every single area where the two systems can be compared.[8] This finding is of course, limited by data incompatibility. Average GP waiting times

[4] Jonathan Montgomery, 'Patient no longer? What next in healthcare law?', *Current Legal Issues* 70 (1) (2017), 73–109. Also see Tamara Hervey and Jean McHale, 'Law, health and the European Union', *Legal Studies* 25 (2) (2005), 228–59 and John Coggon, *What makes health public? A critical evaluation of moral, legal, and political claims in public health* (Cambridge, 2012), 86–91.

[5] *Byrne v Ireland* [1972] IR 241; *Meskell v CIE* [1973] IR 121; *Glover v BLN* [1973] IR 388.

[6] *Grant v Roche Products* [2008] 4 IR 679.

[7] John Burn-Murdock, 'Britons now have the worst access to healthcare in Europe, and it shows', *Financial Times*, 4 November 2022.

[8] Sheelagh Connolly, Aoife Brick, Ciarán O'Neill and Michael O'Callaghan, *An analysis of the primary care systems of Ireland and Northern Ireland* (Economic and Social Research Institute, Research Series 137, Dublin, 2022).

are a day or less in RoI compared to two weeks in NI, life expectancy is higher in RoI;[9] infant mortality is almost 50 per cent higher in NI;[10] relative to population the overall NI hospital waiting list is 50 per cent worse than the Republic's and more than 75 per cent worse when comparing those waiting longer than a year.[11] Notwithstanding these positive findings in RoI, much can still be done in terms of adding to the cohesion of delivery of healthcare.

We have chosen to focus on three 'big' topics that occupy discussion within the realm of the discipline: (i) capacity; (ii) abortion (including conscientious objection to abortion); and (iii) clinical negligence. In terms of capacity, the focus of the article is on patients who lack the capacity to make decisions. The relevant legislation in both RoI and NI does not pertain to children. Capacity and abortion are two leading public law topics in health law. Capacity affects every healthcare interaction. Abortion directly affects fewer people but is a topic of great personal and political significance and is, arguably, uniquely shaped by the particular religious context of this island. Clinical negligence is undoubtedly the most important private law topic in health law. The topics chosen draw out a further notable aspect of health law in the jurisdictions, namely the fact that some areas of health law are virtually identical across England and Wales, NI and RoI, but others are markedly different. Abortion and capacity are areas where there is a distinct body of law in both NI and RoI. Clinical negligence, by contrast, is very similar across the jurisdictions and the laws of England and Wales are applied wholesale in NI. As such, the interesting points of comparison are in the finer details of the subject.

Capacity is central to the application of health law in both RoI and NI and, in many ways, can be seen as a cross-cutting topic that has crucial relevance in the context of consenting to or refusing medical treatment.[12] The fact that two major statutes are being commenced in RoI and NI—Assisted Decision Making (Capacity) Act 2015 and Mental Capacity Act (Northern Ireland) 2016 respectively—makes this a fascinating opportunity to consider whether, or to what degree, the law diverges or converges in these two jurisdictions. Attitudes to and (existing or prospective) healthcare practices aligned with abortion have seen radical legal shifts in the RoI and NI in recent years,

[9] Connolly et al., *Analysis of the primary care systems of Ireland and Northern Ireland*; Rebecca Black, 'Ireland better than NI in terms of life expectancy and infant mortality: report', *Belfast Telegraph*, 9 March 2022.
[10] Connolly et al., *Analysis of the primary care systems of Ireland and Northern Ireland*, 8.
[11] Connolly et al., *Analysis of the primary care systems of Ireland and Northern Ireland.*
[12] See Brice Dickson, *The Law in Northern Ireland* (Oxford, 2002).

following the Health (Regulation of Termination of Pregnancy) Act 2018 in RoI and the Northern Ireland (Executive Formation etc) Act 2019/Abortion (Northern Ireland) Regulations (No. 2) 2020/Abortion (Northern Ireland) Regulations 2021 in NI. It is, therefore, timely to analyse the similarities and differences in the law in its application. Finally, it is hard to imagine writing a comparative paper on health law without exploring the topic of clinical negligence. This type of comparative investigation allows us to consider what, if any, differences apply between the law (or the processes involved in the application of the law) on the island.

It is important to note the relevance of human rights as a unifying force in health law on the island and, in particular, in two of the chosen case studies: capacity and abortion.[13] The inclusion of this human rights element on the island of Ireland differs somewhat, for example, from the development of health law in England and Wales.[14] Arguably, the approach adopted in England and Wales focused more heavily on the use of ethical frameworks and analysis in the adoption of laws than on the applicability of human rights.[15] It is our view that human rights are not tangential and that new laws being enacted in both RoI and NI reflect the centrifugal nature of human rights in the administration of health law. It is thus important to view the operation of health law on the island of Ireland through this prism, particularly in relation to at least two of the key case studies chosen (capacity and abortion). In respect of clinical negligence, an interesting question for future consideration is whether the horizontal nature of RoI constitutional rights has any practical impact in distinguishing clinical negligence in RoI and NI.

The idea of solidarity between NI and RoI, for some, will be embraced enthusiastically and reflectively. For others, it will be reviled and treated with caution and dissension. For yet another group, it will be recognised as having the potential to provide pragmatic apolitical solutions to cross-jurisdictional

[13] Focus is placed on the European Convention on Human Rights and the United Nations Convention on the Rights of Persons with Disabilities in terms of the cross-jurisdictional human rights documents. In RoI the most significant human rights document is Bunreacht na hÉireann, the Constitution.
[14] See Ernest Owusu-Dapaa, 'The historical development of health care law and bioethics in England and Wales: a symbiotic relationship', *Medicine and Law* 33 (1) (2014), 22–39.
[15] For example, it is very common for any health law textbook to start with an introduction to bioethics, and little focus is placed on the significance of human rights laws/norms.

issues.[16] At some point, all of these approaches are rooted in political tribalism of a type that is not, perhaps, experienced in other jurisdictions, because even neutrality in Ireland suggests an otherness that conflicts with the orange and green divide. These entrenched perspectives are, perhaps, more visibly represented in NI than in RoI: the lack of recent historical conflict in the latter jurisdiction has, arguably, led to a somewhat liberal and laissez-faire attitude to conflicting perspectives. For that reason, our work here may touch a political nerve at some level, but we respectfully suggest that the possible positive consequences of combined learning have the potential to improve healthcare provision.

THE HEALTHCARE CONTEXT

Before we consider the three substantive areas of investigation, it is important to briefly set out the context of healthcare provision in RoI and NI.

Northern Ireland

Health is a devolved matter in NI.[17] This means that money is distributed by Westminster to NI following the 'Barnett formula'.[18] Health and Social Care (HSC) operates based on the idea of prioritisation of treatment by need and it is free at the point of delivery.[19] HSC, unlike the NHS in England and Wales, fuses health and social care. HSC also differs from the English NHS in the sense that the market does not play a role. In 2009, five HSC Trusts were established

[16] See Deirdre Heenan, 'Cross-border cooperation health in Ireland', *Irish Studies in International Affairs* 32 (2) (2021), 117–36. Some cross-border provision already exists, including the Cross-Border Healthcare Directive. This is relatively uncontroversial.

[17] See Deirdre Heenan and Derek Birrell, *The integration of health and social care in the UK: policy and practice* (London, 2018). Also see Heenan, 'Cross-border cooperation health in Ireland', 124.

[18] According to Keep, 'The Barnett formula takes the annual change in a UK Government department's budget multiplies it [*sic*] by two figures that take into account the relative population of the devolved administration (population proportion) and the extent to which the UK department's services are devolved (comparability percentage). The calculation is carried out for each UK department and the amount reached is added to the devolved administrations' block grant.' Matthew Keep, *The Barnett formula and fiscal devolution* (11 July 2022), available at: https://researchbriefings.files.parliament.uk/documents/CBP-7386/CBP-7386.pdf (30 January 2023).

[19] See 'Health and social care in Northern Ireland (HSC)', Northern Health and Social Care Trust, available at: http://www.northerntrust.hscni.net/about-the-trust/trust-overview-2/health-and-social-care-in-northern-ireland/ (30 January 2022).

(instead of nineteen Trusts pre-reform).[20] Each Trust is responsible for the management of its own staff and has control of its own budget.[21] The Department of Health, for example, had an overall budget of £7 billion in NI in 2021–2022.[22] The HSC Board and the Public Health Agency (PHA) work together to meet the needs of the population. The HSC Board consults with Local Commissioning Croups (LCGs). LCGs were established by s9 of the Health and Social Care (Reform) Act (Northern Ireland) 2009. The Board also must reply to the priorities set out by the NI Department of Health by publishing a Commissioning Plan. Each Trust produces a Delivery Plan establishing how the Trust intends to meet the needs of patients in that Trust.[23] The LCGs are represented by different members, including healthcare professionals, carers, voluntary workers and councillors. These budgetary constraints provide the monetary backdrop to healthcare provision in NI, which at the moment seems to be beset by administrative problems, staffing problems and resource problems and is perceived by many to be faltering in its delivery of mainstream services. The lack of a currently functioning Executive in NI, due to the political impasse relating to Brexit and the related NI Protocol, has reportedly had a negative impact on funding and resourcing of health and social care in NI.[24]

It is important to note that in NI, the role of 'soft law' is quite important as it relates to ethical and non-legal bodies, including the General Medical Council and the Health and Social Care Research Committee. It also has an impact on the development of different policies (such as the Primary Care Strategy[25]). The same is true of RoI, where equivalent bodies such as the Irish

[20] There has been a process of review of the provision of health in NI, and recommendations for reform. See for example Department of Health NI, *The right time, the right place: an expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland* (the Donaldson Report) (2014), available at: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf (30 January 2022). Also see Department of Health NI, *Systems, not structures: changing health and social care* (2016), available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf (30 January 2022).

[21] See Health and Social Care Board, *Financial plan 2021/22* (2021), available at: https://hscbusiness.hscni.net/pdf/pd6.pdf (30 January 2022).

[22] Department of Health NI, 'Update on building, reform and budget', available at: http://www.niassembly.gov.uk/assembly-business/official-report/written-ministerial-statements/department-of-health---update-on-building-reform-and-budget/ (31 January 2022).

[23] Michael Donnelly and Ciaran O'Neill, 'Integration – reflections from Northern Ireland', *Journal of Health Services Research & Policy* 23 (1) (2018), 1–3.

[24] See for example Conor Spackman, 'NI health crisis: no money to ease A&E pressure, says top official', *BBC News*, 20 December 2022, available at: https://www.bbc.com/news/uk-northern-ireland-64033018 (31 January 2023).

[25] Department of Health NI, 'Primary Care Strategy', available at: https://www.health-ni.gov.uk/topics/health-policy/primary-care-strategy (31 January 2023).

Medical Council would broadly act in the same manner and have a similar impact. There has been a slow increase of private healthcare provision in NI, particularly in light of the growth of private hospitals. It is likely that some of the reasons why people in RoI seek private healthcare provision are similar to the reasons that motivate people in NI to seek private healthcare. These reasons are aligned with waiting lists and ease of access. There is, however, a need to acknowledge that this growth in private healthcare in both NI and RoI is testimony, perhaps, to a combined failure to address the medical needs of those who are financially unable to access private healthcare.

