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Enright, Mairead; Duffy, Deirdre

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Law and childbirth in Ireland after the 8th Amendment: notes on women's legal consciousness

MÁIRÉAD ENRIGHT¹ | DEIRDRE DUFFY²

¹Birmingham Law School, University of Birmingham, Edgbaston, Birmingham, B15 2TT, England

²Department of Sociology, Lancaster University, Lancaster, LA1 4YW, England

Correspondence

Máiréad Enright, Birmingham Law School, University of Birmingham, Edgbaston, Birmingham, B15 2TT, England
Email: m.enright@bham.ac.uk

Abstract

Drawing on a survey of women's experiences of obstetric care in Ireland between 2000 and 2017, this article examines women's legal consciousness of the 8th Amendment; a fetal rights provision that formed part of the Irish Constitution until 2018. Though it was widely agreed that the Amendment had some influence on pregnancy and childbirth, even where the woman had not sought an abortion, the scope of that influence was poorly understood. The courts produced few published judgments, and state-issued guidance was limited. This article shows that the Amendment's meanings were not confined to those validated by the courts. A significant minority of our survey respondents felt that the Amendment had influenced some very ordinary decisions in pregnancy, and that it was bound up with a range of non-legal norms. Most of these women saw the Amendment to be at work even though the medical professionals treating them had not invoked it. The Amendment was a felt part of a coercive legal atmosphere around childbirth and pregnancy in Ireland.

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1 | INTRODUCTION

In May 2018, a referendum removed the 8th Amendment ('the Amendment') from Ireland's Constitution.¹ The Amendment was in force between 1983 and 2018. It was best known as a near-absolute prohibition on abortion. It also affected childbirth and continued pregnancy, though it is difficult to say precisely how. There were almost no reported judgments on obstetric care under the Amendment, and the state provided little guidance. During the 2018 referendum campaign, pro-choice activists insisted that the Amendment constrained women's choices in childbirth.² Using a survey of women's obstetric care experiences in Ireland between January 2000 and November 2017,³ we argue that the Amendment's perceived everyday uses were wider and more invasive than state policy and court judgments suggested.

Scholars worldwide document how women's autonomy is undermined in pregnancy and childbirth; they are spoken to forcefully,⁴ intimidated,⁵ treated insensitively,⁶ or infantilized.⁷ Our survey disclosed similar experiences. Respondents said that healthcare practitioners (HCPs) did not explain procedures, touched them (vaginally and anally) forcefully and without forewarning,⁸ and pressured them to accept unwanted interventions.⁹ Some repeatedly encountered the same issues across several pregnancies.¹⁰ Others found their autonomy repeatedly overridden during one pregnancy; for example, one respondent was denied treatment for hyperemesis gravidarum, abortion access, and early delivery. She was also denied sterilization when, traumatized, she decided to avoid future pregnancies.¹¹

How did women relate these experiences to the Amendment? Of 516 respondents, 134 said that the Amendment impacted their care in some way. Of these, 12 reported that their HCPs gave the Amendment or the Constitution as a justification for refusing or imposing an intervention in pregnancy or childbirth.¹² Very few respondents reported that their HCPs directly referenced the Amendment in a dispute over treatment. By far the majority of those who discerned the Amendment to be at work were relying on their own interpretation of the situation. We did not survey HCPs, and we cannot know how they understood the law from women's survey responses alone.

¹ It is common to speak of the 'repeal' of the Amendment. In fact, it was repealed and replaced by the 36th Amendment, which permits the legislature to make law in relation to 'termination of pregnancy'.

² Midwives for Choice, *Submission to the Citizens Assembly* (2016), at <<http://midwivesforchoice.ie/wp-content/uploads/2017/01/MfC-Submission-CA-Master.pdf>>; Parents for Choice, *Paper of Parents for Choice Delivered to the Citizens Assembly* (2016), at <<https://www.citizensassembly.ie/en/Meetings/Parents-for-Choice-s-Paper.pdf>>.

³ The Association for Improvements in Maternity Services (AIMS) Ireland undertook large-scale surveys of patient experience between 2007 and 2014: see AIMS Ireland, 'Surveys' *AIMS Ireland*, at <<http://aimsireland.ie/surveys/>>. However, these did not engage as directly as our survey with women's sense of the Amendment's impact on their care.

⁴ E. Hodnett, 'Pain and Women's Satisfaction with the Experience of Childbirth: A Systematic Review' (2002) 186 *Am. J. of Obstetrics and Gynecology* 160.

⁵ S. R. Baker et al., "'I Felt as though I'd Been in Jail": Women's Experiences of Maternity Care during Labour, Delivery and the Immediate Postpartum' (2005) 15 *Feminism & Psychology* 315.

⁶ U. Waldenström, 'Modern Maternity Care: Does Safety Have to Take the Meaning out of Birth?' (1996) 12 *Midwifery* 165.

⁷ Baker et al., op. cit., n. 5.

⁸ For example R70 and R137.

⁹ For example R193 and R75.

¹⁰ For example R159.

¹¹ R174.

¹² Four women had had experience of both. Some women gave examples across more than one pregnancy.

Therefore, we do not claim that the Amendment was the dominant regulatory influence on these women's experiences, or that it wholly distinguishes the Irish experience from that in other jurisdictions. We make no causal claims about the Amendment's regulatory impact on obstetric care – about whether clinicians refused interventions or imposed them in individual cases because clinicians or their advisers determined that the Amendment required it. Instead, we discuss how some women read the Amendment into often difficult personal experiences. Drawing on the literature on legal consciousness, we argue that the 'hidden transcript'¹³ of women's reported experience of the Amendment provides a valuable supplement to the limited public transcript in judgments and policy documents. While a disparate field, legal consciousness theory broadly coalesces around the contention that 'legality', presented as a pluralistic understanding of what the law is or does, is embedded within, manifests through, and is reproduced by social relations.¹⁴ Our analysis is particularly influenced by the legal consciousness literature's identification of empirical accounts as important vehicles for expanding our understanding of legal influence and effect, albeit partially and from specific subjects' perspectives. Critical exploration of women's legal consciousness tells us something about the Amendment's everyday life in hospital wards, waiting rooms, and birthing suites.

We begin the article by describing our survey and methods of analysis. We then outline what little state policy documents and court judgments say about the Amendment, pregnancy, and childbirth. We use the survey to demonstrate that the Amendment, as women lived it, was more expansive and complex than official discourse suggested. First, we examine responses from women whose HCPs clearly used the Amendment to justify overriding their treatment preferences. On a strict reading, the Amendment should only have influenced care where the fetus' life, rather than its health or welfare, was at risk. However, women reported that the Amendment affected treatment in a wider range of cases, where the fetus could not survive or where the fetus was not at risk. These women never found themselves in court, and so could contest their HCPs' legal reasoning in depth. Nevertheless, taking their cue from what their HCPs said, they framed their experiences in terms of the Amendment. They came to their own conclusions about how the Amendment affected their care; they perceived it as a wide-ranging protection for fetal life. Some saw it as enforcing wider ideological commitments rooted in Catholic social teaching, anti-abortion politics, or fetocentric risk management. Second, we consider how women who did not point to a particular conflict with their HCPs nevertheless understood that the Amendment affected their experiences in birth and pregnancy. It travelled via a multi-faceted, disempowering atmosphere around pregnancy, sometimes manifesting in unwanted or violent touch, and at other times only exerting affective force. Finally, we discuss what our analysis means for births and pregnancies in Ireland, now that the Amendment is (officially) gone.

2 | THE SURVEY

We draw on a November 2017 anonymous¹⁵ mixed-methods survey of relationships between the Amendment and women's reproductive healthcare experiences. Manchester Metropolitan

¹³ J. C. Scott, *Domination and the Arts of Resistance: Hidden Transcripts* (1990).

¹⁴ S. Halliday, 'After Hegemony: The Varieties of Legal Consciousness Research' (2019) 28 *Social & Legal Studies* 859; S. Halliday and B. Morgan, 'I Fought the Law and the Law Won? Legal Consciousness and the Critical Imagination' (2013) 66 *Current Legal Problems* 1; S. S. Silbey, 'After Legal Consciousness' (2005) 1 *Annual Rev. of Law and Social Science* 323.

¹⁵ Qualtrics automatically allocated each respondent a unique identifier. Any names used are pseudonyms.

University's Research Ethics and Governance Committee approved the survey. We asked 48 questions, including yes/no, multiple-choice, and free-response questions. The survey included one question – 'To what extent do you feel your views were respected?' – with a five-point Likert scale response. Questions focused on types of treatment/care requested and received, and interactions with HCPs. We set out the content of the questions relevant to this article's inquiry in the next section. To ensure that questions were appropriate and accurate, we requested feedback from the campaigning groups Parents for Choice and Midwives for Choice. To guarantee rigour and minimize potential bias, researchers with no connection to debates in maternity care or to Ireland also reviewed the survey. The survey was designed and administered with Qualtrics software. Participants could use the back button to change any answers and could withdraw from completing the survey at any point. No questions were compulsory. We publicized a URL link to the anonymous Qualtrics survey using social media, email contacts, and word of mouth. Convenience sampling was used. The URL link remained active for one month before we downloaded data to SPSS 23.