Republic of Ireland

In Ireland, the body responsible for the delivery of public health services is the HSE, which replaced a system of regional health boards. The HSE delivers services both in the community and via publicly owned hospitals. In addition, it funds a number of voluntary hospitals. These are hospitals that are usually owned by private bodies such as charities or religious orders but receive all or most of their funding from the state.[26] Where voluntary bodies are owned by religious orders, this can have a particular bearing on their ethos, and that may impact the range of healthcare services they are willing to provide, or the kind of medical or scientific research they are willing to conduct. This tension is currently under the spotlight due to the plans to relocate the National Maternity Hospital to the St Vincent's campus at Elm Park, which is owned by the Sisters of Charity.[27] Questions have been raised as to whether the full range of lawful reproductive healthcare interventions will be provided, where such procedures conflict with Catholic teaching.[28] Until the current controversy there was very little public discussion of the issue of religious patronage in healthcare, in marked contrast to the widespread debate regarding Catholic Church patronage in education. This is probably due in part to the fact that abortion was not legal until 2018 and that IVF was not publicly funded until 2023,[29] thereby avoiding two of the principal potential

[26] Laurence M. Geary, Brendan Lynch and Brian Turner, *The Irish healthcare system: an historical and comparative review*, report commissioned by the Health Insurance Authority, September 2018.
[27] Paul Cullen, 'Maternity hospital move gets mired even deeper in controversy', *Irish Times*, 3 May 2022.
[28] Ellen Coyne, 'Abortions, IVF and gender affirming surgery will all be available at new maternity hospital, St Vincent's bosses confirm', *Irish Independent*, 13 May 2022.
[29] The Irish government announced the first programme of public funding for IVF in September 2022. At the time of writing some uncertainty remains as to the roll-out of this funding programme.

flashpoints. We expect that religious patronage in healthcare may receive—and should receive—more attention in the coming years.

The Irish healthcare system is two-tiered—public and private—and a very large segment of the population buys private health insurance. Recent estimates suggest that approximately 47.7 per cent of the population of RoI have private health insurance.[30] Historically the persistence of the private system has its roots in the dominant position of the Catholic Church and the medical profession, who, for different reasons, opposed reforms that would have expanded state provision of healthcare.[31] Some commentators suggest that care received in the public system is of a markedly worse quality than that received in the private system, but this is debated.[32] What seems undisputed is that waiting lists in the public sector are extremely long, and circumventing these waiting times is one of the key motivators for seeking private healthcare.[33]

Cross-border healthcare

There is an important cross-border dimension to healthcare on the island of Ireland. Strand 2 of the Belfast/Good Friday Agreement established the North/South Ministerial Council, bringing together ministers from both governments 'to develop consultation, co-operation and action' on an all-island and cross-border basis. Among the six agreed areas of cooperation under the Agreement is health.[34] Prior to Brexit, cross-border health was governed primarily by EU law. The Cross-Border Healthcare Directive 2011/24/EU entitled patients in Ireland to avail of treatment or surgery privately across the border, or indeed in any other EU state. This was a reciprocal arrangement—patients from NI were able to access healthcare in RoI on the same terms. Since 1 January 2021 the Northern Ireland Planned Healthcare Scheme (NIPHS) ensures Irish citizens can access private healthcare in NI.[35] The scheme was originally in place for twelve months but was extended into 2022. Since 1 July 2021, a recip-

[30] The Health Insurance Authority, 'Quarterly report on health insurance Q1 2023', available at: https://www.hia.ie/publications/market-reports-and-bulletins (27 August 2023).

[31] Sheelah Connolly and Maev-Ann Wren, 'Universal health care in Ireland—what are the prospects for reform?', *Health Systems & Reform* 5(2) (2019), 94–9.

[32] Maev-Ann Wren, *Unhealthy state: anatomy of a sick society* (Dublin, 2003).

[33] Euro Health Consumer Index 2018 (Health Consumer Powerhouse).

[34] Deirdre Heenan, 'Collaborating on healthcare on an all-Ireland basis: a scoping study', *Irish Studies in International Affairs* 32 (2) (2021), 413–47.

[35] HSE, 'Northern Ireland Planned Healthcare Scheme', available at: https://www2.hse.ie/services/schemes-allowances/niphs/ (21 June 2023).

rocal scheme exists for Northern Irish patients availing of healthcare in RoI.[36] These are both temporary schemes, but a permanent scheme is pending.[37]

Arrangements are in place between certain NI healthcare trusts and the HSE or discrete hospital groups to share services in border areas.[38] For example, Altnagelvin Hospital, Derry provides radiotherapy services to public cancer patients in the North-West under a service-level agreement.[39] Cross-border schemes are partially overseen and facilitated by Cooperation and Working Together (CAWT), a 'partnership between the Health and Social Care Services in Northern Ireland and Republic of Ireland, which facilitates cross border collaborative working in health and social care'.[40] CAWT was established by the Ballyconnell Agreement in 1992, and thus predates the Good Friday Agreement, and indeed the Downing Street Declaration. It covers eleven border counties—six in RoI and five in NI. In total, CAWT represents a total population of 1.26 million people—21 per cent of the island's population—and 25 per cent of the island's landmass. Other notable examples of shared island services include paediatric cardiology[41] and the Human Donor Breast Milk Bank.[42]

CAPACITY

Northern Ireland

Pre-reform, no specific legislation existed relating to mental capacity. Instead, the common law and the doctrine of necessity (best interests) were used when making decisions for patients who lacked capacity. The Bamford Review concluded that the law failed to comply with key ethical principles such as

[36] Mater Private, 'Republic of Ireland Reimbursement Scheme', available at: https://www.materprivate.ie/for-patients-visitors/roi-reimbursement-scheme (21 June 2023).
[37] See Citizens Information, 'Cross-Border Healthcare Directive', available at: https://www.citizensinformation.ie/en/health/eu_healthcare/cross_border_directive.html (12 June 2023).
[38] Health Service Executive, 'EU and North South Unit', available at: https://www.hse.ie/eng/about/who/national-services/eu-and-north-south-unit/ (21 June 2023).
[39] HSE National Service Plan 2021, available at: https://www.hse.ie/eng/services/publications/serviceplans/national-service-plan-2021.pdf (21 June 2023).
[40] https://cawt.hscni.net/about-us/ (21 June 2023).
[41] Department of Health, 'Health Ministers welcome the appointment of professors of paediatric cardiology by the All-Ireland Congenital Health Disease Network', available at: https://www.gov.ie/en/press-release/92919-health-ministers-welcome-the-appointment-of-professors-of-paediatric-cardiology-by-the-all-island-congenital-heart-disease-network/ (21 June 2023).
[42] Health Service Executive, 'EU and North South Unit'.

autonomy, justice, beneficence and non-maleficence.[43] The Mental Capacity Act (Northern Ireland) 2016 (MCANI) was enacted in 2016. The Act fuses mental health law and mental capacity law across a range of medical areas. The focus of the article is not on the operation of the law on capacity generally. Instead, attention is given to mental capacity legislation. The scope of the article is limited to people over the age of sixteen who have capacity. It also applies to those who may decide to make provision for themselves in the future when they may lack capacity (such as patients in the early stages of dementia). In 2002, the Bamford Review evaluated the delivery of mental health and disability learning services in NI, including the Mental Health (Northern Ireland) Order 1986.[44] Article 3(1) of the 1986 Order describes a 'mental disorder' as 'mental illness, mental handicap and any other disorder or disability of the mind'. Under the 1986 Order, an assessment can be made if the patient is 'suffering from mental disorder of a nature which warrants his detention in hospital' (Article 4(1)(a)) and 'failure to detain him would create a substantial likelihood of serious harm to himself or to other people' (Article 4(1)(b)).

Following the MCANI's Royal Assent in 2016, the Department of Health NI has been implementing the Act in a phased manner. Once the Act is fully commenced, the 1986 Order will no longer apply to those over the age of sixteen. The first stage of the MCANI's implementation was launched on 2 December 2019. This concerns the introduction of Deprivation of Liberty Safeguards (DoLS), which is accompanied by a Code of Practice. The Code sets out several relevant principles. Its purpose is to assist those who work with persons who lack capacity and it is not designed to aid the person or family members. For example, a presumption of capacity exists, no assumptions can be made based on the person's characteristics, all practical steps must be taken to enable the person to make the decision, an unwise decision does not mean that a person cannot make a decision, and any act done on behalf of a person who lacks capacity must be in the person's best interests.[45]

[43] Gerard Lynch, Catherine Taggart and Philip Campbell, 'Mental Capacity Act (Northern Ireland) 2016', *BJPsych Bulletin* 41 (6) (2017), 353–7. See Colin Harper, Gavin Davidson and Roy McClelland, 'No longer "anomalous, confusing and unjust": the Mental Capacity Act (Northern Ireland) 2016', *International Journal of Mental Health and Capacity Law* 22 (2016), 57–70.
[44] Department of Health, *A comprehensive legislative framework: the Bamford Review of Mental Health and Learning Disability (Northern Ireland)* (Belfast, 2007).
[45] Northern Ireland Department of Health, *Deprivation of Liberty Safeguards Code of Practice* (Belfast, 2019), 14, available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/mca-dols cop-november-2019.pdf (6 April 2022).

The decision to opt for 'fusion legislation' is particularly interesting. The approach adopted draws heavily on the work of Dawson and Szmukler. In 2006, they proposed a framework that would align physical and mental illnesses in joined legislation.[46] Dawson and Szmukler argued that this model would reduce stigma associated with mental illness, avoid discrimination against individuals who have mental disorders, and apply consistent ethical principles throughout medical law.[47] The potential for the introduction of this type of legislation had been identified by Richardson in 1999 and Millan in 2001.[48] Dawson and Szmukler claimed that fusion legislation would mean that there would be no need to 'define the complex boundaries between the spheres of operation of two distinct (but closely related) schemes'.[49] Under their proposed framework, decision-making incapacity would be the 'central criterion for involuntary treatment in all medical contexts'.[50] This would then remove the 'twin criteria of mental disorder and risk of harm' that exist under mental health legislation.[51]

In our opinion, this debate influenced the drafting of the MCANI. It is also likely that the UK's decision to follow the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2009 had a greater influence than the theoretical debate in relation to fusion legislation, given the shift towards a more rights-based approach in legal and medical reasoning. Recent UK case law has put rights-based discourse at the centre of decision-making.[52] At this juncture, it is worth noting that the new legislation in RoI pertaining to capacity adopts a rights-based approach and arguably goes further than the MCANI in complying with the CRPD. Why has NI decided to adopt this fusion model? The benefits of the fusion model have been discussed by Lynch et al., who state that fusion legislation 'puts impaired decision-making capacity at the heart of all non-consensual interventions', reduces stigma associated with mental health and respects patient autonomy.[53] As such, parity exists between mental and physical illness—they are treated equally under this new regime.

[46] John Dawson and George Szmukler, 'Fusion of mental health and incapacity legislation', *British Journal of Psychiatry* 188 (6) (2006), 504–9.
[47] Dawson and Szmukler, 'Fusion of mental health and incapacity legislation'.
[48] Genevra Richardson, *Review of the Mental Health Act 1983: Report of the Expert Committee* (London, 1999); Bruce Millan, *New Directions: Report on the review of the Mental Health (Scotland) Act 1984* (Edinburgh, 2001).
[49] Dawson and Szmukler, 'Fusion of mental health and incapacity legislation', 504.
[50] Dawson and Szmukler, 'Fusion of mental health and incapacity legislation', 504.
[51] Dawson and Szmukler, 'Fusion of mental health and incapacity legislation', 504.
[52] See for example *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
[53] Lynch et al., 'Mental Capacity Act (Northern Ireland) 2016', 354.

The conventional approach used in mental health legislation that applies a diagnostic test for involuntary treatment could violate Article 14(1)(b) of the CRPD. Lynch et al. contend that no UK legislation pertaining to mental health complies with this provision: 'the existence of a disability shall in no case justify a deprivation of liberty'. In the same vein, Farrell and Hann note that the MCANI 'has been criticised on the grounds that it does not recognise 'legal capacity' as set out in Article 12 of the CRPD, which affirms that persons with disabilities have the right to recognition everywhere as persons under the law.[54]

The incapacity test is functional at its root and is not inherently linked to diagnosis, but the MCANI does retain a diagnostic component. Under s3(1) of the MCANI, 'a person who is 16 or over lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for himself or herself about the matter (within the meaning given by section 4) because of an impairment of, or a disturbance in the functioning of, the mind or brain'. This is known as the diagnostic test. The MCANI is very similar to the MCA in England and Wales. There is a presumption that a patient has capacity. Two tests must be satisfied to determine that the patient lacks capacity—the *diagnostic* test (s3) and the *functional* test (s4).[55] The functional test determines that a person is unable to make a decision if he or she is unable to understand the relevant information, retain that information, appreciate the relevance of the decision, weigh the information as part of the decision-making process, or communicate the decision. The diagnostic and functional tests are interlinked in the sense that a *causal link* must exist.

Section 2 of the MCANI states that if a patient lacks capacity, the act done or the decision made on behalf of the patient must be in the patient's *best interests*. The application of the best interests principle is expanded on in s7 of the Act. The inclusion of best interests in the MCANI puts the Northern Irish common law position into statute. The best interests principle acts as a safeguard for a non-capacious person. It concerns both medical and social best interests—thus, best interests involve, according to the Code of Practice, 'a holistic consideration of all relevant factors that would be reasonable to consider under the circumstances'.[56] The starting point is consideration of

[54] Anne-Maree Farrell and Patrick Hann, 'Mental health and capacity laws in Northern Ireland and the COVID-19 pandemic: examining powers, procedures and protections under emergency legislation', *International Journal of Law and Psychiatry* 71 (2020), 101602, 3.
[55] See Lynch et al., 'Mental Capacity Act (Northern Ireland) 2016'.
[56] Northern Ireland Department of Health (Code of Practice), 27 (para. 6.3).

what the patient would have done if he or she were capacious. The relevant factors include anything that the patient would regard as important, and this would involve communicating with the patient's family members, carers and friends.[57]

The MCANI has commenced the DoLS stage. Deprivation of liberty is considered to be a human rights violation under Article 5 ECHR and Article 14 CRPD unless, in this context, the person is 'of unsound mind'. Thus, if a patient has capacity, they cannot be deprived of their liberty under this regime. (They could be deprived of their liberty by, for example, committing a criminal offence.) The individual merits of the circumstances need to be considered, including addressing criteria such as the type of deprivation, length and the manner of the implementation. As discussed above, when the MCANI is fully commenced, the 1986 Order will be repealed for those over the age of sixteen. Until then, a dual system will be in place. If a patient is deprived of liberty, all necessary DoLS will be put in place.

What are the implications of the MCANI? Harper et al. indicate that a driving force behind the Act was the need to ensure that the law did not discriminate against individuals with mental health or intellectual disabilities.[58] However, it is likely that this Act fails to fully comply with Article 12 CRPD because it uses both a diagnostic and a functional test for incapacity. This is an area where there is a notable difference between RoI and NI. There are also concerns about the fact that the Act does not apply to children under the age of sixteen. This approach differs from the recommendations of the Bamford Review, which said that consideration could be given to a presumption of capacity for children aged twelve to sixteen.[59] According to the Bamford Review:

> While most people would agree that parents be substitute decision makers for children up to the age of 10 or 12, consideration might be given to a rebuttable presumption of capacity between 12 and 16. When a young person is deemed to lack capacity, parents would ordinarily have substitute powers until the age of 16. However if

[57] Northern Ireland Department of Health (Code of Practice), 29 (para. 6.10).
[58] Harper et al., 'No longer "anomalous, confusing and unjust"'.
[59] *A comprehensive legislative framework: the Bamford Review.*

the child's best interests are considered to be at significant risk, then treatment may have to be authorised.[60]

Republic of Ireland

Capacity law in RoI is undergoing reform. The Assisted Decision-Making Act 2015 was signed into law in 2015 but was not commenced until 26 April 2023.[61] On commencement, the wards of court system was abolished but provision remains for those whose wardship proceedings were made prior to commencement of the Act. This means that the Lunacy Regulation (Ireland) Act 1871 is repealed. The 1871 Act describes a ward of court as 'a person who has been declared to be of unsound mind and incapable of managing his person or property'. The 1871 Act refers to people who lack capacity as 'idiots' and 'lunatics'.[62] It is hard to believe that this Victorian Act remains in operation in 21st-century Ireland. The current law involves limited structure and is based on what Áine Flynn calls 'custom and practice'.[63] Families and services have been left in a system that lacks formality.[64]

Capacity more broadly is governed by the common law and Bunreacht na hÉireann.[65] A presumption of capacity was recognised by Laffoy J in *Fitzpatrick v K*.[66] However, according to Donnelly and O'Keefe, this presumption is removed if the person is unable to 'comprehend and retain information about the treatment; cannot believe this information; and, cannot weigh the information in the balance in reaching a decision'.[67] Following *Fitzpatrick v K*, the Irish Medical Council issued guidance based on a *functional* interpretation of capacity.[68] In this case, the court had to decide if the court could intervene in a situation where a patient who claims to have capacity refuses medical

[60] *A comprehensive legislative framework: the Bamford Review*.
[61] HSE, 'Assisted Decision Making – Frequently Asked Questions', available at: https://www.hse.ie/eng/about/who/national-office-human-rights-equality-policy/assisted-decision-making-capacity-act/faqs/ (30 October 2022).
[62] See Jacqueline Grogan, 'The making of the Assisted Decision-Making (Capacity) Act 2015', in Mary Donnelly and Caoimhe Gleeson (eds), *The Assisted Decision-Making (Capacity) Act 2015: personal and professional reflections* (Newbridge, 2021).
[63] Áine Flynn, 'Foreword', in Donnelly and Gleeson, *The Assisted Decision-Making (Capacity) Act 2015*.
[64] Grogan, 'The making of the Assisted Decision-Making (Capacity) Act 2015', 25.
[65] See *Ryan v Attorney General* [1965] IR 294 and Article 40.3 of the Irish Constitution.
[66] [2008] IEHC 104.
[67] Mary Donnelly and Shaun O'Keefe, 'Who decides? Consent, capacity and medical treatment', in Donnelly and Gleeson, *The Assisted Decision-Making (Capacity) Act 2015*.
[68] Medical Council, *Guide to professional conduct and ethics* (Dublin, 7th ed., 2009; 8th ed., 2019).

treatment. Laffoy J drew attention English case law (e.g. *Re T Re C* (*adult: refusal of medical treatment*) and *St George's Healthcare NHS Trust v S*). Laffoy J said that the presumption of capacity can be removed if the patient is not able to understand or retain information, cannot believe the information, and cannot weigh it when making a decision.[69] If a person lacks capacity, health-care professionals should act in accordance with the HSE's National Consent Policy, specifically paragraph 5.6.[70] This involves consideration of whether the lack of capacity is permanent or temporary and the options available that would allow for the best clinical outcome. The Policy also requires consideration of the view of patient advocates and people who are close to the relevant person, such as family members.[71] The Policy says that patients should be encouraged to be involved in the decision-making process.[53]

The High Court has recognised the importance of the wishes and feelings of the patient in *Re C*.[72] In *Re SCR*, Baker J endorsed the approach adopted in *Fitzpatrick v K* and confirmed that the legal test for capacity must be a functional one.[73] Baker J stated that 'capacity must be tested having regard to the function being undertaken, and at the time of the execution of the instrument'. This is consistent with the test of capacity explained in *Fitzpatrick v K*.[74] Even though this functional interpretation has been part of Irish common law since 2007, Rickard Clarke argues that many wardship applications were still focused on a diagnostic test for capacity. However, following the Supreme Court decision in *AC v Cork University Hospital and AC v Fitzpatrick and Ors*,[75] there is recognition that the Irish Constitution supports a functional test for capacity and this test is now being applied more frequently, notwithstanding the lack of guidance or rules.[76]

The 2015 Act will effect wide-ranging reforms. It includes a new definition of capacity, the introduction of a regulated three-tier framework for decision-making and a statutory presumption of capacity. The Act also involves consideration of the relevant person's will and preferences.

[69] See Donnelly and O'Keefe, 'Who decides?', 139.
[70] HSE, *National Consent Policy*, available at: https://www.hse.ie/eng/about/who/national-office-human-rights-equality-policy/consent/documents/hse-national-consent-policy.pdf (30 January 2022).
[71] HSE, *National Consent Policy*.
[72] [2021] IEHC 318.
[73] (2015) IEHC 308.
[74] HSE, *National Consent Policy*.
[75] (2019) IESC 73.
[76] Patricia T. Rickard-Clarke, 'Decision-making capacity: standards required by the Constitution', in Donnelly and Gleeson, *The Assisted Decision-Making (Capacity) Act 2015*.

It creates a range of mechanisms, including the creation of the Decision Support Service.[77] Crucially, the 2015 Act has placed a significant focus on compliance with the CRPD, which was ratified in Ireland in 2018. Article 3 CRPD requires states to respect the 'inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons'. As indicated previously, Article 12 is particularly important in this context.

In line with *Fitzpatrick v F* and *AC*, the functional definition of capacity is apparent in the 2015 Act. Section 3(1) states that 'a person's capacity shall be assessed on the basis of his or her ability to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made by him or her in the context of available choices at that time'. Under s3(2), a person lacks capacity if he or she cannot 'understand the information relevant to the decision', 'retain that information long enough to make a voluntary choice', 'use or weigh that information as part of the process of making the decision', or 'communicate his or her decision' by whatever means. Under the Act, 'all practical steps' must be taken to ensure that the person is supported in making the decision. Thus, according to Donnelly and O'Keefe, 'supporting the relevant person to make the decision for themselves must be an essential part of clinical practice'.[78] The relevant person is able to appoint a supporter, either as a decision-making assistant or as a co-decision-maker. Once a supporter has been appointed, he or she must play a role in the consent process.[79] Additionally, a decision-making representative may be appointed by the Circuit Court—this will usually be someone who is close to the relevant person. If permitted by the Court, the decision-making representative has the power to consent to or refuse treatment on the relevant person's behalf.[80] The focus is on the 'will and preference' of the relevant person and this will be crucial for those who are helping the relevant person decide. In most instances, the person will decide who their supporter will be, but even in a situation where a supporter is appointed by the Court (i.e. decision-making representative), Gath stresses that 'they need to take the will and preference of the person into consideration when appointing the supporter'.[81] Gath states that the supporter

[77] Flynn, 'Foreword'.
[78] Donnelly and O'Keefe, 'Who decides?', 42.
[79] Donnelly and O'Keefe, 'Who decides?', 42.
[80] Donnelly and O'Keefe, 'Who decides?', 42.
[81] Leigh Gath, 'Removing wardship', in Donnelly and Gleeson, *The Assisted Decision-Making (Capacity) Act 2015*.

works 'in partnership with the person' and listens to the relevant person.[82] This focus on the *will and preference* of the person is autonomy-maximising. According to Gath, patients with dementia or intellectual disabilities 'might need support to make or execute their decisions, but they can make their decisions, and they have a right to have those decisions honoured'.[83]

Flynn recognises that this Act is not a flawless piece of legislation—it is complex in parts, difficult to read and 'incomplete'.[84] Donnelly and O'Keeffe argue that the new Act will clarify the law around consent and medical treatment, but they claim that gaps remain. For example, the relevant person needs to be over the age of eighteen and no direction is given in the Act as to 'where a person lacks capacity and none of the arrangements in the 2015 Act are in place'.[85] They also argue that a gap exists since the decision-making representative lacks the authority to refuse life-sustaining treatment on the relevant person's behalf.[86]

Divergence and convergence in the new legislative approaches in RoI and NI

The 2015 Act in RoI makes use of the language of 'will and preferences' rather than 'best interests' as in the MCANI.[87] This is not a semantic difference. At its heart is an ethical shift towards a rights-based (CRPD-compliant) conception of capacity/incapacity that promotes autonomy and gives less prominence to (well-meaning) paternalism.