Parents for Choice distributed the survey link to their membership and we advertised the survey independently. At the time, the Amendment was a significant topic of public debate. This offered an opportunity to explore its effects on pregnancy and childbirth at a time of heightened awareness. We were not interested in general attitudes to the Amendment in Ireland. Instead, we were interested in legal consciousness of the Amendment among women who not only had political awareness of it but could articulate how it connected with their own experiences. This justifies our sampling. Using Parents for Choice as a facilitator likely shaped who accessed and completed the survey, and how conscious they were of the Amendment. Ultimately, however, the majority of respondents did not say that the Amendment affected their maternity care experiences. We used closed responses asking for specific examples from respondents' own healthcare experiences to limit the impact of respondents' political commitments on our findings.

Respondents were asked to provide basic demographic information related to ethnicity, sexual orientation, gender identity, and disability. While economic status and educational status are known social determinants of health, we excluded this information as these could have changed following or between experiences in reproductive care. For example, a currently employed respondent educated to post-secondary level may have focused on a previous experience that occurred while she was at school or unemployed. That said, changes in education may have impacted how respondents now read their experience. Their awareness of whether and how their autonomy was respected may have changed over time. The difference between how they read experiences in 2017 as compared to how they read those experiences at the time does not invalidate the study; however, it does deserve analysis in future research.

Our sample was relatively homogeneous. Of the respondents, 97.9 per cent were white women. Ethnic minorities are over-represented in Ireland's maternal death statistics,¹⁶ and so the absence of their perspectives from the survey data is a significant limitation of the study. The survey was only available in English and we did not offer assistance with completion. Future studies should specifically target ethnic minority communities.

Documentary evidence relating to the Amendment, pregnancy, and childbirth – such as legislation, policies, clinical guidelines, and appellate judgments – is limited. Day and Lury discuss

¹⁶ S. M. Lyons et al., 'Cultural Diversity in the Dublin Maternity Services: The Experiences of Maternity Service Providers When Caring for Ethnic Minority Women' (2008) 13 *Ethnicity and Health* 261; R. Lentin, 'A Woman Died: Abortion and the Politics of Birth in Ireland' (2013) 105 *Feminist Rev.* 130; D. J. Shandy and D. V. Power, 'The Birth of the African-Irish Diaspora: Pregnancy and Post-Natal Experiences of African Immigrant Women in Ireland' (2008) 46 *International Migration* 119.

combining closed numeric data, documentary data, and personalized accounts to gain comprehensive insights into a social problem.¹⁷ This enables both a ‘view from above’ and ‘being alongside’ experience.¹⁸ The Irish state records maternal deaths¹⁹ and some kinds of severe morbidity.²⁰ Documenting treatments refused and imposed in cases where women did not die or suffer long-term harm provides a partial ‘view from above’ of maternity care in Ireland. Detailed personal narratives about coercion, control, and denial of choice afford insight into the lived experience of maternity care in Ireland and enrich data from closed questions and documentary evidence.

3 | CHILDBIRTH, PREGNANCY, AND THE AMENDMENT: OFFICIAL ACCOUNTS

The Amendment read:

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 Amendment’s consequences for continuing pregnancy and childbirth are poorly understood. The Amendment did not mention abortion; instead, it enshrined a broad duty to protect ‘unborn’ life. It is possible – though no court ever confirmed it – that the Amendment constitutionalized a presumption in favour of continued pregnancy, and therefore sometimes required coercive care, even at the expense of women’s health. No legislation was ever passed to guide how the Amendment should apply to childbirth. While the Amendment was still in force, the *National Consent Policy* suggested that a pregnant woman’s refusal of consent to medical treatment could be overridden where it placed the fetus’ life at risk.²¹ In such an instance, the hospital could apply to the High Court. In the few known cases that followed such applications by the Health Services Executive (HSE), the High Court granted orders requiring women to accept C-sections,²² restraint,²³ detention,²⁴ and forced feeding and hydration.²⁵ The only circumstance in which HCPs could

¹⁷ S. Day and C. Lury, ‘New Technologies of the Observer: #BringBack, Visualization and Disappearance’ (2017) 34 *Theory, Culture & Society* 51.

¹⁸ J. Edmeades et al., ‘Methodological Innovation in Studying Abortion in Developing Countries: A “Narrative” Quantitative Survey in Madhya Pradesh, India’ (2010) 4 *J. of Mixed Methods Research* 176.

¹⁹ The Coroners (Amendment) Act 2019 later provided for compulsory inquests in cases of maternal death.

²⁰ National Perinatal Epidemiology Centre (NPEC), ‘NPEC National Audit of Severe Maternal Morbidity’ *National Perinatal Epidemiology Centre*, at <<https://www.ucc.ie/en/npec/npec-clinical-audits/severematernalmorbidity/>>. For a supplementary non-governmental study covering less ‘severe’ morbidity, see the Maternal Health and Maternal Morbidity in Ireland study: <<https://www.mammi.ie>>.

²¹ HSE, *National Consent Policy* (2017) 41, at <<https://www.tusla.ie/uploads/content/National-Consent-Policy-August-2017.pdf>>.

²² *Mother A v. Waterford Regional Hospital*, 11 March 2013, per Hedigan J; *HSE v. B* [2016] No. 8730P; R. Fletcher, ‘Contesting the Cruel Treatment of Abortion-Seeking Women’ (2014) 22 *Reproductive Health Matters* 10.

²³ *HSE v. B*, id.

²⁴ *HSE v. BS* [2017] IEDC 18.

²⁵ In 2015, Ms Y, who was compelled to undergo a C-section following repeated refusal to consider her entitlement to a life-saving abortion, settled her case against the state. There is no reported judgment. See further Fletcher, op. cit., n. 22.

offer care that placed the fetus' life at risk – whether an abortion or another intervention – was to save the mother's own life, where that life was at real and substantial risk.²⁶

Officially, therefore, the Amendment was an emergency provision intended to safeguard fetal life – rarely used, poorly defined, and reliant on judicial oversight. However, our research suggests that some women perceived the Amendment's everyday role as much more expansive, creeping into cases where the fetus was not at meaningful risk, and increasing the regulatory weight of religious, political, and medical norms that had no strict legal force.

4 | WHAT DID IT MEAN TO BE AFFECTED BY THE AMENDMENT?

Our survey asked respondents a range of questions about their experiences of obstetric and gynaecological care in Ireland. Section 2 asked whether the respondent was refused requested treatment or required to accept unwanted treatment in pregnancy or childbirth. Respondents could answer questions identifying the intervention(s) involved. Where a respondent indicated that she was refused requested treatment, the survey asked follow-up questions concerning reasons given to the woman for overriding her treatment decision. Where a respondent indicated that she was required to accept treatment, the survey asked the same follow-up questions. Respondents were asked whether their HCPs gave reasons, and invited to select from the following options:

- 'law' or 'legal advice'
- 'negligence' or 'duty of care'
- 'the 8th Amendment' or 'the Constitution'
- the hospital's 'ethos' or 'policy'
- your doctor's own moral or religious position
- other (please explain)
- no justification given.

Respondents could select more than one option.

Responses to this part of Section 2 initially suggested that the Amendment had little impact on respondents' experiences of maternity care. The other reasons cited for refusing or imposing care were more prominent.²⁷ Just 12 respondents indicated that 'the 8th Amendment' or 'the Constitution' were invoked as a reason for refusing or imposing an intervention in labour or continuing pregnancy, other than abortion. Some provided further detail on how their HCPs referred to the Amendment. For instance, Maeve reported that it was read to her when she tried to assert control over her birth plan:

I was told in advance that they would not have to seek my consent for an episiotomy (when I had detailed in a birth plan that I would like reasons for this to be outlined). As a result of this being said to me by my obstetrician, I refused for her to be in the room when I was in labour. She had not listened to me several times during my

²⁶ This based on a reading of the abortion case *AG v. X* [1992] IESC 1.

²⁷ Responses overlapped. For instance, of the 29 respondents who said that negligence was directly mentioned in their cases, four said that HCPs also mentioned the Amendment and 21 felt that the Amendment had affected their cases. Of the 24 respondents who said that HCPs mentioned 'law'/'legal advice', 12 said that the Amendment was also directly mentioned, 18 said that the Amendment affected their cases, and only two said that it did not.

pregnancy and refused to let me submit my birth plan into my file (nothing radical in it!) as it was *not consistent with the constitution* – on the grounds that I requested to be told (or my husband be told) the reason for each intervention in advance of enacting it. I was simply told *the fetus was their concern and was constitutionally protected* ... No justification was considered necessary – I pushed for reasons as to why certain options and even information about them would be denied outright. *I was read the wording of the 8th amendment and told that this isn't just hospital policy, it was policy dictated by the constitution of Ireland.*²⁸

Similarly, Dara reported that '[t]he 8th amendment was outlined for me while I was in labour ... If I had refused the C-section the courts would have been involved.'²⁹

We did not confine our inquiry to instances where the Amendment was mentioned by name. Elsewhere, the survey asked about proxies for the Amendment. First, a question in Section 3 asked: 'Did any doctor, nurse, or other healthcare professional suggest that the police, social workers, or the courts might be involved if you continued to insist on/refuse a particular course of treatment?' Four of the 12 women who reported that their HCPs referenced the Amendment also answered this question in the affirmative. Claire, who said that she 'did not feel her baby was ready to be born', was threatened with the police:

When being pressured to present for induction it was strongly hinted that the guards would bring me to hospital if I didn't come voluntarily. I replied that it was my body, and I had the right to refuse medical treatment, and the doctor laughed.³⁰

Orla, who was refused a termination for a fetal anomaly earlier in pregnancy, understood that the police could be involved in her child's birth: 'During delivery, a midwife showed me a picture of a Garda statement and asked me not to make a fuss or she would be required to use her "direct line to the Guards".'³¹ These were not empty threats. In 2016, the HSE invoked the Amendment when it sought orders requiring police assistance to return a woman to hospital if she 'absconded' rather than accept a C-section.³² Though this order was ultimately refused, it tells us how the HSE perceived the Amendment's scope. Two women responded that they were warned that the courts might be involved.³³ No court actions were brought in these cases.³⁴

Second, we did not include 'fetal rights' or 'baby's rights' as a reason in Section 2. Though the Amendment was the only legal source of fetal rights at the time, we wanted to allow for the broad vernacular meanings attaching to 'rights', such that 'fetal rights' was not a perfect proxy for the Amendment. However, in Section 3, the survey asked: 'Did any doctor, nurse, or other healthcare professional talk about the rights or interests of your fetus?' Only two women answered in the

²⁸ R215, emphasis added.

²⁹ R447.

³⁰ R23.

³¹ R231.

³² *HSE v. B*, op. cit., n. 22. Cases of this kind were not about the woman's capacity to make birth decisions, but about the likely impact of their decisions on the baby who would be born.

³³ R40 and R145.

³⁴ To address the possibility that any action might have been concerned with decision-making capacity rather than the Amendment, Section 3 also asked: 'Did any doctor, nurse, or other healthcare professional question whether you were competent to make your own medical decisions?' Neither of these two women reported that their capacity was in question.

affirmative.³⁵ They were among the 12 whose HCPs had mentioned the Amendment. In other free-text responses, women raised the theme of the ‘baby’s safety’, but this is not a synonym for fetal rights.

Third, in Section 5, we asked respondents an open-ended question: ‘Do you believe the 8th Amendment affected your experience?’ A total of 134 women, including the 12 who indicated in Section 2 that the Amendment affected their care, provided a positive answer.³⁶

We can distinguish, then, between the few instances in which HCPs explicitly invoked the Amendment, the Constitution, the courts, or the police, and instances in which the women themselves interpreted their situation in light of the Amendment even though none of these sources of power was directly involved. The great majority of these respondents associated the Amendment with episodes in which their wishes were not respected. Of the 134, only eight did not use Section 2 to identify a specific intervention refused or imposed.

At the end of this analysis, we have three interlocking groups of respondents. Group A (12 women) and Group B (112 women) experienced direct conflict with an HCP over a specific intervention refused or imposed. Group A’s HCPs invoked the Amendment, the Constitution, the police, or the courts. Group B’s HCPs did not do any of this, but the women themselves surmised from the circumstances that the Amendment was at work. Group C is a small group of eight women who could not point to a specific application of the Amendment in their cases. Groups B and C pose difficulties for traditional legal analysis because there is no clear moment of contact with the law. When we examine them with an eye to women’s legal consciousness, however, we open up important questions about how the Amendment operated beyond the formal system. Studies of legal consciousness typically redirect focus from formal legal structures and texts, attending instead to personal narratives of ‘legality’. ‘Legality’ here denotes meanings, sources of authority, practices, and subjectivities that are constitutive of law’s power and meaning,³⁷ albeit not directly authorized by the state. It describes how we use legal ideas to interpret and negotiate lived experiences, and to evaluate others’ behaviour.³⁸ By extension, it includes our sense of ourselves as people whose lives and actions are threatened, protected, legitimated, or stigmatized by law.³⁹ From this perspective, Davies writes,

[l]aw is discursive, performed, assumed, located, relational and material. It is emergent in social space – through performances, intra-actions and material relations, and also through the imaginings, narratives and self-constructions that inform and are informed by these things.⁴⁰

³⁵ R49 and R242.

³⁶ A majority of respondents did not answer this question. We received 213 responses in total. Six women were unsure of whether the Amendment had affected them. Of the 73 remaining, 65 clearly answered that the Amendment had not affected them. Three of these respondents made short comments indicating a moral objection to abortion. A number were clear that while the Amendment had not affected them personally, it had affected other women. Some felt that they had been ‘lucky’ to have avoided the Amendment.

³⁷ D. Delaney, ‘What Is Law (Good) For? Tactical Maneuvers of the Legal War at Home’ (2009) 5 *Law, Culture & the Humanities* 337.

³⁸ P. Ewick, ‘Law and Everyday Life’ in *International Encyclopedia of the Social & Behavioral Sciences*, ed. J. D. Wright (2015, 2nd edn) 471.

³⁹ M. Galanter, ‘Reading the Landscape of Disputes: What We Know and Don’t Know (and Think We Know) about Our Allegedly Contentious and Litigious Society’ (1983) 31 *UCLA Law Rev.* 4.

⁴⁰ M. Davies, *Law Unlimited* (2017) 89.

5 | THE AMENDMENT IN CONTEXT

Two themes emerge when we view Groups A and B through a legal consciousness lens. First, women framed the Amendment as a much broader and stronger inhibition on their medical decision making than was ever directly authorized by the judiciary or the legislature. Second, they constructed the Amendment as importing other norms – religious, moral, political, and medical – into their intimate decision-making space, giving them something like legal force.

5.1 | Broadening the Amendment

The reported instances, though few, in which women perceived that the Amendment was a significant reason for overruling their treatment preferences may suggest that its legality was broader and more fluid than any official discourse acknowledged. The cases in which HCPs invoked the Amendment, the Constitution, the police, or the courts are especially striking. Maeve took issue with an episiotomy,⁴¹ Dara with a C-section,⁴² and Claire with an induction.⁴³ None of them suggested that their fetus' life was ever at risk. Orla reported that HCPs mentioned the Amendment explicitly and that she was told that the police would be called if she continued to 'make a fuss' during delivery.⁴⁴ Maureen was similarly threatened with police action if she did not accept induction of labour.⁴⁵ In these cases, it was not clear that any risk to the fetus arising from the women's refusal was serious enough to trigger the Amendment. Similar themes emerge in cases where the Amendment was not directly invoked. Women reported that they faced the Amendment when they contested procedures associated with the management of labour,⁴⁶ including induction,⁴⁷ membrane sweeps,⁴⁸ breaking of waters,⁴⁹ episiotomy,⁵⁰ mandatory use of fetal monitors during labour,⁵¹ and refusing labouring women permission to move around.⁵² Nuala referenced the interpretation of the Amendment in the *National Consent Policy* as mandating the application of techniques related to active management of labour:

I was not given any choice in the way my second child was delivered. I was told that I had 16hrs to deliver or I would have to have a c-section. I was administered with oxytocin to speed up my labour without consent. I believe that because of the 8th

⁴¹ R215.

⁴² R447.

⁴³ R23.

⁴⁴ R231.

⁴⁵ R23.

⁴⁶ J. Murphy-Lawless, 'Reading Birth and Death through Obstetric Practice' (1992) 18 *Cdn J. of Irish Studies* 129.

⁴⁷ For example R7, R22, R43, R267, R198, and R28.

⁴⁸ For example R235 and R122.

⁴⁹ For example R236.

⁵⁰ For example R62, R101, and R210.

⁵¹ For example R99 and R25.

⁵² For example R134 and R148.

amendment that I had no rights to refuse consent as laid out in the HSE consent policy.⁵³

The applicable law was never clear. Neither the *National Consent Policy* nor the *National Maternity Strategy* specified a threshold of risk to fetal life at which women's decisions could be overridden.⁵⁴ One of the few cases to generate a published judgment, *HSE v. B*, clarified that women could refuse very invasive treatment, such as a C-section, where the resulting risks to the fetus' life were low.⁵⁵ It did not articulate how serious the risk to fetal life must be before a woman must accept highly invasive treatment. Second, the *Policy* contradicted the *Strategy*. While the *Policy* focused on risk to life, the *Strategy* stated that a woman's informed refusal could be overridden where that refusal would 'threaten the life of or have a deleterious effect on the baby', or where her decision 'has implications for the health or life of the baby'.⁵⁶ It is not surprising that the boundaries of risk to life and health blurred in everyday practice.

Women also reportedly encountered the Amendment where their preferred decision did not pose any risk to the fetus, because, arguably, there was no fetus to protect. For instance, three women reported that HCPs referenced the Amendment when dealing with miscarriage. They felt compelled to accept expectant or conservative miscarriage management because other interventions overlapped with then-illegal abortion care.⁵⁷ For example, Marion's use of the word 'terminate' suggests that she perceived that she was denied miscarriage care because of the abortion law required under the Amendment: 'I was having miscarriage lots of bleeding pain contractions over 3 days was told pregnancy could not survive but due to Irish law could not terminate.'⁵⁸ Marie and Georgia respectively reported that they were refused medical or surgical management of an inevitable miscarriage, not because of any association with abortion, but because the fetus had a heartbeat:

With a failing pregnancy, even though it was unviable and absolutely going to end in miscarriage I was denied care and/termination because there was a heartbeat, albeit an extremely slow one, because of the law.⁵⁹

[Intervention] was against the law and although the hospital knew it was not going to be a viable pregnancy they had to wait for the heartbeat to stop before they could do anything.⁶⁰

⁵³ R66.

⁵⁴ HSE, op. cit., n. 21; HSE, *National Maternity Strategy* (2016), at <<https://www.gov.ie/en/publication/0ac5a8-national-maternity-strategy-creating-a-better-future-together-2016-2/>>.