In relation to deprivation of liberty in RoI, future mental health legislation is required to sit in parallel with the 2015 Act. As it stands, Keene states that the Act in the RoI 'does not purport to address the regulation of treatment and detention for purposes of addressing mental disorders, which remain covered by separate mental health legislation'.[88] There is a significant difference in jurisdictional approaches here. Unlike NI, the approach in RoI does not fuse mental capacity and mental health law. The MCANI is quite radical in the sense that it fuses the two regimes so that separate legislation is not required for anyone

[82] Gath, 'Removing wardship', 67.
[83] Gath, 'Removing wardship', 67.
[84] Flynn, 'Foreword'.
[85] Donnelly and O'Keefe, 'Who decides?', 43.
[86] Donnelly and O'Keefe, 'Who decides?', 43.
[87] See Alex Ruck Keene, 'Lessons from abroad', in Donnelly and Gleeson, *The Assisted Decision Making (Capacity) Act 2015*.
[88] Ruck Keene, 'Lessons from abroad'.

over the age of sixteen.[89] On the other hand, the NI approach may equally be perceived as being less radical than the legislation in RoI because it is, according to Keene, 'on its face further from the interpretation of the CRPD'.[90] The lack of a diagnostic test in the 2015 Act is a commendable reflection of the Irish government's commitments to the CRPD, but the implementation of a test that is solely functional may be difficult to apply in practice.[91]

It will be extremely interesting to see how the inclusion of assisted- and co-decision-makers in the 2015 legislation operates in the RoI. No doubt, there will be complexity and difficulty in the application of these roles, but this approach represents a laudable attempt to give voice to those who have traditionally been voiceless in the decisions that have often been made for them rather than with them. Although the MCANI encourages the participation of incapacitated patients in decision-making, there is no specific provision in the MCANI for roles such as assisted- and co-decision makers. The intent of the MCANI is enabling, but the provisions are somewhat vague and miss the opportunity for the empowerment of incapacitated patients through dialogically supportive measures.

The model of functional capacity in RoI appears to be more closely aligned with a rights-based interpretation of capacity and patient empowerment than the model that is used in the MCANI in NI. Notwithstanding that, the fusion legislation is a laudable interpretation of both capacity and mental health law, which has the potential to be streamlined and to remove the stigmas attached to mental health disorders. The MCANI offers a positive step forward. However, it is still aligned significantly with the MCA 2005 in England and Wales. An opportunity may have been missed here to become even more rights-focused. There have been challenges to the UK's arguably tepid commitment to CRPD rights.[92] A significant body of case law exists in England and Wales pertaining, in particular, to the application of the best interests test (such as *Aintree University Hospital NHS Foundation Trust v James*[93]) and this may help to provide a very useful steer in terms of future direction for NI. This is helpful because the new legislation in NI adopts a

[89] Ruck Keene, 'Lessons from abroad', 56.
[90] Ruck Keene, 'Lessons from abroad'.
[91] Ruck Keene, 'Lessons from abroad', 59.
[92] See 'Debate on challenges facing disabled people in the UK in 2018' (briefing by the UK Independent Mechanism), available at: https://www.equalityhumanrights.com/sites/default/files/parliamentary-briefing-debate-on-challenges-facing-disabled-people-house-of-lords-june-2018.pdf (31 January 2022).
[93] [2013] UKSC 67.

virtually identical best interests test to that used in England and Wales. Thus, it makes the English/Welsh case law post-MCA 2005 and the related guidance directly applicable to the NI context. Equally, following the RoI's functional interpretation of capacity, the application of the new wording 'will and preference' offers a particularly exciting approach to incapacity. This approach is less paternalistic and more autonomy-maximising than the best-interest approach in NI. The MCANI, however, includes very explicit and potentially supportive delineation of best interests in all its iterations, including both medical and social best interests and past and present wishes, feeling and values. This ensures that this approach balances different variables in the decision-making process.

In effect, both jurisdictions have attempted to enact legislation that is more rights-based than the previous regimes, although there are differences in the approaches adopted and in the emphasis placed on human rights/ CRPD compliance. It is too early to assess the prospective effectiveness of the approaches; however, a provisional assessment indicates that they represent a positive step in the vindication of the rights of incapacitated people. We will have a better understanding of how significant the improvement is only when the courts consider the application of the new Acts. There are plans to reform the mental health elements in RoI, which could, indeed, resemble aspects of the fusion legislation approach in NI.[94]

Ultimately, the role of external human rights instruments/norms within the jurisdictions (e.g. Committee on the Elimination of Discrimination against Women (CEDAW), CRPD, European Convention on Human Rights (ECHR)) is significant. The use or lack of use of international human rights instruments can be seen in the failure to act on CEDAW and subsequent legislation in the practical operation of abortion provision in NI. This is reflective of conflict that can exist between the application of human rights provisions and practical realities. There may be differences in the models adopted in relation to capacity in NI and RoI, but they are travelling on a similar journey (mindful of human rights).

Concerns have been raised about the UK's commitment to human rights, especially due to more recent discussions about reform of the Human Rights

[94] See Government of Ireland, Implementation plan 2022–2024. 'Sharing the Vision: A Mental Health Policy for Everyone', available at: https://www.hse.ie/eng/about/who/mentalhealth/sharing-the-vision/sharing-the-vision.html (21 June 2023). See also Irish Human Rights and Equality Commission, 'Significant reform needed to proposed mental health policy and law' (17 May 2022), available at: https://www.ihrec.ie/significant-reform-needed-to-proposed-mental-health-policy-and-law/ (31 January 2022).

Act 1998. Such debate has even encompassed removal of the Act. This marks a difference between the two jurisdictions. RoI has yet to see any significant recent anti-human rights discourse. This is all the more surprising given the traditional Catholic conservative attitudes of the past in this jurisdiction. In RoI, human rights are being stressed in both legislative change and public debate, as can be seen in the discussion of abortion law reform below. The practical consequence of this is to be seen in very many societal changes that have occurred in recent decades.

The application of human rights instruments in the adoption of mental capacity laws in both jurisdictions has been successful. The Act in RoI explicitly uses Article 12 CRPD and moves away from the more confined and limiting language of best interests towards a broader conceptualisation of will and preference. The Act in NI, while not explicitly addressing Article 12 CRPD, does move towards a more holistic and human rights conception of the wholeness of the person in comparison with the previous legislation. Thus, the approaches adopted in the two jurisdictions, while containing nuances of difference, show solidarity of approach in terms of the application of human rights perspectives.

PART III: ABORTION

It is impossible to write a paper on healthcare on the island of Ireland without drawing attention to the link between governmental policy and the religious context from which that policy often evolved. Historically, there has been a strong relationship between law and religion in both jurisdictions, although little case law exists in NI that pertains to the often contentious interaction between the manifestation of religious belief and the vindication of autonomy. RoI came into being in the 20th century and as its republican roots became firmly entrenched, its links to religion intensified with the coming into being of the Constitution of 1937, which was strongly framed from the ethos of Catholicism.[95]

The religious base for change and resistance to change in NI perhaps began to soften towards the end of the 1960s, but some could argue that the current iteration of parliamentary power has led to even more hardened

[95] See Christopher McCrudden, Oran Doyle and David Kenny, 'Religion and law in Ireland and Northern Ireland', *Irish Studies in International Affairs* 34 (2) (2023), forthcoming.

political alignment based on religious affiliation. Of course, in NI nothing is simple when it comes to religion and politics. Sometimes religious affiliation is more closely linked to a type of political identification than to a theological expression of identity or of belief. Developments in power sharing, the Anglo-Irish Agreement, the Good Friday Agreement, Brexit and its related NI Protocol have perhaps led to a liberalism in relation to employment, educational opportunities, job opportunities and, indeed, the freedom to live peacefully. The same liberty has not, however, come to pass in respect of aspects of healthcare. There have been movements towards secularisation and changes to legislation in terms of divorce and sexuality and still impending change to abortion services.[96] However, the changes that have been brought about are not due to a newfound independence from the yoke of English parliamentary power in the form of decisions made in the NI Assembly, but rather such changes have been wrought by Westminster or by the secretaries of state. The NI Executive ministers from particular political parties such as the DUP have circumvented the need to act on legislation, perhaps, because such legislation is seen as an affront to their personal religious belief or to the religious beliefs of the people who vote for them. They have, thus, used their power of veto to prevent change. This has happened in particular in respect of abortion provision.

Northern Ireland

Within NI, the subject of abortion has always been linked to political affiliation and, indeed, religion. This is not surprising, given the strong links between religious identity and life in NI. Traditionally, those from a Catholic background identify as nationalists while Protestants identity as unionists. Until quite recently, all the major political parties were opposed to abortion (and could be regarded as 'pro-life'). However, within the nationalist political community there has been a sea-change. Sinn Féin has argued in favour of reform of the law, and it also played an important role in the repeal movement in RoI.[97] The SDLP's official position is 'pro-life,' but prominent members of the party have argued for change.[98] However, the views of the DUP are cat-

[96] See Family Law Act 2019; Marriage Act 2015.

[97] Clayton Ó Néill, 'Abortion and conscience: a crossroads for Northern Ireland', in Clayton Ó Néill, Charles Foster, Jonathan Herring and John Tingle (eds), *Routledge handbook of global health rights* (Abingdon, 2021), 102–21.

[98] See Andrea Ferguson, 'Abortion in Northern Ireland: where do the parties stand?', *Irish Times*, 7 June 2018.

egorical—they are strongly linked to religious (Protestant) affiliation and are staunchly opposed to abortion.[99]

Prior to the recent reform of the law in NI, sections 58 and 59 of the Offences Against the Person Act 1861 were in force.[100] The Criminal Justice Act (Northern Ireland) allowed for abortion of a 'child capable of being born alive' if there were a risk to the life of the mother. 'Capable of being born alive' was interpreted as abortion following 28 weeks of gestation. The case of *R v Bourne* is relevant. It allowed for abortion if there were a risk to the mental or physical health of the mother.[101] This could, therefore, be regarded as a very restrictive approach. The NI position was blatantly in breach of CEDAW. Paragraphs 85 and 86 of CEDAW's report recommended that sections 58 and 59 of the 1861 Act should be repealed and that legislation should be implemented in NI that would legalise abortion in cases of incest and rape, of severe fetal impairment and where the physical or mental health of a woman is threatened.[102]

The Stormont institutions were essentially closed during a period of political intransigence between 2017 and 2020. This gave the Westminster government an opportunity to change the law on abortion in NI. It was a reactive response of the Westminster government to ensure compliance with the UK's human rights obligations and implementation of the CEDAW recommendations. The legislation responded to the Supreme Court's decision in *In the matter of an application by the Northern Ireland Human Rights Commission* [NIHRC] *for Judicial Review.*[103] The Supreme Court held that the law in NI violated Article 8 ECHR (respect for private and family life). However, it was held that the NIHRC did not have legal standing to bring the case and, as such, the Supreme Court could not order a declaration of incompatibility. The judgment strongly endorsed a change in the law.[104] Section 9 of the Northern Ireland (Executive Formation etc.) Act 2019 was implemented—it steadfastly indicated that the law in NI had to comply with paragraphs 85 and 86 of the CEDAW report. Thus, s9 of the 2019 Act stated that s58 and s59 of the 1961 Act

[99] Ferguson, 'Abortion in Northern Ireland'.
[100] In England, Scotland and Wales, the Abortion Act 1967 applies. It allows for abortions if certain grounds are met. Under s37 Human Fertilisation and Embryology Act, the time limits were extended. The 1967 Act never applied in NI.
[101] *R v Bourne* [1938] 3 All ER 615. Also see the Infant Life (Preservation) Act 1945.
[102] CEDAW report, 105.
[103] *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27.
[104] For more detailed analysis, see Ó Néill, 'Abortion and conscience', 107–9; Bríd Ní Ghráinne and Aisling McMahon, 'Abortion in Northern Ireland and the European Convention on Human Rights: reflections from the UK Supreme Court', *International and Comparative Law Quarterly* 68 (2) (2019), 477–94.

must be repealed and that no criminal proceedings could be brought against anyone in relation to any of the offences identified in s58 or s59. S9 also stated that the new Regulations must be in line with CEDAW's recommendations.[105]

Prior to the enaction of the Regulations, there was a public consultation relating to key areas, including early terminations, gestational limit periods of twelve or fourteen weeks, fatal fetal abnormality, risk to life or grave permanent injury to the mother, who can undertake an abortion, the specific requirements and conscientious objection to abortion.[106] Following the New Decade, New Approach deal, the Stormont institutions were re-established, but this could not alter the requirement to introduce Regulations.[107] It is worth noting that 79 per cent of those who responded to the public consultation opposed 'any abortion provision in Northern Ireland' other than the very limited circumstances permitted.[108] Nevertheless, it was stated that 'the [UK] Government remains under a legal obligation to introduce a framework in a way that implements the recommendations of the CEDAW report'.[109] The Abortion (Northern Ireland) Regulations 2020 were implemented in March 2020. The Regulations allow women to unconditionally access abortion up to twelve weeks' gestation. Women have faced practical difficulties in accessing these services and many have still had to travel to England, Scotland or Wales.[110] Abortion is permitted beyond the twelve-week period in cases of severe fetal impairment or fatal fetal abnormality—there is no time limit. If there is a risk to the physical or mental health of the pregnant women, the abortion can take place up to 24 weeks. There is no gestational time limit if there is a risk to the life of the women or of grave permanent injury.