⁵⁵ *HSE v. B*, op. cit., n. 22.

⁵⁶ HSE, op. cit. (2016), n. 54, p. 77.

⁵⁷ R47, R48, and R221.

⁵⁸ R488.

⁵⁹ R229.

⁶⁰ R32.

There may be good clinical reasons to offer expectant miscarriage management.⁶¹ However, Marie and Georgia connected their experience to the Amendment and incorporated it into their narratives of denial of care. They suggested that in their cases, fetal demise was inevitable, and they would have preferred prompt intervention. Their statements suggest that they experienced denial of care less as expectant management than as enforcement of a law preventing timely action.⁶²

Marie and Georgia perceived that the Amendment made the heartbeat a legal obstacle to care. Their interpretation illuminates one of the Amendment's many official gaps. References to the 'fetal heartbeat' were frequent across survey responses discussing miscarriage, even where HCPs did not raise constitutional issues. Irish clinical guidelines on the management of ectopic pregnancy and miscarriage did not directly reference the Amendment or emphasize the heartbeat as a key legal criterion. Only a conservative interpretation of the Amendment, equating fetal heartbeat with the presence of constitutionally protected life, might have required withholding treatment until the heartbeat stops, even if the fetus could not be born alive.⁶³ There is evidence that this interpretation had purchase in some hospitals. It came to public attention when Savita Halappanavar died of sepsis in 2012. Her doctors refused to terminate her pregnancy, even though miscarriage was inevitable and her health was at increasing risk. Her medical team believed that the Amendment 'tied their hands' as long as the fetus had a heartbeat, unless and until her condition was immediately life threatening.⁶⁴ After her death, both pro-choice and anti-abortion lawyers debated this interpretation of the Amendment. No court ever came a definitive conclusion. Nevertheless, Marie and Georgia felt that it was possible to invoke the Amendment to prohibit safe miscarriage care.

Evelyn's doctors delayed addressing an ectopic pregnancy; she attributed that delay to the Amendment. While waiting for treatment, she fainted at her doctor's office and was taken to hospital by ambulance: 'Had an ectopic pregnancy of unknown origin. Had to wait so many weeks to show wasn't developing due to 8th amendment even though I knew myself.'⁶⁵ Following the

⁶¹ Royal College of Physicians of Ireland (RCPI), *Clinical Practice Guideline: The Diagnosis and Management of Ectopic Pregnancy* (2014), at <<https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2016/05/28.-Diagnosis-and-Management-of-Ectopic-Pregnancy.pdf>>; RCPI, *Clinical Practice Guideline: Ultrasound Diagnosis of Early Pregnancy Miscarriage* (2010), at <<https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2016/05/1.-Ultrasound-Diagnosis-of-Early-Pregnancy-Loss.pdf>>; RCPI, *Clinical Practice Guideline: Management of Early Pregnancy Miscarriage* (2014), at <<https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2016/05/9.-Management-of-Early-Pregnancy-Miscarriage.pdf>>. See further T. De Vere, 'Maternity Expert Says Every Pregnancy Is Affected by the 8th Amendment' *Her*, at <<https://www.her.ie/news/maternity-expert-says-every-pregnancy-is-affected-by-the-8th-amendment-404854>>. In 2010, following public reports of miscarriage misdiagnosis using ultrasound in Drogheda and Galway, the HSE ran a national review: HSE, *National Miscarriage Misdiagnosis Review* (2011), at <<https://www.hse.ie/eng/services/publications/Clinical-Strategy-and-Programmes/Miscarriage-Misdiagnosis-Report-2011.pdf>>. The guidelines on ultrasound diagnosis cited above were published after this review.

⁶² R229 and R32.

⁶³ The presence of a heartbeat can legitimately determine the care offered. See, for example, Malak Thawley's case: *Irish Times*, "'Cascade of Negligence' Led to Pregnant Woman's Death' *Irish Times*, 12 January 2018, at <<https://www.irishtimes.com/news/crime-and-law/courts/high-court/cascade-of-negligence-led-to-pregnant-woman-s-death-1.3353142>>.

⁶⁴ S. Arulkumaran, *Investigation of Incident 50278 from Time of Patient's Self Referral to Hospital on the 21st of October, 2012 to the Patient's Death on the 28th of October, 2012* (2013), at <<https://www.hse.ie/eng/services/news/nimtreport50278.pdf>>. In response to Halappanavar's death, a new system for the detection of life-threatening illness in pregnancy and the post-natal period – the Irish Maternity Early Warning System (IMEWS) – was developed.

⁶⁵ R148.

so-called ‘doctrine of double effect’,⁶⁶ doctors may be reluctant to directly end fetal life, unless the woman’s own life is at immediate risk.⁶⁷ Instead of ending a tubal ectopic pregnancy, they might wait to see if it ends spontaneously.⁶⁸ To some extent, the Amendment constitutionalized the doctrine of double effect, establishing equivalent fetal and maternal rights to life, prioritizing the former, and disregarding maternal autonomy and health. However, no law-making authority ever validated this approach to the Amendment in childbirth.

Finally, six respondents linked the Amendment to refusal of requests for scans or genetic testing that might disclose a fetal anomaly, and in the process give them the information needed to decide to have an abortion.⁶⁹ One respondent said that her HCP explicitly informed her that a scan could not be provided because they would not be able to ‘do anything’ under the Amendment.⁷⁰ This suggests that while the scan was permissible, its availability was conditioned by the Amendment’s prohibition on abortion. Tests and scans for anomalies were never illegal in Ireland; neither was it ever illegal to travel abroad for an abortion based on scan or test results.⁷¹ Indeed, the 13th Amendment recognized a constitutional right to travel for abortion. Only expansive misinterpretation of the Amendment – suggesting that a possible future abortion in another jurisdiction was a legally cognizable risk to fetal life – could justify denying access to these services.

It is unsurprising that women’s accounts suggest that the Amendment was instrumentalized in ways that the courts never scrutinized. Legal precepts may be vernacularized in strained and unforeseen ways, ‘dragging’ unexpected issues into their orbit.⁷² The production of legality ‘may include innovations as well as faithful replication’.⁷³ Though our data cannot tell us about HCPs’ legal consciousness, it can tell us that some women perceived the Amendment to be at work behind clinical decision making.

5.2 | Entanglement with other powerful discourses

Law is inseparable from social life. It is applied by and to social individuals with imperfect legal knowledge, in fields where law depends on other norms for influence.⁷⁴ Women perceived that the

⁶⁶ B. G. Prusak, ‘Double Effect, All Over Again: The Case of Sister Margaret McBride’ (2011) 32 *Theoretical Medicine and Bioethics* 271; C. Tollefsen, ‘Double Effect and Two Hard Cases in Medical Ethics’ (2015) 89 *Am. Catholic Philosophical Q.* 407.

⁶⁷ M. A. Anderson et al., ‘Ectopic Pregnancy and Catholic Morality: A Response to Recent Arguments in Favor of Salpingostomy and Methotrexate’ (2011) 11 *National Catholic Bioethics Q.* 65; L. R. Freedman and D. B. Stulberg, ‘Conflicts in Care for Obstetric Complications in Catholic Hospitals’ (2013) 4 *AJOB Primary Research* 1.

⁶⁸ Anderson et al., id.

⁶⁹ R43, R154, R189, R209, R210, and R177.

⁷⁰ R47.

⁷¹ In 2017, only seven of 19 Irish maternity hospitals offered fetal anomaly scanning to all patients. See L. Kenny, Joint Oireachtas Committee on Health, 16 February 2017, at <https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2017-02-16/2/>.

⁷² M. Croce, *The Politics of Juridification* (2018).

⁷³ P. Ewick and S. S. Silbey, *The Common Place of Law: Stories from Everyday Life* (1998) 45.

⁷⁴ J. Griffiths, ‘The Social Working of Legal Rules’ (2003) 35 *J. of Legal Pluralism and Unofficial Law* 1.

Amendment resonated with other powerful social discourses, including Catholic social teaching, anti-abortion sentiment, and biomedical accounts of risk.

Unsurprisingly, some women associated their Amendment experiences with Catholic medical ethics. This was not an abstract association. Beth's account attributing difficult miscarriage experiences at a 'Catholic run' hospital to the Amendment shows how the Amendment, Catholic institutional power, and Catholic pastoral presence intersected in one experience:

My treatment for miscarriages was awful and I was patted on the leg and told better luck next time and that my womb was empty ... no empathy, no aftercare ... [A] nun appeared and told me it was God's will. [It] is a Catholic run hospital where clearly the 8th puts the unborn child above the woman's wishes.⁷⁵

Meanwhile, when Frances asked why her requests for anomaly scans were refused, she was told that Ireland was a 'Catholic country' and that abortion was illegal in Ireland due to the Amendment.⁷⁶

In other cases, refusals of care and information depended on abortion stigma independent of the Amendment, even if the Amendment reinforced it. For instance, some miscarrying women felt that HCPs treated them with hostility because they were suspected of seeking an abortion. Abortion, of course, was forbidden by the Amendment.⁷⁷ This is clear from Tina's account:

I received no after care or post-miscarriage advice apart from being given a leaflet and a few snide remarks from nurses that why was I so upset if I wanted to kill my baby anyway. I was less than 6 weeks pregnant. It wasn't a baby. I had never mentioned that I wanted an abortion. I was upset during one of the scans when the radiologist kept telling me to look at the screen and say goodbye to my baby. I told her I didn't want to see something I never asked for. I don't think I have recovered yet from the trauma of being spoken to like that.⁷⁸

In Irish public discourse around maternity care, distressing experiences are often attributed to conservative Catholicism and anti-choice sentiment. However, in survey responses, the Amendment's focus on risk to 'unborn life' aligned with purportedly secular biomedical fetocentric risk discourses. Some women associated the Amendment with 'active management' of labour. The majority gave birth in hospital; only two women said that their HCPs invoked the Amendment

⁷⁵ R152. Beth named the hospital in her response. The hospital was run and owned by a Catholic order until the late 1990s, when it was sold to the HSE. At the time that Beth gave birth, therefore, it was not strictly speaking 'Catholic run'. The 'nun' is likely to have been a hospital chaplain.

⁷⁶ R47. A similar remark was made to Savita Halappanavar when she requested that her doctors end her pregnancy: P. Cullen and K. Holland, 'Midwife Manager "Regrets" Using "Catholic Country" Remark to Savita Halappanavar' *Irish Times*, 10 April 2013, at <<https://www.irishtimes.com/news/health/midwife-manager-regrets-using-catholic-country-remark-to-savita-halappanavar-1.1355895>>.

⁷⁷ For example R22 and R86.

⁷⁸ R90.

when denying access to home birth.⁷⁹ Active management of labour⁸⁰ is connected to the late-twentieth-century dominance of a biomedical obstetric-led model of childbirth care in Ireland⁸¹ and elsewhere in the West.⁸² Under this model, the fetus is fragile and susceptible to the inherent risks of pregnancy.⁸³ This model legitimates active management,⁸⁴ encourages intervention,⁸⁵ and constructs less medicalized modes of childbirth – including woman-centred midwifery models – as intrinsically dangerous.⁸⁶ Inevitably, its risk discourses are reinforced by practitioners' and HSE perceptions of legal liability for birth injuries,⁸⁷ and by lack of staff resources and its impact on the organization of care.⁸⁸ Within this model, HCPs are positioned as directors of pregnancy

⁷⁹ R73 and R149. HSE legal advice suggested that the Amendment may be relevant to home birth without specifying how: M. O'Shea, *The Legal Aspects of the HSE National Home Birth Service: A Review of Legislation and Case Law* (2016), at <<https://www.hse.ie/eng/services/list/3/maternity/new-home-birth-policies-and-procedures/legislative-dataset.pdf>>. The regulation of home births in Ireland under the Amendment was clearly risk centred, and home births were rare. There is no statutory right to home birth. Home deliveries can be undertaken by private self-employed community midwives (SECMs). Access was prohibited in 'high-risk' cases, and only permitted in 'medium-risk' cases following review by an obstetrician: HSE, *Midwifery Practice Guidelines: HSE Home Birth Service* (2018), at <<https://www.hse.ie/eng/services/list/3/maternity/hb004-midwifery-practice-guidelines-hse-home-birth-service-2018.pdf>>. An SECM who continued to work with a woman designated medium or high risk could face criminal sanction under the Nurses and Midwives Act 2011. Legal challenges to this system failed: *O'Brien and Ors v. South Western Area Health Board* [2003] IESC 56; *Aja Teehan v. The Health Service Executive and The Minister for Health* [2013] IEHC 383, unreported judgment, 16 August 2013; *Tarrade and Ors v. Northern Area Health Board* [2000/184 JR] unreported judgment, 15 May 2002. For HCPs' criticisms of home birth advocacy, see E. D. Slutsky and L. C. Kenny, 'Home Birth: The Case Against' (2012) 22 *Obstetrics, Gynaecology & Reproductive Medicine* 28.

⁸⁰ C. M. Begley et al., 'Active versus Expectant Management for Women in the Third Stage of Labour' (2019) 13 *Cochrane Database of Systematic Reviews* 3; J. Murphy-Lawless, 'Fertility, Bodies and Politics: The Irish Case' (1993) 1 *Reproductive Health Matters* 53.

⁸¹ Murphy-Lawless, op. cit., n. 46.

⁸² H. MacKenzie Bryers and E. van Teijlingen, 'Risk, Theory, Social and Medical Models: A Critical Analysis of the Concept of Risk in Maternity Care' (2010) 26 *Midwifery* 488.

⁸³ K. Coxon et al., 'Risk, Pregnancy and Childbirth: What Do We Currently Know and What Do We Need to Know? An Editorial' (2012) 14 *Health, Risk & Society* 503; R. Chadwick, *Bodies that Birth: Vitalizing Birth Politics* (2018); M. Scamell, 'The Swan Effect in Midwifery Talk and Practice: A Tension between Normality and the Language of Risk' (2011) 33 *Sociology of Health & Illness* 987; M. Scamell and A. Alaszewski, 'Fateful Moments and the Categorisation of Risk: Midwifery Practice and the Ever-Narrowing Window of Normality during Childbirth' (2012) 14 *Health, Risk & Society* 207.

⁸⁴ R. Mander and J. Murphy-Lawless, *The Politics of Maternity* (2013); D. Lupton, "'Precious Cargo": Foetal Subjects, Risk and Reproductive Citizenship' (2012) 22 *Critical Public Health* 329.

⁸⁵ Scamell and Alaszewski, op. cit., n. 83.

⁸⁶ Z. Spendlove, 'Medical Revalidation as Professional Regulatory Reform: Challenging the Power of Enforceable Trust in the United Kingdom' (2018) 205 *Social Science & Medicine* 64; D. Ferndale et al., "'You Don't Know What's Going On in There": A Discursive Analysis of Midwifery Hospital Consultations' (2017) 19 *Health, Risk & Society* 411.

⁸⁷ S. Panda et al., 'Clinicians' Views of Factors Influencing Decision-Making for Caesarean Section: A Systematic Review and Metasynthesis of Qualitative, Quantitative and Mixed Methods Studies' (2018) 13 *PLoS ONE* e0200941. On the ambivalent connections between the legalization of medicine and 'defensive' practice, see M. Fischer and G. McGivern, 'Medical Regulation, Spectacular Transparency and the Blame Business' (2010) 24 *J. of Health Organization and Management* 597; R. Surtees, "'Everybody Expects the Perfect Baby ... and Perfect Labour ... and So You Have to Protect Yourself": Discourses of Defence in Midwifery Practice in Aotearoa/New Zealand' (2010) 17 *Nursing Inquiry* 82; L. Mulcahy, *Disputing Doctors: The Socio-Legal Dynamics of Complaints about Medical Care* (2003). On the risk of litigation as promoting positive change in medical practice, see Mulcahy, id., p. 109. On legalism and the 'demoralisation' of medicine, see J. Montgomery, 'Law and the Demoralisation of Medicine' (2006) 26 *Legal Studies* 185.

⁸⁸ S. Huschke, 'Decision-Making in the Birth Space' (2021) 29 *Brit. J. of Midwifery* 294.

and childbirth⁸⁹ responsible for preventing harm to the fetus and the pregnant person. Women are treated as passive and vulnerable, but ‘responsible for, and able to control, the health of their own body that of their fetus’.⁹⁰ This division of responsibility means that women can be constructed as potentially risking the fetus’ safety and requiring technocratic management for its sake.

Several respondents were accused of deliberately or irresponsibly risking their fetus’ life.⁹¹

While pregnant, I was told that by refusing induction at gestation 40 weeks and 10 days, I was placing my bab[y’s] life at risk. That my baby could be stillborn, I was given figures of stillborn deaths if I went past this gestation.⁹²

I was delaying things I was endangering my baby by refusing to allow labour to be induced/speeded up ... I was frequently told this wasn’t about what I wanted it was about getting the baby out safely and that was the only important thing.⁹³

I believe [the Amendment] provides a justification and imperative to ignore the right to informed consent in labour and birth ... When refusing non-essential elective induction techniques I was told I couldn’t refuse, they were happening, as this was best for the baby.⁹⁴

[I was t]old several times by the consultant that if I waited past 12 days that they would not be responsible for a dead baby.⁹⁵

Risk discourses circulated and shaped relationships between woman and fetus as subjects in childbirth, and their responsibilities to each other.⁹⁶ Survey responses identified a fetal subject, called ‘the baby’, who was vulnerable to multiple risks, much wider than the constitutionally prescribed risk to life.⁹⁷ Sometimes these risks were not specified.⁹⁸ Women were reminded of the baby’s needs, welfare, safety, or best interests. These could trump women’s preferences. Respondents were told that HCPs would do ‘whatever is necessary’,⁹⁹ and birth plans were ‘quickly discarded’ without consultation if judged to present fetal safety concerns.¹⁰⁰

⁸⁹ Ferndale et al., op. cit., n. 86.

⁹⁰ Id., p. 412. See also Lupton, op. cit., n. 84.

⁹¹ For example R178, R134, R291, R233, and R122.

⁹² R138.

⁹³ R208.

⁹⁴ R128.

⁹⁵ R240. See also P. M. Niles et al., ‘“I Fought My Entire Way”: Experiences of Declining Maternity Care Services in British Columbia’ (2021) 16 *PLoS ONE* e0252645.

⁹⁶ Ferndale et al., op. cit., n. 86; Coxon et al., op. cit., n. 83; Scamell, op. cit., n. 83.

⁹⁷ For example R226. An HSE patient leaflet on miscarriage referred to the fetus as a ‘tiny baby’: HSE, *Ultrasound Diagnosis of Early Pregnancy Miscarriage: Clinical Practice Guideline* (2010), at <<https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/ultrasound-diagnosis-of-early-pregnancy-miscarriage.pdf>>.