Conscientious objection is also permissible unless the treatment 'is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman or girl'. This is very similar to the approach adopted under the Abortion Act 1967 in England, Scotland and Wales.

[105] Ó Néill, 'Abortion and conscience', 106.

[106] HM Government, *A new legal framework for abortion service in Northern Ireland: implementation of the legal duty under section 9 of the Northern Ireland (Executive Formation etc) Act 2019*, government consultation (4 November 2019). See Ó Néill, 'Abortion and conscience', 111.

[107] *New Decade, New Approach* (2020), available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856998/2020-01-08_a_new_decade__a_new_approach.pdf (20 April 2022).

[108] HM Government, *A new legal framework for abortion service in Northern Ireland*, 10.

[109] HM Government, *A new legal framework for abortion service in Northern Ireland*, 10.

[110] Cate McCurry, 'Number of women and girls travelling to Britain for abortions rising' (21 June 2022), available at: https://www.breakingnews.ie/ireland/number-of-women-and-girls-travelling-to-great-britain-for-abortions-rising-1322890.html (16 August 2023).

According to the UK government, 'anyone can opt out of participation in treatment of abortion services to which they have a conscientious objection, but … this protection does not extend to the ancillary, administrative and managerial tasks that might be associated with that treatment'.[111] However, Regulation 12(3) states that a healthcare professional cannot conscientiously object in the context of participation in 'treatment which is necessary to save the life, or to prevent grave permanent injury to the physical or the mental health, of a pregnant woman'. The House of Lords Secondary Legislative Scrutiny Committee published a report on the 2020 Regulations and stated that further clarification may be required in relation to the interpretation of Regulation 12 because there is potential for the conscientious objection to discriminate against people who are not directly involved in the clinical treatment.[112] The committee raised concerns about the 2020 Regulations and criticised the short consultation period, which lasted for only six weeks.[113] Further clarification was requested in relation to the interpretation of conscientious objection, the issue of disability and sexual and reproductive health rights and services.[114]

Following some errors in the drafting of the initial Regulations, the Abortion (Northern Ireland) (No. 2) Regulations 2020 were implemented in June 2020. It is worth noting that a non-binding motion was passed in the NI Assembly which stated that the Assembly disagreed with 'the imposition of abortion legislation that extends to all non-fatal disabilities, including Down's Syndrome'. This vote makes no change to the Regulations.[115]

There have been significant delays in the full implementation of abortion services. The Westminster government has consistently indicated that responsibility lies with the NI minister of health.[116] However, the current minister of health, Robin Swann (who is a member of the Ulster Unionist Party), indicated that there was no obligation on the Executive to deliver abortion services. The NIHRC has legally challenged this stance. At the High Court in

[111] HM Government, *A new legal framework for abortion service in Northern Ireland*, 33.
[112] House of Lords Secondary Legislation Scrutiny Committee, Proposed Negative Statutory Instrument under the European Union (Withdrawal) Act 2018 drawn to the special attention of the House: Abortion (Northern Ireland) Regulations 2020 (23 April 2020) (HL Paper 49, 2019–2021).
[113] House of Lords Secondary Legislation Scrutiny Committee, Proposed Negative Statutory Instrument under the European Union (Withdrawal) Act 2018.
[114] See Elizabeth Rough, *Abortion in Northern Ireland: recent changes to the legal framework* (House of Commons Library, 15 March 2022), available at: https://researchbriefings.files.parliament.uk/documents/CBP-8909/CBP-8909.pdf (20 April 2022).
[115] Rough, *Abortion in Northern Ireland*, 6.
[116] Rough, *Abortion in Northern Ireland*.

May 2021, Colton J held that there was a failure on the part of the NI secretary of state to undertake his obligations under s9 of the 2019 Act.[117] The UK government introduced the Abortion (Northern Ireland) Regulations 2021 to fill the lacunae in abortion provision. The 2021 Regulations 'direct Northern Ireland Ministers and, departments or relevant agencies to implement all of the recommendations in paragraphs 85 and 86 of the CEDAW report, consistent with the conditions set out in the Abortion Regulations (Northern Ireland) (No. 2) 2020'.[118] These 2021 Regulations are, according to the secretary of state, necessary because 'women and girls in Northern Ireland are still unable to access high-quality abortion and post-abortion care'. The secretary of state articulated that the UK government's 'strong preference is, and remains, for the Minister of Health and his Department to take responsibility for upholding these rights, commissioning services, and delivering on what the law now clearly allows'.[119] However, following a lack of movement, the secretary of state issued a written statement in July 2021 indicating that abortion services must be available in NI by 31 March 2022 at the latest (i.e. the Abortion Services Directions 2021).[120] This has now been changed to October 2023. The direction included 'a requirement to commission, provide and fund abortion services so that they are available in all of the circumstances in which abortions are lawful' including in the cases of fatal fetal abnormality or severe fetal impairment.[121] The NI health minister indicated that the process of establishing abortion services in NI was under way.[122] The secretary of state suggested that if progress were not being made or there were an attempt to block the commissioning of abortion services, he would 'take further steps to ensure that women and girls have access to abortion services as decided by Parliament, and to which they have a right'.[123]

[117] *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review – In the matter of the failure by the Secretary of State, Executive Committee and Minister of Health to provide women with access to Abortion and Post Abortion Care in All Public Health Facilities in Northern Ireland* [2021] NIQB 91.

[118] Written Statement UIN HCWS875, The Abortion (Northern Ireland) Regulations 2021 (23 March 2021).

[119] HC Debate, 25 March 2021 (Brandon Lewis).

[120] The Abortion Services Directions 2021, Statement UIN HCWS238 (22 July 2021), available at: https://questions statements.parliament.uk/written statements/detail/2021-07-22/hcws238 07 April 2022 (21 June 2023).

[121] The Abortion Services Directions 2021, Statement UIN HCWS238.

[122] Northern Ireland Assembly, Committee for Health, *Report on the Severe Fetal Impairment Abortion (Amendment) Bill, Report NIA 88/17–22* (11 November 2021), para. 66.

[123] PQ 71520 (22 November 2021), available at: https://questions-statements.parliament.uk/written-questions/detail/2021- 11-08/71520 (7 April 2022). See Rough, *Abortion in Northern Ireland.*

On 24 March 2022, the UK government indicated that it would prepare further Regulations to directly commission abortion services in NI.[124] It became quite obvious that that the NI Department of Health was reluctant to implement the mandatory change. These new Regulations would remove the need to seek approval from the NI Executive for abortion services to be commissioned and funded. The secretary of state has now established a team in the Northern Ireland Office to work alongside the NI Department of Health. He stated in March 2022 that, if it were determined that the Department of Health was not complying with the duty placed on it, he would use his powers to intervene.[125] Faced with delay upon delay, the secretary of state has, accordingly, recently intervened to commission abortion services.[126] This marks a significant milestone in healthcare provision in this jurisdiction.

The consultative path towards this end has had its own challenges: the consultation process in NI was survey-based and had its origins in Westminster rather than NI itself.[127] It was arguably, as a consequence, insufficiently democratic. This differed from the democracy-maximising Citizens' Assembly that provided a broad-based consultative basis for decision-making in RoI. The results of the consultation process in NI indicated that there was an extremely high level of opposition to abortion in the community in all sectors. It may have appeared to politicians and community members that their opinions were not listened to or were listened to insufficiently, or that the consultation process was just a window-dressing exercise and that action had to take place anyhow in order to comply with CEDAW.

The lack of consultation is especially problematic in respect of conscientious objection. Those drafting the legislation were, in our view, too quick to cut and paste the decision in *Doogan v Greater Glasgow and Clyde Health Board*[128] into the NI context. This UK Supreme Court case applied a narrow definition of

[124] Statement UIH HCWS716 (Brandon Lewis) (24 March 2022), available at: https://questions statements.parliament.uk/written statements/detail/2022-03-24/hcws716 (2 June 2023).
[125] Statement UIH HCWS716 (Brandon Lewis) (24 March 2022).
[126] Northern Ireland Office and The Rt Hon Chris Heaton-Harris MP, 'Secretary of State for Northern Ireland instructs the Department of Health to commission abortion services', available at: https://www.gov.uk/government/news/secretary-of-state-for-northern-ireland-instructs-the-department-of-health-to-commission-abortion-services (1 February 2022).
[127] See HM Government, *A new legal framework for abortion services in Northern Ireland* (4 November 2019), available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/844394/Government_consultation_-__A_new_legal_framework_for_abortion_services_in_Northern_Ireland__November_2019_.pdf (30 January 2022).
[128] [2014] UKSC 68.

‘participate’ in the Abortion Act 1967, a stance that arguably does not fully align with Article 9 of the ECHR—freedom of religion, thought and conscience.[129] While there had been some discussion at an earlier stage of the ECHR/Human Rights Act 1998 aspects of the claimant’s case, these were not advanced before the Supreme Court, and the case proceeded as one concerned with the ‘ordinary principles of statutory construction’ as applied to the Abortion Act 1967.[130] In fact, there had been no need to apply *Doogan* in the NI context because the Abortion Act 1967 does not apply in NI. In its failure to properly consider the adoption of a wider interpretation of conscientious objection, the UK government searched for consistency, but, for a wide range of sociological, political and religious reasons, NI is not identical to Great Britain and the abortion context, given the 79 per cent opposition in the NI consultation process, inter alia, differs. Equally, however, the healthcare needs of women and their rights are crucial in any legislative development in this area. A better effort should have been made for the twain to meet in legal policy and healthcare practice.

Although abortion services are now commissioned, it is clear that there has been a consistent practice of kicking the can down the mythical road with no one taking the steer. Politicians in NI may, indeed, have ultimately recognised the need to comply with CEDAW, but, by allowing the secretary of state to intervene and commission abortion services, they can now, in the eyes of their electorate, operate at a remove, politically and theologically, from any difficult decisions.[131]

Republic of Ireland

The history of Irish abortion law is well documented.[132] At common law, abortion had historically been regarded as a misdemeanour.[133] In Ireland,

[129] Clayton Ó Néill, ‘Conscientious Objection in *Greater Glasgow Health Board v Doogan* [2014] UKSC 68’, *Medical Law International* 15 (4) (2016), 140–7. This narrow definition of ‘participate’ means that conscientious objection to abortion only relates to those with a hands-on direct role in abortion, thus excluding those with an administrative or non-direct role. This approach arguably gives insufficient weight to the manifestation of religious beliefs under Article 9 ECHR. See Clayton Ó Néill, *Religion, medicine and the law* (Abingdon, 2018).

[130] *Doogan* [24].

[131] See *Hansard*, 21 June 2022 (Vol. 823), available at: https://hansard.parliament.uk/Lords/2022-06-21/debates/A2A5E4AE-5ED8-47FB-B333-42CBEE64D36E/Abortion(NorthernIreland)Regulations2022

[132] See James Kingston, Anthony Whelan and Ivana Bacik, *Abortion and the law* (Dublin, 1997); Irish Family Planning Association, ‘History of abortion in Ireland’, available at: https://www.ifpa.ie/advocacy/abortion-in-ireland-legal-timeline/ (31 January 2023). Also see Simon Mills and Andrea Mulligan, *Medical Law in Ireland* (3rd ed., London, 2017), Chapter 13.

[133] Kingston et al., *Abortion and the law*, Chapter 3. Lord Ellenborough’s Act, passed in 1803, made abortion of a quickened fetus a felony, and the Offences Against the Person Act 1837 extended the felony to all fetuses, quickened or not. ‘Quickening’ was the point at which the fetus’s movements became apparent to the pregnant woman.

abortion was expressly prohibited under the Offences against the Person Act 1861.[134] Arising from concern that the courts might liberalise abortion law,[135] in 1983 66.9 per cent of the people voted to insert a new Article 40.3.3 into the Constitution (the Eighth Amendment). This provided that:

> The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.

The Eighth Amendment remained in place until 2018, when it was removed and replaced with the following:

> Provision may be made by law for the regulation of termination of pregnancy.

This amendment cleared the way for the Oireachtas to legislate for legal abortion, which it did via the Health (Regulation of Termination of Pregnancy) Act 2018, which came into effect in January 2019.

Repeal/Replacement of the Eighth Amendment: popular sovereignty to the fore

In sharp contrast to the position in NI, the evolution of RoI abortion law has been characterised by a high degree of popular sovereignty, due to the fact that it was regulated at a constitutional level, and changing the Constitution required a referendum. The successful campaign to repeal[136] the Eighth Amendment involved a very high degree of grassroots activism, as typified by the title of the leading campaign group: 'Together for Yes'. In addition, the question of whether to amend the law was considered by the 2016–18 Citizens' Assembly. The Citizens' Assembly was established by the RoI government in October 2016 and concluded its work in spring 2018.[137] It entailed the selection of 99 members chosen at random by a

[134] Sections 58 and 59. Both sections were confirmed by Section 10 of the health (Family Planning) Act 1979.
[135] Raymond Byrne and William Binchy, *Annual review of Irish law 2009* (Dublin, 2009), 471.
[136] The Eighth Amendment was in fact replaced, not repealed, but the campaign focused on the concept of 'repeal' and so this terminology will at times be used in this paper.
[137] David M. Farrell, Jane Suiter and Clodagh Harris, '"Systematizing" constitutional deliberation: the 2016–18 citizens' assembly in Ireland', *Irish Political Studies* 34 (1) (2019), 113–23.

marketing research company, Red C, to be demographically representative. The members heard presentations from experts and from advocacy groups and had the opportunity to ask questions and to hold discussions.[138]

The Citizens' Assembly considered a number of topics, one of which was the question of whether to repeal the Eighth Amendment. It recommended replacement of the Eighth Amendment, and its report was sent to government on 29 June 2017.[139] Ultimately the referendum took place on 25 May 2018 and passed, with a vote of 66.4 per cent in favour. Importantly, the draft abortion legislation was published in advance of the referendum and was widely discussed during the course of the debates. As such, while the people voted on the question of whether to delegate decision-making on abortion to the Oireachtas, they made that decision having had sight of the legislation that was proposed. There were only minimal changes to the legislation after the referendum passed.

Accordingly, the whole process of reform of RoI abortion law was one in which the public was closely involved, and over which they could feel a strong sense of ownership. The formal legal reason for the contrasting approaches is the different constitutional structures of RoI and NI, together with the fact that abortion was regulated at constitutional level in RoI. As such, a referendum was required, and a by-product of that legal structure was that abortion could only change by way of a popular movement that commanded the support of a majority. Referendums are not commonly used in NI, though they are of course possible: two examples in relatively recent political history are the Brexit referendum in 2016 and the referendum on the Good Friday Agreement in 1998.

The Health (Termination of Pregnancy) Act 2018

The 2018 Act is a short piece of legislation that in just fourteen pages establishes the regime for lawful abortion in Ireland.[140] There are four different

[138] Maeve Taylor, Alison Spillane and Sir Sabaratnam Arulkumaran, 'The Irish journey: removing the shackles of abortion restrictions in Ireland', *Best Practice and Research Clinical Obstetrics & Gynaecology* 62 (2020), 36–48.
[139] The Citizens' Assembly recommended replacement rather than repeal, albeit with a different provision to that which was ultimately put to the people. It favoured a provision that would allow the Oireachtas to legislate to address termination of pregnancy, any rights of the unborn and any rights of the woman.
[140] It is supplemented by three sets of regulations that contain procedures and standard-form documents, for certain processes contained in the Act: S.I. No. 595/2018 – Health (Regulation of Termination of Pregnancy) Act 2018 (Application for Review of Relevant Decision) Regulations 2018; S.I. No. 596/2018 – Health (Regulation of Termination of Pregnancy) Act 2018 (Certification) Regulations 2018; S.I. No. 597/2018 – Health (Regulation of Termination of Pregnancy) Act 2018 (Notifications) Regulations 2018.

circumstances in which the Act provides for lawful termination of pregnancy. In each case, the statutory requirements are slightly different. First, Section 12 provides for abortion in 'early pregnancy'; that is, within the first twelve weeks. The doctor carrying out the termination must be of the 'reasonable opinion formed in good faith' that the pregnancy has not exceeded twelve weeks.[141] This interesting choice of words can be found in various places in the legislation. It would appear to require both that the opinion be objectively reasonable and that it be formed in good faith. Abortion under Section 12 requires a three-day cooling-off period between the certification by the doctor and the carrying out of the procedure. Section 12 makes clear that the three-day cooling-off period must be within the first twelve weeks of pregnancy; if it falls outside that, the termination is no longer lawful under this section.

Section 9 of the 2018 Act addresses termination in cases of risk to life or health. Here, termination is lawful where: (a) there is a risk to the life, or of serious harm to the health, of the pregnant woman, (b) the fetus has not reached viability and (c) it is 'appropriate' to carry out the termination of pregnancy in order to avert the risk to life or health.[142] Again, the certification must be based on a 'reasonable opinion formed in good faith', but this time from two medical practitioners. Section 10 of the Act addresses termination of pregnancy in cases of risks to life or health in an emergency situation. The risk in this instance must be 'immediate', and it must be 'immediately necessary' to carry out the termination.[143] There is no requirement that the fetus not have attained viability, and certification is by just one medical practitioner.

Finally, Section 11 addresses termination of pregnancy where the fetus suffers from a condition that is likely to lead to its death, colloquially known as cases of fatal fetal anomaly. To fall into this category, it must be 'likely' that the condition will lead to the death of the fetus either before or within 28 days of birth. Certification by two medical practitioners is required. The 2018 Act sets out review procedures for decisions under Section 9 (risk to life or health) and Section 11 (conditions likely to lead to the death of the fetus). It makes no provision for review of decisions under Section 10 (emergencies), understandably, as if there is a sufficiently immediate risk there is no realistic prospect of there being time for review. Presumably because Section 12 (early pregnancy)

[141] Section 12(1), 2018 Act.
[142] See discussion of Sections 9, 10 and 11 of the 2018 Act in Lorraine Grimes, Joanna Mishtal, Karli Reeves, Dyuti Chakravarty, Bianca Stifani, Wendy Chavkin, et al., '"Still travelling": access to abortion post-12 weeks gestation in Ireland', *Women's Studies International Forum* 98 (May–June 2023), 102709.
[143] Section 10(1).

addresses termination without a particular indication, no provision is made for review of decisions under Section 12. The absence of a review provision could be problematic if a woman wishes to challenge the assessment of the duration of her pregnancy.

A crucial feature of the 2018 Act is its approach to the concept of viability, a definition that is most important in respect of termination on the basis of risk to life or health. Rather than adopting a bright-line gestational limit, such as 22, 23 or 24 weeks,[144] the Act defines viability as follows:

> 'viability' means the point in a pregnancy at which, in the reasonable opinion of a medical practitioner, the foetus is capable of survival outside the uterus without extraordinary life-sustaining measures.

This definition is wholly specific to (a) the characteristics of one particular fetus and (b) the reasonable opinion of one medical practitioner. Furthermore, the phrase 'extraordinary life-sustaining measures' is not defined.

A number of features of the 2018 Act are contentious. The Irish Family Planning Association is a vocal critic of its restrictive regime, arguing in particular against the mandatory waiting period and the strict twelve-week gestational limit.[145] The Irish Human Rights and Equality Commission (IHREC) has called for abolition of the three-day waiting period and the removal of all criminal penalties from the 2018 Act.[146] It is notable that there was a high degree of support for the 2018 Act among those in favour of a 'yes' vote at the time of the referendum, but that silent consensus was possibly pragmatically driven, and directed at successfully carrying the popular vote. De Londras has criticised the law as perpetrating continuing harms.[147]

[144] See studies conducted by EPICure, available at www.epicure.ac.uk. See also, for example, Fermín García-Muñoz Rodrigo, Lourdes Urquía Martí, José Ángel García Hernández, Josep Figueras Aloy, Alfredo García-Alix Pérez and SEN1500 Network of the Spanish Neonatal Society, 'End of life care and survival without major brain damage in newborns at the limit of viability', *Neonatology* 111 (2017), 234–9.

[145] Irish Family Planning Association, '12-week gestation limit for abortion care is exclusionary and inequitable' (26 April 2022), available at: https://www.ifpa.ie/12-week-gestation-limit-for-abortion-care-is-exclusionary-and-inequitable/

[146] Submission to the Review of the Health (Regulation of Termination of Pregnancy) Act 2018 (Irish Human Rights and Equality Commission, November 2022).

[147] Fiona de Londras, 'A hope raised and then defeated'? The continuing harms of Irish abortion law', *Feminist Review* 124 (1) (2020), 33–50; Joanna Mishtal, Karli Reeves, Dyuti Chakravarty, Lorraine Grimes, Bianca Stifani, Wendy Chavkin, et al., 'Abortion policy implementation in Ireland: lessons from the community model of care', *PLoS One* (2022), https://doi.org/10.1371/journal.pone.0264494

A separate objection concerns the possibility that some women who are entitled to access lawful abortion within the terms of the 2018 Act are not practically able to access the service. There is some evidence that this has arisen in the context of fatal fetal anomaly. The Unplanned Pregnancy and Abortion Care (UnPAC) Study observed a level of indeterminacy about access to abortion on grounds of fatal fetal anomaly, with the result that women were inclined to explore options for treatment abroad, even where there was a possibility that they could access abortion in Ireland.[148] At least one news story has detailed a situation whereby a fetus is diagnosed with a medical condition that appears to fall squarely within the Section 11 criteria, but the woman is unable to access termination in Ireland and resorts to travelling to the UK to undergo the procedure.[149] IHREC has also observed that Section 11 may be limiting access to termination for pregnant women who receive fatal fetal abnormality diagnoses but are required to travel to access healthcare.[150]

This situation illustrates an uncomfortable divergence between law and clinical practice. To a lawyer, Section 11 is broadly drafted. The legal test of '*likely* to lead to the death of the foetus' (emphasis added) does not impose an exacting burden of proof on the diagnosing doctor—it would probably be interpreted to require only that the death of the fetus would be more likely than not, on a simple balance of probabilities. Yet clinicians seem to be reluctant to make use of this apparent flexibility to provide procedures that they clearly think are clinically indicated. The reason for this is not clear, but one might speculate that the existence of a criminal penalty for abortion carried out outside of the terms of the 2018 Act may influence clinicians in this regard. The UnPAC Study found some evidence that some women denied abortions in Ireland are quasi-'referred' by Irish hospitals for termination in the UK, but both the availability and the meaning of 'referral' varied widely.[151]

This situation whereby the right to access abortion exists in law but cannot be accessed in practice is reminiscent of the position under the previous

[148] Catherine Conlon, Kate Antosik-Parsons and Éadaoin Butler, *Unplanned Pregnancy and Abortion (UnPAC) Study* (July 2022), Section 12.3, available at: https://www.sexualwellbeing.ie/for-professionals/research/research-reports/unpac.pdf (21 June 2023).

[149] See Michelle Hennessy, '"Two-tier system" means couples still forced to travel for termination after severe foetal diagnoses', *The Journal*, available at: https://www.thejournal.ie/fetal-diagnosis-5386250-Mar2021/

[150] Submission to the Review of the Health (Regulation of Termination of Pregnancy) Act 2018 (Irish Human Rights and Equality Commission, November 2022), 15.