⁹⁸ For example R64.

⁹⁹ R152.

¹⁰⁰ R14.

The Amendment's meanings were constituted through processes of interaction between the formal norm itself and HCPs' interpretations. Those interpretations, in turn, circulated through women's efforts to make sense of a vague and open-textured law as it applied at key moments in their reproductive lives. Some respondents observed the Amendment at work where it had no strict legal application, actively 'travelling to where it shouldn't'.¹⁰¹ Delaney reminds us that what is displaced or unacknowledged by formal law retains life elsewhere.¹⁰² This cluster of responses suggests that for some women, the Amendment was more than a law of last resort; on the contrary, it was an expansive power to overrule decisions in pregnancy and childbirth. From a legal consciousness perspective, it is not surprising that, in women's accounts, the Amendment's force and scope extended beyond anything imposed by the formal legal system and were entangled with several extra-legal concerns. In addition, women perceived that the Amendment gave extra-legal discourses something akin to legal force. Perhaps many HCPs avoided or did not consciously engage with the Amendment, preferring to displace the work of overriding women's decision making onto other norms.¹⁰³ Nevertheless, some women perceived the Amendment's effects when their HCPs overrode their intimate decisions.

6 | THE AMENDMENT AS FELT REGULATION

HCPs' failure to 'name' the Amendment is not determinative. Not all respondents received reasons for an HCP's decision in the moment.¹⁰⁴ Thirty-one stated that they received no justification for having to accept particular interventions, and 11 reported that they received no justification for the refusal of a care request. Some women said that their consent was taken 'as a given',¹⁰⁵ or that procedures 'just happened' without further discussion.¹⁰⁶ One respondent described a membrane sweep and rupture of membranes without prior discussion. When she asked if her waters had been broken, the doctor 'just smiled and said we all need a little help from time to time'.¹⁰⁷ Sorcha described a forceps delivery done without discussion or being asked for consent: 'It just happened. I was satisfied with my care, but I wouldn't say that there was consent required or given.'¹⁰⁸ Lorna

¹⁰¹ E. Cloatre, 'Law and ANT (and Its Kin): Possibilities, Challenges, and Ways Forward' (2018) 45 *J. of Law and Society* 646, at 658.

¹⁰² D. Delaney, 'Tracing Displacements: Or Evictions in the Nomosphere' (2004) 22 *Environment and Planning D: Society and Space* 847.

¹⁰³ On displacement away from law, see M. Hertogh, *Nobody's Law: Legal Consciousness and Legal Alienation in Everyday Life* (2018).

¹⁰⁴ For example R14. While there is a legal obligation to ensure patients' informed consent, there is no necessary obligation to inform them of the applicable law: see HSE, *National Consent Policy* (2022) s. 3, at <<https://www.hse.ie/eng/about/who/national-office-human-rights-equality-policy/consent/documents/hse-national-consent-policy.pdf>>.

¹⁰⁵ R236, R49, and R97. Failure to obtain consent for interventions was noted in the 2018 review of maternity services at Portiuncula Hospital: J. Walker et al., *External Independent Clinical Review of the Maternity Services at Portiuncula Hospital, Ballinasloe (PUH) and of 18 Perinatal Events which Occurred between March 2008 and November 2014* (2018) 83, at <<https://www.saolta.ie/sites/default/files/publications/Clinical%20Review%20of%20Portiuncula%20Maternity%20services%202018.pdf>>.

¹⁰⁶ R43 and R124.

¹⁰⁷ R43.

¹⁰⁸ R53.

said: ‘I had a double episiotomy – I didn’t refuse treatment because I wasn’t asked to consent. No consent given. It was just done.’¹⁰⁹ Gillian’s membranes were ruptured without her consent:

On first birth, on admission for induction, was told by doctor she was going to do an internal exam. I saw her unwrap a crochet hook kind of thing¹¹⁰ and she broke my waters fully (had been seeping). I was already stressed out about induction and I’m very sure she didn’t warn me she might do this. It was excruciating and to my knowledge without warning or requesting permission. I believe this is because of the 8th amendment and consent policy for pregnant women. Nothing was said though.¹¹¹

Others recalled that, if an explanation was given, it was vague,¹¹² contained ‘scant information’,¹¹³ or amounted to blunt assertion of common practice¹¹⁴ or medical authority.¹¹⁵ One respondent was simply told that anomaly scans were ‘not necessary’.¹¹⁶ Eighty-two women reported that they were made to accept a treatment because it was ‘best practice’, but no detailed further explanation was given. These vague or partial reasons can be framed as ‘directive assertion’. For Jackson and colleagues, directive assertions are instances where ‘a course of action is formulated by HCPs as something that is either going to or needs to happen’.¹¹⁷ They argue that directive assertions can be verbal (‘We are going to need to ...’ or ‘We have to ...’) or non-verbal (such as when a course of action is imposed without a preceding discussion of alternative options). Directive assertions differ from assertive talk; they are not part of an open conversation about the justification for the course of action.¹¹⁸ At their most extreme, they are reinforced by judgment or aggression. Our survey shows that directive assertion was not confined to minor, non-invasive, painless, or quick interventions.

For many women, directive assertion was part of a wider Amendment-influenced environment undermining their decision-making capacity. Women described pregnancy and childbirth under the Amendment as sites of contestation where they sought, but failed, to assert their autonomy. Even efforts to plan for the birth in advance did not mean that their wishes would be respected: ‘It was taken for granted that I had no say. When I mentioned a birth plan, the consultant informed me that he “didn’t do birth plans” and that he would make the decision.’¹¹⁹ Respondents described presenting themselves as authoritative decision makers – good mothers who were knowledgeable

¹⁰⁹ R105.

¹¹⁰ The instrument used for the artificial rupture of membranes is called an amnihook.

¹¹¹ R243.

¹¹² For example R68, R205, and R2.

¹¹³ R72.

¹¹⁴ For example R64, R73, R265, and R121.

¹¹⁵ For example R29, R210, R301, and R249.

¹¹⁶ R2.

¹¹⁷ C. Jackson et al., ‘Healthcare Professionals’ Assertions and Women’s Responses during Labour: A Conversation Analytic Study of Data from *One Born Every Minute*’ (2017) 100 *Patient Education and Counseling* 465, at 466.

¹¹⁸ J. Watson, ‘Responsible, Assertive, Caring Communication in Nursing’ (2015) 100 *Communication in Nursing* 465.

¹¹⁹ R242.

about their health care¹²⁰ and concerned for their babies.¹²¹ None of this guaranteed decision-making agency. Women who equipped themselves with research or detailed birth plans were frustrated.¹²² Other researchers have found that ‘feeling invisible’ characterizes Irish birth experiences,¹²³ and this is borne out in our survey. Women reported feeling that they did not matter¹²⁴ and were ‘ignored’,¹²⁵ ‘irrelevant’,¹²⁶ or an ‘inconvenience’.¹²⁷ One said ‘I simply wasn’t part of the birthing process’.¹²⁸ Others said that they were unable to make ‘decisions about their own health-care’¹²⁹ and that they were ‘passengers’ in giving birth.¹³⁰ One described her doctor as ‘baffled that I would expect a say’.¹³¹ Elaine’s doctor initially ignored her birth plan:

On my first pregnancy I had a birth plan. It stated no induction, no membrane sweep etc. unless unusual circumstances. On admission the registrar was examining me and started foostering around; I asked what she was doing – she said she was doing a membrane sweep to get things going. I pointed out I had expressly asked for this not to happen – she was unimpressed, but left me alone.¹³²

Others who contested decisions taken on their behalf were belittled¹³³ and criticized as ‘selfish’,¹³⁴ ‘silly’,¹³⁵ ‘ridiculous’,¹³⁶ ‘insane’,¹³⁷ ‘idiots’,¹³⁸ ‘agitated and emotional’,¹³⁹ and entertaining ‘notions’.¹⁴⁰ Some HCPs spoke to women’s husbands over their heads, and some women had more success in being heard if male partners advocated for them.¹⁴¹ Women sometimes deployed tactics of resistance when persuasion failed. These included refusing to show up to future

¹²⁰ For example R146, R166, R220, R177, R178, and R211.

¹²¹ For example R195. On pregnant women’s concerns for safety, see C. G. Fawsitt et al., ‘What Women Want: Exploring Pregnant Women’s Preferences for Alternative Models of Maternity Care’ (2017) 121 *Health Policy* 66.

¹²² For example R14, R60, R42, R188, R210, and R231.

¹²³ D. Daly et al., ‘The Maternal Health-Related Issues that Matter Most to Women in Ireland as They Transition to Motherhood: A Qualitative Study’ (2022) 35 *Women and Birth* e10.

¹²⁴ For example R33 and R60.

¹²⁵ R148.

¹²⁶ R249.

¹²⁷ R356.

¹²⁸ R14.

¹²⁹ R23, R56, R89, and R7.

¹³⁰ R7.

¹³¹ R60.

¹³² R212.

¹³³ For example R75 and R210. See also Niles et al., *op. cit.*, n. 95.

¹³⁴ R249.

¹³⁵ R129.

¹³⁶ R240.

¹³⁷ R496.

¹³⁸ R280.

¹³⁹ R255.

¹⁴⁰ R123.

¹⁴¹ For example R75 and R101.

appointments¹⁴² or refusing a particular doctor's care,¹⁴³ switching to private care,¹⁴⁴ changing hospital or catchment area,¹⁴⁵ travelling abroad to give birth,¹⁴⁶ or planning home birth.¹⁴⁷ One threatened to go to the media.¹⁴⁸ Another threatened to end the pregnancy.¹⁴⁹

Some women found enforced passivity in decision-making dehumanizing. During labour, one respondent felt that she was 'an object to use as [her consultant] saw fit'.¹⁵⁰ Another was treated 'like a lump of meat not a person'.¹⁵¹ A third concluded 'I honestly don't think I mattered a jot'.¹⁵² Some women contrasted this sense of 'not mattering' with the value ascribed to the fetus. One explained her sense that once the baby was born, she was expected to stop making a 'fuss', despite her injuries, and focus on her 'lovely baby'.¹⁵³ Brenda reported: I did not matter at any stage. Baby's health only.¹⁵⁴ Joan commented: 'The 8th is only still there because Ireland doesn't care about women. The only thing that mattered was getting the baby out & they didn't care what happened to me.'¹⁵⁵

While hospitals are 'repeat players' in these scenarios, women often felt unable to mobilize their legal rights.¹⁵⁶ Some were ill equipped to do so at the time.¹⁵⁷ Such a challenge would require confidence, support, and awareness of one's rights¹⁵⁸ as well as a willingness to assert them repeatedly¹⁵⁹ in a moment of dependence on the medical team.¹⁶⁰ One respondent noted the difficulty of being made to justify her decision while in labour.¹⁶¹

Feminist literature stresses how women's bodies become targets of disciplinary power in labour,¹⁶² and this manifests in pregnant patients' feelings, in how their bodies are touched, and in how HCPs speak about them. We can think of law as incarnated in and through personal

¹⁴² For example R177.

¹⁴³ For example R210 and R140.

¹⁴⁴ For example R70, R215, and R94.

¹⁴⁵ For example R137.

¹⁴⁶ For example R154.

¹⁴⁷ For example R471.

¹⁴⁸ R280.

¹⁴⁹ R85.

¹⁵⁰ R235.

¹⁵¹ R142.

¹⁵² R396.

¹⁵³ R43.

¹⁵⁴ R33.

¹⁵⁵ R183.

¹⁵⁶ A.-M. Farrell and S. Devaney, *When Things Go Wrong: Patient Harm, Responsibility and (Dis)Empowerment* (2015).

¹⁵⁷ For example R255 and R144.

¹⁵⁸ For example R43.

¹⁵⁹ For example R42.

¹⁶⁰ For example R186.

¹⁶¹ R42.

¹⁶² S. C. Shabot, 'Making Loud Bodies "Feminine": A Feminist-Phenomenological Analysis of Obstetric Violence' (2015) 39 *Human Studies* 231; R. Chadwick, 'Ambiguous Subjects: Obstetric Violence, Assemblage and South African Birth Narratives' (2017) 27 *Feminism & Psychology* 489.

encounters – as materializing, albeit haphazardly, in space and on flesh.¹⁶³ The Amendment came alive in the interactions of patients, partners, HCPs, consent forms, diagnostic tests, and women's bodies.¹⁶⁴ Amendment legalities emerge from memories of these corporeal interactions – 'from within the controlled, their bodies of appearance and their corridors of movement'.¹⁶⁵

As Cooper notes, touch produces 'proximal knowledge' of the law or the state in the one who is touched.¹⁶⁶ A woman subjected to an invasive procedure may not have a complete, ordered, stable sense of the legal reasoning that legitimates it, but she has an intimate and visceral knowledge of that law's effects. This reflects Cluley's argument that subject positions within systems of control are produced through the way in which medical professionals treat flesh.¹⁶⁷ In this respect, the violence of perceived applications of the Amendment is important. For example, some respondents described its legal influence through accounts of intrusive touch – that is, touch not preceded by shared decision-making conversations or, sometimes, by a request for consent. These encounters affirmed women's 'object' status under law. Siona said:

During my first birth I was tiring after being induced over 24 hours previously. My baby started to tire too. The doctor told me I had two more pushes 'or else'. He then proceeded to insert his fingers into my anus to show me where to push towards ... Doctors feel they can do what they want to women giving birth in Ireland.¹⁶⁸

Many women maintained that the refusal or imposition of treatment under the Amendment had mental¹⁶⁹ and physical effects¹⁷⁰ during and after pregnancy. They described how they were left traumatized after birth without any postpartum support¹⁷¹ and said that HCPs dismissed their concerns about their own health.¹⁷² Some used violent imagery. For example, one spoke about the sense that the birth ended abruptly, leaving her lying in a pool of her own blood, as if in a 'war zone'.¹⁷³ Others' experiences exacerbated the effects of past trauma.¹⁷⁴ Some reported that experiencing pregnancy under the Amendment made them fearful of future pregnancies.¹⁷⁵

Some respondents who mentioned the Amendment sensed that it had regulated their decision making even before or without the direct application of any touch and certainly without any direct

¹⁶³ D. Delaney, *The Spatial, the Legal and the Pragmatics of World-Making: Nomospheric Investigations* (2010); J. D. M. Shaw, 'The Spatio-Legal Production of Bodies through the Legal Fiction of Death' (2021) 32 *Law and Critique* 69.

¹⁶⁴ E. Grabham, *Brewing Legal Times: Things, Form, and the Enactment of Law* (2016) 9.

¹⁶⁵ A. Philippopoulos-Mihalopoulos, 'Atmospheres of Law: Senses, Affects, Lawscapes' (2013) 7 *Emotion, Space and Society* 35, at 36.

¹⁶⁶ D. Cooper, 'Reading the State as a Multi-Identity Formation: The Touch and Feel of Equality Governance' (2011) 19 *Feminist Legal Studies* 3, at 6; K. Hetherington, 'Spatial Textures: Place, Touch, and Praesentia' (2003) 35 *Environment and Planning A: Economy and Space* 1933.

¹⁶⁷ V. Cluley, 'Becoming-Care: Reframing Care Work as Flesh Work Not Body Work' (2020) 26 *Culture and Organization* 284.

¹⁶⁸ R70.

¹⁶⁹ For example R194, R90, and R481.

¹⁷⁰ For example R43.

¹⁷¹ For example R107, R356, and R134.

¹⁷² For example R138. This resonates with Spendlove, op. cit., n. 86.

¹⁷³ R356.

¹⁷⁴ For example R159, R267, R85, and R164.

¹⁷⁵ For example R235 and R253.

discussion of the law.¹⁷⁶ They were attuned to the possibility that they would be confronted with force if they transgressed the Amendment's boundaries. Writing on psychiatric treatment, Szmukler notes that patients may live under a 'coercive shadow' produced by threats, inducement, and persuasion that may be as effective as formal legal sanctions.¹⁷⁷ Women associated the Amendment with a 'culture' or 'mentality'¹⁷⁸ exerting an unspoken atmospheric pressure that demanded compliance. One respondent described feeling as though 'the 8th is like an invisible cage around all women of child-bearing age'.¹⁷⁹ Uncertainty around the Amendment's scope ensured women's compliance. This calls to mind Woodward and Bruzzone's concept of 'cathexis' – the idea that the anticipated 'touch' of the state, or the law, can co-opt subjects' reactions within a wider oppressive apparatus.¹⁸⁰ Cathexis relies on law's capacity to generate affects that exert force on its subjects that exceeds any direct encounter, bringing those subjects into alignment with law.¹⁸¹ Literature on affect, regulation, and health similarly explains how emotional atmospheric intensities produce and orientate subjects and subjectivities. The work of Duff¹⁸² and Pykett¹⁸³ connects the orientation of subjects' actions to atmospheres of fear and guilt. Berlant¹⁸⁴ and Ahmed¹⁸⁵ emphasize temporality and anticipation, arguing that pressures to move towards the future direct the actions of subjects in the present. Affect theory conceptualizes regulation as operating at a visceral level, proposing that the exercise of power involves the constitution of subjects' habitual modes of thought and action according to (1) the association of particular *future* states of being and achievements with specific emotional registers, and (2) the suspension of these futurities above the subject in the *present* to evoke particular emotional reactions. The contention that regulation materializes as affective atmospheres intersecting and moving with temporally located visceral, embodied encounters resonates with literature on how we should think about consent during birth.¹⁸⁶ In a time-space where physicality is so prominent, reported emotions and sensations are central to women's legal consciousness of the Amendment.

¹⁷⁶ For example R61.

¹⁷⁷ G. Szmukler, 'Compulsion and "Coercion" in Mental Health Care' (2015) 14 *World Psychiatry* 259.

¹⁷⁸ R7, R47, R66, and R167.

¹⁷⁹ R21. Participants in Baker and colleagues' study of practitioner–patient relations described feeling as if they were 'in jail': Baker et al., op. cit., n. 5.

¹⁸⁰ K. Woodward and M. Bruzzone, 'Touching like a State' (2015) 47 *Antipode* 539.

¹⁸¹ E. Grabham, 'Shaking Mr. Jones: Law and Touch' (2009) 5 *International J. of Law in Context* 343.

¹⁸² C. Duff, *Assemblages of Health: Deleuze's Empiricism and the Ethology of Life* (2014).

¹⁸³ J. Pykett, 'The New Maternal State: The Gendered Politics of Governing through Behaviour Change' (2012) 44 *Antipode* 217; R. Jones et al., *Changing Behaviours: On the Rise of the Psychological State* (2013).