[151] Conlon et al., *UnPAC Study*, Section 12.3.

abortion regime. Pursuant to the X Case, there was an entitlement to an abortion—arguably a constitutional right to an abortion—where there was a 'real and substantial' risk to the life of the pregnant woman. In *A, B and C v Ireland*,[152] the European Court of Human Rights found, however, that the right was more illusory than real, and on this basis found a breach of the ECHR.[153]

An important way in which RoI law differs from that in NI is that RoI law makes no mention whatsoever of disability outside the context of fatal fetal anomaly. This follows on from apparent consensus in the debate leading up to the 2018 referendum that lawful abortion should not extend to abortion on grounds of disability. Again, it is possible that this was a pragmatic consensus designed to maximise the chances of the amendment passing. Anecdotally, it seems clear that there is a nexus between genetic testing and the provision of abortion services in RoI, as first trimester genetic testing is widely being offered on the basis that the results of the test may lead a couple to decide to terminate a pregnancy, and that this is lawful in Ireland up to twelve weeks. This allows for a very short window in which such testing can be done and decisions made, as most genetic testing cannot be done until nine weeks' gestation.[154] The UnPAC Study found evidence of women discovering fetal anomalies through non-invasive prenatal testing, and an intersection between this and conversations about the availability of abortion. [155] The law finds itself in a strange position here. Despite the consensus around the referendum that abortion on grounds of disability should not be permitted, the reality is that non-invasive prenatal testing does play a role in the pathway to abortion, but this is both unregulated and undiscussed in RoI.

Conscientious objection in abortion in Ireland: the role of fundamental rights protections

The right to conscientious objection is provided for under Section 22 of the 2018 Act, as follows:

> (1) Subject to subsections (2) and (3), nothing in this Act shall be construed as obliging any medical practitioner, nurse or midwife

[152] *A, B and C v Ireland* (Application no. 23379/05) Decision of the Grand Chamber, 16 December 2010.
[153] *A, B and C v Ireland*, paras 264–5.
[154] Non-invasive prenatal testing is offered on a private basis by clinics in RoI. See for example https://rotundaprivate.ie/non-invasive-prenatal-testing/ (21 June 2023).
[155] See Conlon et al., *UnPAC Study*, Section 11.3.ii.

> to carry out, or to participate in carrying out, a termination of pregnancy in accordance with section 9, 11 or 12 to which he or she has a conscientious objection.
> (2) Subsection (1) shall not be construed to affect any duty to participate in a termination of pregnancy in accordance with section 10.

The first notable aspect of this provision is that the right to conscientious objection is limited to medical practitioners, nurses and midwives. No other person who might be involved in the provision of abortion services, such as administrative employees, healthcare assistants or other hospital employees, enjoys a right to conscientious objection under the Act. Second, the activity that may be objected to is the 'carrying out' or the 'participation in the carrying out' of an abortion. These limitations immediately signpost potential conflicts. It may be that persons who are not doctors, nurses or midwives would seek to exercise a right of conscientious objection if they perceived themselves as 'participating' in abortion services. One notable category of person who might seek to exercise a conscientious objection right is pharmacists, who may play a role in the prescription of medications used in medical abortion. Alternatively, a doctor, nurse or midwife might object to playing a clerical or administrative role in abortion services that could be deemed not to fall within 'carrying out' or 'participation'.

Third, the Act provides that no right of conscientious objection exists whatsoever in respect of termination in an emergency situation. This is an element of the regime that could prove especially controversial, as it is the only instance in which the right is completely abrogated, albeit clearly with a view to prioritising the life and health of the pregnant woman. A fourth notable aspect can be seen in Section 22(3), which creates a duty on the part of the conscientious objector to refer onward:

> (3) A person who has a conscientious objection referred to in subsection (1) shall, as soon as may be, make such arrangements for the transfer of care of the pregnant woman concerned as may be necessary to enable the woman to avail of the termination of pregnancy concerned.

A significant difference between RoI and NI is that the right to conscientious objection is underpinned in RoI by an express constitutional provision. Article 44.2.1 of the Constitution provides:

> freedom of conscience and the free profession and practice of religion are, subject to public order and morality, guaranteed to every citizen.

Because abortion was illegal in almost all circumstances until 2019, this provision has received very little judicial attention.[156] Historically, conscientious objection was accommodated in healthcare provision in Ireland, where it did arise, such as in the context of prescribing and dispensing contraception.[157] It seems likely that the novel context of legal abortion services will lead to a new emphasis on the parameters of Article 44.2.1. An obvious question that now arises is whether the statutory protection for conscientious objection adequately protects the constitutional right. One aspect that may be particularly problematic is the limitation of the statutory right to certain professions—it is difficult to see how this could be constitutionally justified. All conscientious objection regimes must draw the line somewhere if they wish to preserve access to services, but there is no reason why professional status should be the determinant.

If the decision in *Doogan* is right, conscientious objection in NI has no fundamental rights protection. There, the matter was characterised as simply a matter of statutory interpretation. This is potentially a very significant divergence between NI and RoI.

Review of the 2018 Act

An unusual feature of the 2018 Act—and again, probably a pragmatic measure—is that it contains a clause requiring it to be reviewed within three years.[158] The review incorporated a short public consultation period, and the report of independent chair Marie O'Shea BL was published in April 2023.[159] The report made a wide range of recommendations, encompassing both recommendations for implementation of abortion services and proposed amendments to the 2018 Act. This includes amending the three-day waiting period to ensure it cannot result in the woman being deprived of access to abortion on the basis

[156] See *McGee v Attorney General* [1974] IR 284; *AM v Refugee Appeals Tribunal* [2014] IEHC 388.
[157] Cicely Roche, 'Conscientious objection: the right to refuse to dispense', *Irish Pharmacy Journal* 86 (2) (2008), 8–19; Protection of Life in Pregnancy Act 2013, Section 17.
[158] Section 7, 2018 Act.
[159] Marie O'Shea, *The Independent Review of the Operation of the Health (Regulation of Termination of Pregnancy) Act 2018* (February 2023). The report was submitted to government in February 2023 and made public in April 2023.

of falling outside the gestational limits. At the time of writing, the RoI government has given no commitment to act on any or all of the recommendations.

Concluding comments on abortion: divergence and convergence

In comparison with Britain, both RoI and NI adopt a more human rights-oriented approach. The Abortion Act 1967[160] includes statutory defences, while this is not the case in NI and RoI. In NI the law was introduced to protect women's individual rights (in accordance with CEDAW). Equally, women's rights were to the fore in debate around the 2018 referendum,[161] but notably the referendum did not insert a right to an abortion into the Constitution. In terms of their evolution, the abortion laws of NI and RoI provide very interesting points of comparison. The law in RoI is the product of a long—and often bitter—process of public engagement stretching back to the 1980s. In contrast, abortion law reform in NI was insufficiently democratic. As to the substance of the law, there are some marked similarities—such as the twelve-week gestational limit—but some important differences such as the place of abortion on grounds of disability and the role of fundamental rights in conscientious objection. In both jurisdictions, law and clinical practice remain, to some extent, in flux, and we anticipate interesting developments in the coming years.

Important points of convergence and divergence can be identified in substantive RoI and NI law on abortion. Most notably, the bases on which one can access abortion in RoI are more limited than in NI. Travel to Great Britain to obtain an abortion remains a feature of abortion practice in RoI. If access to abortion in NI becomes more widespread, it may be the case that travelling north rather than east into the UK becomes a more common route for RoI women. Conscientious objection is an area that may present both convergence and divergence. The Irish Constitution provides very robust protection for religious rights, but RoI courts have never really had to grapple with the difficulties of conscientious objection, and certainly not in the abortion sphere. Conscientious objection will be new to NI courts also if it does end up being litigated, but the question will arise as to whether they will elect to follow *Doogan*. In both cases, conscientious objection in abortion

[160] Section 1, Abortion Act 1967.
[161] The judgment of the European Court of Human Rights in *A, B and C v Ireland* was a major factor in the passage of the Protection of Life in Pregnancy Act 2013.

is something of a *tabula rasa,* and it will be interesting to see how the law develops in each jurisdiction.

CLINICAL NEGLIGENCE

As Hamill and Hackett have observed in their paper on obligations as part of this project, NI courts owe nothing more than polite respect to the Court of Appeal of England and Wales.[162] That minimal duty is not apparent in the field of clinical negligence, where the NI courts apply English law in its entirety. Generally, reported judgments do not even advert to the fact that the body of law being applied is that of a different jurisdiction, albeit a different jurisdiction in the UK legal system. A standard example of this can be found in the case of *Murphy v King*,[163] where Gillen J commented:

> The general principles of law applicable in clinical negligence cases … are rarely in dispute in modern cases. The test is that set out by McNair J in *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582 at 586. This is so well known that it does not require detailed recitation by me.[164]

Gillen J went on to cite the subsequent leading precedents from English law. It is quite clear from this sample judgment that the courts of NI apply English law in clinical negligence. Accordingly, this discussion will focus on mapping the divergences between English and RoI law on key points in clinical negligence. An interesting consequence of those differences is that it seems the NI courts could elect to follow RoI law on certain points, if they were minded to do so. We are curious, therefore, as to whether in practice there are attempts by counsel to persuade NI courts to diverge from English law. The application of RoI law might for example be an attractive alternative for plaintiffs in relation to recovery for loss of a chance, discussed below. One distinctive aspect of RoI tort law is that because constitutional rights are horizontally applicable, tort law—including clinical negligence—is framed as

[162] Hackett and Hamill (ARINS, forthcoming), citing F.H. Newark, 'Law and precedent in Northern Ireland', *Northern Ireland Legal Quarterly* 23 (1972), 100, 103.
[163] [2011] NIQB 1.
[164] [2011] NIQB 1 §21.

operating as a vehicle for the vindication of constitutional rights.[165] We are curious as to whether this results in any practical differences between NI and RoI. This complex issue is beyond the scope of this paper, but we feel it would be a fruitful avenue for future research.

Contextual factors

At the outset we note some contextual factors that have an important bearing on the development of clinical negligence law across the jurisdictions. Perhaps the most significant of these is the fact that there are very few decisions of the RoI courts in the field of clinical negligence, in contrast to the courts of England and Wales. As a result, the law of medical negligence is not well developed in RoI, a trend that is particularly evident in respect of causation. The reason for this is not that there is a dearth of medical negligence litigation in RoI—there certainly is not—but rather that almost all cases settle. Both awards of damages and legal costs are high in RoI—as discussed below—with the result that running a case is intensely risky for defendants. Often not insignificant sums will be paid to get a plaintiff with a weak case to 'go away', when in other jurisdictions that plaintiff would be inclined to run a novel point in the case, rather than walk away with nothing.

Another important practical factor is that very limited legal aid is available for clinical negligence claims in RoI,[166] whereas more legal aid is available for such claims in NI. This divergence is balanced to some extent by the prospect of higher awards in RoI, with the result that most statable clinical negligence cases will attract a solicitor who will take them on a 'no foal, no fee' basis. This means that the client is only liable to pay their own lawyer's fees in circumstances where the case succeeds. However, the absence of legal aid probably means that fewer novel points are run in litigation.

The standard of care

The standard of care in clinical negligence in England and Wales is the test in *Bolam v Friern Hospital Management Committee*,[167] as qualified in *Bolitho v City and Hackney Health Authority*.[168] The standard of care in clinical neg-

[165] *Byrne v Ireland* [1972] IR 241; *Meskell v CIE* [1973] IR 121; *Glover v BLN* [1973] IR 388; *Grant v Roche Products* [2008] 4 IR 679.
[166] Legal Aid Board, 'Medical negligence', available at: https://www.legalaidboard.ie/en/our-services/legal-aid-services/common-legal-problems/medical-negligence/ (21 June 2023).
[167] *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582.
[168] *Bolitho v City and Hackney Health Authority* [1998] AC 232.

ligence in RoI is contained in *Dunne v National Maternity Hospital*,[169] which was the first birth injury case decided in RoI. In *Morrissey v HSE and Others*[170] the Supreme Court stated that there were 'significant similarities' between *Dunne* and *Bolam/Bolitho*.[171] In effect, each seems to adopt a two-stage test. Bolam says there is no negligence where a doctor 'acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art'. Dunne says that the defendant must be guilty of acts or omissions that 'no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care'. On their faces, *Dunne* looks like a more stringent test, which is harder to meet for the plaintiff. It seems that the *Bolam* defendant needs to find a responsible body of medical men to support them, while the *Dunne* defendant need only identify one other professional acting with ordinary care.

Turning to the second stage, *Bolitho* establishes a subsidiary test whereby the Court can find negligence even without expert evidence if the supportive expert evidence 'is not capable of withstanding logical analysis'. *Dunne* allows for a court to find negligence in the absence of expert evidence if a 'practice has inherent defects which ought to be obvious to any person giving the matter due consideration'. These tests appear similar. In each case the Court is invested with the power to make its own determination about the reasonableness of an action. *Bolitho* more expressly vests that power in the court, while *Dunne* refers to the notional 'any person', who presumably is more or less the same person as tort law's beloved 'reasonable man'.

In summary, stage 2 of the tests seems quite similar, while there is potentially a significant difference in stage 1, in terms of how difficult it is for a defendant to resist a claim of negligence. It looks like *Dunne* might make claims significantly more difficult for plaintiffs. The key question then becomes to what extent the inherent defects rule in Irish law makes up for that aspect of the test.[172] Despite the RoI Supreme Court's view that the tests are similar, we have encountered at least some practitioners who regard *Dunne* as harder to satisfy, with one stating that 'The test in Dunne is clearly more onerous and establishes an extremely high threshold for proving medical negligence in the

[169] *Dunne v National Maternity Hospital* [1989] IR 91.
[170] *Morrissey v HSE and Others* [2020] IESC 6.
[171] *Morrissey*, §6.2, 6.4.
[172] We note that the judgment in *Morrissey v HSE* may have reframed *Dunne* somewhat.

Republic of Ireland'.[173] This is an interesting view, as it is certainly not obvious from case law that the test is so radically different. In terms of future exploration of the practical difference in these tests, we are interested in speaking to cross-border legal practitioners who might be able to provide further insight on this issue.

Causation—loss of a chance

Causation in negligence generally and in clinical negligence specifically is disappointingly underdeveloped in RoI. The rule remains the standard 'but for' test.[174] This stands in sharp contrast to the law in England and Wales, and NI, where modified causation tests have been accepted, such as the material contribution test.[175] It is hard to say precisely why RoI lags so far behind, but we believe that it is most likely a result of the situation whereby awards of damages and legal fees are very high in RoI. This leads defendants to be very cautious in choosing which cases to fight and willing to offer some money to settle even weak cases, thereby disincentivising plaintiffs from running novel causation points. There is some suggestion, however, that novel causation cases are not run even where they should be. In the leading case on causation, *Quinn v Midwestern Health Board*,[176] the Supreme Court cuttingly expressed its surprise at the fact that the plaintiff's counsel had presented the case on an 'all or nothing' basis in the High Court when it appeared that some kind of modified, more sophisticated, causation argument was appropriate.[177]

Despite the general paucity of causation case law, there is one significant aspect of causation that is dealt with entirely differently in NI and RoI: loss of a chance. Loss of a chance typically arises in the medical context where a plaintiff alleges that the defendant's negligent treatment (usually an omission such as a delay in diagnosis) deprived him of the opportunity to achieve a better health outcome. In NI—following the English law—this injury is not compensable unless the plaintiff can prove on the balance of probabilities

[173] PA Duffy & Co. Solicitors, 'What is the difference between the legal test for medical negligence in Northern Ireland and the Republic of Ireland?', available at: https://www.paduffy-solicitors.com/en/what-is-the-difference-between the-legal-test-for-medical-negligence-in-northern-ireland-and-the-republic-of-ireland/ (8 May 2022).
[174] *Quinn v Midwestern Health Board* [2005] 4 IR 1.
[175] For an application of this in NI, see *Parkinson v Northern Ireland Fire and Rescue Service* [2009] NIQB 87.
[176] *Quinn v Midwestern Health Board* [2005] 4 IR 1.
[177] *Quinn v Midwestern Health Board* [2005] 4 IR 1 at 12.

that s/he would have recovered if the defendant had not acted negligently.[178] This rule is highly contentious and widely debated among legal scholars.[179] As Lord Nicholls observed in his dissenting judgment in the English leading case, *Gregg v Scott*,[180] the rule against recovery for loss of a chance means that a person who started out with a 45 per cent chance of recovery and has been deprived of treatment cannot recover against the defendant, but a person with a 51 per cent chance of recovery can.

The RoI courts approach loss of a chance in an entirely different way: they treat the lost chance as a form of damage rather than a matter of causation. They do not engage in a lengthy investigation of what the precise chance of recovery was, but instead simply treat the lost chance as a compensable loss. Fennelly J put the matter succinctly in the leading case of *Philp v Ryan*:

> I should say that it seems to me to be contrary to instinct and logic that a plaintiff should not be entitled to be compensated for the fact that, due to the negligent diagnosis of his medical condition, he has been deprived of appropriate medical advice and the consequent opportunity to avail of treatment which might improve his condition.[181]

This decision was, in fact, cited to the House of Lords in *Gregg v Scott*,[182] but attracted little attention from the Court.

In adopting this rule on loss of a chance, the RoI courts have weighed in on one of the leading academic debates in tort law and health law. It is not entirely clear that the court on *Philp v Ryan* was aware of how significant this ruling was, but perhaps that says a lot about the nature of the loss of chance debate: people see either the causation framework or the damages framework as so obviously correct that they have great difficulty in imagining how there might be a different view. In reality, the rule makes a genuine difference to RoI plaintiffs. There is a whole category of clinical negligence cases where it is impossible to prove that the patient would have recovered but for the defendant's negligence. These cases would not be compensable in NI but

[178] In NI see *Magill v Royal Group of Hospitals and Others* [2010] NIQB 10.
[179] See e.g. Marc Stauch, 'Causation, risk, and loss of chance in medical negligence', *Oxford Journal of Legal Studies* 17 (1997), 202–25: 205; James Edelman, 'Loss of a chance', *Torts Law Journal* 21 (1) (2013).
[180] *Gregg v Scott* [2005] UKHL 2.
[181] *Philp v Ryan* [2004] 4 IR 241.
[182] *Gregg v Scott* [2005] UKHL 2, §84.

are compensable in RoI, and are by no means uncommon. For this reason, we are curious as to whether there have been any attempts by counsel in NI to persuade the courts to follow the RoI rule rather than the English rule on this point. We are also curious as to how this kind of argument would be received by an NI judge.

Quantum of damages and civil procedure

Setting aside the purely doctrinal, we believe it is important to acknowledge a very significant practical divergence between clinical negligence in RoI and in NI. That concerns the quantum of damages awarded. It is difficult to identify a precise differential, but some commentators estimate that damages in RoI are as much as three or four times as high as in NI or England.[183] This has significant practical ramifications. There have long been attempts to reduce damages in RoI, but new limits imposed in 2021 do not apply to clinical negligence cases.[184] If the jurisdictions of NI and RoI were to fuse at some point in the future, the divergence in approaches to awards could be highly problematic.

Another important practical difference between the jurisdictions is the fact that NI has a strict litigation protocol in clinical negligence, and RoI does not.[185] The protocol covers exchange of medical notes, exchange of expert reports, alternative dispute resolution and case management. In the absence of a protocol in RoI, clinical negligence litigation proceeds on an ad hoc basis, making litigation far less streamlined and predictable than in NI. The establishment of protocols has been recommended by two separate reviews of the RoI system.[186] The government has committed to implementation of these, as part of general reforms to civil procedure under the Justice Plan 2022.[187]

[183] Colin Gleeson, 'Damages for personal injuries in Republic "among highest in Europe"', *Irish Times,* 19 September 2018; PA Duffy & Co, 'Claims in NI and ROI – benefits of using an All-Ireland law firm', available at: https://www.paduffy-solicitors.com/en/claims-in-ni-and-roi-benefits-of-using-an-all-ireland-law-firm/ (21 June 2023).
[184] The Judicial Council, *Personal Injuries Guidelines* (6 March 2021).
[185] Protocol for Clinical Negligence Litigation in the High Court and Practice Direction for Experts (Practice Direction No. 2 of 2021), available at: https://www.judiciaryni.uk/sites/judiciary/files/decisions/Practice%20Direction%2002-21.pdf (21 June 2023).
[186] Department of Health, 'Expert Group report to review the law of torts and the current systems for the management of clinical negligence claims' (2020), available at: https://www.gov.ie/en/press-release/111ab-publication-of-the-final-report-of-the-expert-group-on-tort-reform-and-the-management-of-clinical-negligence-claims/ (21 June 2023); *Review of the Administration of Civil Justice* (2020), available at: https://www.justice.ie/en/JELR/Review_of_the_Administration_of_Civil_Justice_-_Review_Group_Report.pdf/Files/Review_of_the_Administration_of_Civil_Justice_-_Review_Group_Report.pdf (21 June 2023).
[187] Department of Justice, *Justice Plan 2022* (May 2022).

CONCLUSION

This article has pointed to instances of convergence and divergence in RoI and NI in respect of capacity, abortion and negligence. These similarities and differences can be characterised in the following ways: (1) administrative and procedural similarities/differences; (2) legislative similarities and differences; and (3) contextual similarities/differences.

1. At the level of administration, the two systems are not fully similar insofar as one is free at the point of use for all and the other requires payment from those who are not medical card recipients. However, similarities are evident in the fact that both systems are flawed and have problems with access. It can be argued that healthcare provision in RoI, while deficient, does at the very least provide meaningful access and provision opportunities to patients, while the NHS system is creaking at the seams. The difference in administrative practice leads to differences in clinical practice, which, in turn, lead to different outcomes for patients. Private healthcare is growing in both jurisdictions, probably as a direct consequence of or, at the very least, reflecting the negative impacts of budgetary constraints on availability of clinical care. Some solidarity exists between the jurisdictions in respect of shared island services and cross-border alignment for healthcare provision, but this solidarity is surprisingly narrow given the geographical context of the island.
2. At the level of legislation, we have outlined how, for the most part, human rights are the driving force behind legislative change in both jurisdictions, but a human rights focus on CRPD compliance is more evident in RoI than in NI. In terms of capacity, in particular, there are some similar approaches in the new legislation in NI and RoI, but differences apply to the adoption or otherwise of the fusion model and the incapacity test itself. The connection between legislation and the Irish Constitution is notable. This differs from NI, where no written Constitution exists. A similar focus on and adherence to soft laws and guidelines from medical bodies exists in both jurisdictions.
3. The phrase 'context is everything' is a true assessment of healthcare practice in the island of Ireland. To the nonchalant observer, the context would seem to be similar—both jurisdictions embedded in historically motivated modes of behaviour that are closely aligned to religious belief and to the assumptions made about how thought and action can arise from such belief amid conflicting contexts. At another level, however, there is a growing

shift in RoI from the conservative and religiously affiliated values of previous generations towards a more liberal agenda. This has been seen most recently in the legislative change brought about on foot of the repeal of the Eighth Amendment. Different approaches to conscientious objection have been noted. Both jurisdictions recognise the importance of conscientious objection, but there are differences in how it is interpreted. Equally, there have been significant differences in the level of consultation when coming to decisions about conscientious objection (and, indeed, abortion) in the two jurisdictions. The lack of a Citizens' Assembly in NI was arguably a misstep in building public confidence in legislative change and in providing a vehicle for people to raise their objections or their support in an open and consultative forum. In NI, certain political parties have, indeed, embraced a more liberal agenda, but some more vocal parties (such as the DUP), which represent a large proportion of the population, adhere to stringent principles that have had an impact on the implementation of some legislation. In summary, context is complicated in NI and RoI, and a connection between context and healthcare provision still exists in both jurisdictions.

Comparisons at the level of jurisdictional approach to legislative change are complicated by contextual factors—life is not exactly the same in the two jurisdictions, healthcare systems are different, judicial systems vary, social mores differ in levels of liberalism and conservatism, religion holds a particular sway in particular parts of particular communities in both NI and RoI, which is often aligned to political ways of seeing the world. So, context is key and the lens through which we view legislative change in respect of the dimensions analysed here is always going to be reflective of policy, practice and perception. Context may, therefore, be a key ingredient in how the legislative world is shaped, but in our view, another factor transcends context, i.e. the human being—capacitated or incapacitated—and the rights that that human being has to act with autonomy and to be treated with dignity and respect. There is no doubt that the new health-related legislation in both jurisdictions represents an attempt to achieve that aim, notwithstanding the differences in approaches adopted and the lacunae identified.