¹⁸⁴ L. Berlant, *Cruel Optimism* (2011).

¹⁸⁵ S. Ahmed, *The Promise of Happiness* (2010).

¹⁸⁶ We were concerned to ensure that respondents could participate without needing to identify individuals, and we were interested in a structural rather than a 'bad apples' framing of coercive care: see C. Murray, 'Troubling Consent: Pain and Pressure in Labour and Childbirth' in *Women's Birthing Bodies and the Law: Unauthorised Intimate Examinations, Power and Vulnerability*, eds C. Pickles and J. Herring (2020) 155.

7 | CONCLUSION

This article cannot tell us what HCPs thought of the Amendment or which HCPs made greatest use of it.¹⁸⁷ It cannot show how HCPs, hospitals' ethics committees, legal advisers, or HSE employees understood the Amendment or applied it in individual cases. It cannot tell us whether the Amendment was more often invoked in some hospitals than in others,¹⁸⁸ or whether it was invoked as a last or first resort. It cannot tell us about undocumented shifts in practice around interpretation of the Amendment between 2000 and 2017. These are important questions for future study. Our article nevertheless makes some important interventions. Anker writes that we can understand law as 'a permanent interplay of ideas and principles in peoples' minds, gleaned from innumerable sources, that resolves into "the law" for any one person in any one situation'.¹⁸⁹ A legal consciousness perspective recognizes that subjective accounts of law have importance, whether or not they cohere with official legal discourse.

First, we have suggested that reported experiences pre-2018 show that at least some HCPs actively extended the Amendment's scope beyond that established in the case law. Some used the Amendment and its supporting discourses to delay treatment of miscarriage and ectopic pregnancy, to refuse care indirectly associated with abortion, and to justify active, hospital-based management of labour. This finding is potentially an important corrective to an Irish public discourse that discussed the law only in terms of 'chilling effects' on HCPs' clinical autonomy. During the Repeal campaign, leading doctors repeatedly described themselves as afraid of the Amendment, and of the consequences of overstepping legal boundaries.¹⁹⁰ An overemphasis on 'chilling effects' obscures HCPs' authoritative everyday role in interpreting the law, and respondents' sense that, as one put it, 'the doctor's word is law'.¹⁹¹ There was already evidence of expansive interpretation of the Amendment in the court archives. For example, it is not at all clear that the Amendment required the maintenance of a brain-dead pregnant woman's body on life support in the interests of the fetus, as happened in one case,¹⁹² or the detention of a suicidal teenager who requested an abortion, as happened in another.¹⁹³ This article adds to that body of evidence and demonstrates the need for further research.

Second, we have shown that many women perceived the Amendment's influence even where their HCPs did not expressly invoke it. It is likely that many respondents were aware of

¹⁸⁷ See further C. Pickles, 'Eliminating Abusive "Care": A Criminal Law Response to Obstetric Violence in South Africa' (2015) 54 *South African Crime Q.* 5.

¹⁸⁸ Some respondents named the hospital, but we did not directly ask for this information. For evidence of variations in practice from hospital to hospital, see J. E. Lutomski et al., 'Regional Variation in Obstetrical Intervention for Hospital Birth in the Republic of Ireland, 2005–2009' (2012) 12 *BMC Pregnancy and Childbirth* 123.

¹⁸⁹ K. Anker, *Declarations of Interdependence: A Legal Pluralist Approach to Indigenous Rights* (2016) 187.

¹⁹⁰ See for example in statements before the Oireachtas: R. Mahony, Joint Committee on Health and Children, 8 January 2013, at <https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health_and_children/2013-01-10/2/>; S. Arulkumran, Joint Committee on the Eighth Amendment, 18 October 2017, at <https://www.oireachtas.ie/en/debates/debate/joint_committee_on_the_eighth_amendment_of_the_constitution/2017-10-18/3/>; F. Malone, Joint Committee on the Eighth Amendment, 11 October 2017, at <https://www.oireachtas.ie/en/debates/debate/joint_committee_on_the_eighth_amendment_of_the_constitution/2017-10-11/3/>.

¹⁹¹ R71.

¹⁹² *PP v. HSE* [2014] IEHC 622.

¹⁹³ *HSE v. BS* [2017] IEDC 18.

pro-choice campaigners' arguments about the reach and role of the Amendment and were consciously integrating them into their personal narratives. As one respondent put it,

I am currently pregnant and every stage is filled with fraught tension that I will end up powerless at some point during my pregnancy or labour. I feel like I have to get everything perfectly right so I can't have my judgement questioned by medical staff later. I am afraid I'll end up in a coma or intensive care or dead because doctors could not choose to save my life. I worry that we will see something on a scan that will indicate a fatal foetal abnormality and then I'll have a legal battle on my hands at a vulnerable time. It's just really shit, and I am more vehement about the need for removing the 8th than ever before.¹⁹⁴

As Martin writes, ordinary narratives of legal experience inevitably reflect some retrospective 'sensemaking', influenced by personal beliefs and identity.¹⁹⁵ The impact of pro-choice discourse on women's efforts to make sense of their own experiences is visible in survey responses. One woman, for example, appropriated campaigning language when she described herself as a 'vessel' under Irish law.¹⁹⁶ Our survey did not directly explore connections between legal consciousness and legal mobilization. We did not ask respondents how they planned to vote in the 2018 referendum or whether they were involved in any pro-choice groups. However, even women who were not active in the campaign were aware of efforts to mobilize a new critical legal consciousness around maternity care.¹⁹⁷ New birth rights groups such as AIMS Ireland,¹⁹⁸ Midwives for Choice,¹⁹⁹ the Elephant Collective,²⁰⁰ and Parents for Choice²⁰¹ used personal narrative²⁰² to make the Amendment relevant to women voters who had not had abortions, framing it as the driving force behind oppressive maternity care. The story of Savita Halappanavar, which rejuvenated Irish pro-choice activism, concerned wanted pregnancy ending in avoidable death. In that context, to borrow from Ewick and Silbey, many of our respondents perceived themselves to be 'up against the law'.²⁰³ Some may have been 'legal detractors' whose accounts of law may reflect a suspicion of legal

¹⁹⁴ R3.

¹⁹⁵ R. Martin, 'Righting the Police: How Do Officers Make Sense of Human Rights?' (2022) 62 *Brit. J. of Criminology* 551.

¹⁹⁶ R43. See R. Doyle, 'Irish Abortion Laws: NO MORE THAN A VESSEL' *Irish Examiner*, 20 August 2014, at <<https://www.irishexaminer.com/opinion/commentanalysis/arid-20282582.html>>.

¹⁹⁷ The movement for reform of abortion law was called Repeal though the Amendment was repealed and replaced.

¹⁹⁸ AIMS Ireland, 'Think the 8th Amendment Is Only an Abortion Issue? Please Read' *Ireland: No Country for Pregnant Women*, 20 August 2014, at <<https://nocountryforpregnantwomen.blogspot.com/2014/08/think-8th-amendment-is-only-abortion.html>>; AIMS Ireland, 'The Eighth Amendment: Its Effects on Continuing Pregnancy' *AIMS Ireland*, 28 September 2017, at <<http://aimsireland.ie/the-8th-amendment-its-effects-on-continuing-pregnancy/>>.

¹⁹⁹ P. Canning, 'Why I'm Marching: The Battle over Abortion Is Far from Won' *Abortion Rights Campaign*, 28 September 2018, at <<https://www.abortionrightscampaign.ie/why-im-marching-the-battle-over-abortion-is-far-from-won/>>.

²⁰⁰ J. Murphy-Lawless, 'Holding the State to Account: "Picking Up the Threads" for Women Who Have Died in Irish Maternity Services' (2021) 56 *Éire-Ireland* 51.

²⁰¹ International Campaign for Women's Right to Safe Abortion, 'Ireland: Parents for Choice' *International Campaign for Women's Right to Safe Abortion*, at <<https://www.safeabortionwomensright.org/isad/ireland-parents-for-choice/>>.

²⁰² L. Smyth, 'Understanding the Transformed Moral Landscape in Ireland Following the "Repeal the 8th" Referendum' *LSE Europ Blog*, 29 May 2018, at <<http://blogs.lse.ac.uk/europpblog/2018/05/29/understanding-the-transformed-moral-landscape-in-ireland-following-the-repeal-the-8th-referendum/>>.

²⁰³ Ewick and Silbey, *op. cit.*, n. 73, p. 48.

authority.²⁰⁴ However, that self-understanding does not invalidate their reported experience. In adopting a legal consciousness approach, we are not concerned with testing whether women are accurate in their discussion of the Amendment. Rather, we seek to honour their conceptions of the Amendment, treating them as ‘knowledgeable agents’.²⁰⁵ As a basic point, we are not concerned with any bias affecting the neutrality of women’s legal analysis. Instead, we are interested in how the Amendment is enacted in their stories of pregnancy and birth.

Reproductive care in Ireland remains politicized. Recent years have seen inquiries into historical obstetric violence,²⁰⁶ campaigns for mandatory inquests in cases of maternal death,²⁰⁷ a ground-breaking inquiry into cervical cancer screening,²⁰⁸ and an ongoing dispute over perceived religious involvement in the new National Maternity Hospital.²⁰⁹ In respondents’ legal consciousness, the Amendment intersected with other normative forces. There is no reason to believe that the referendum has displaced their influence. Irish abortion providers report professional isolation and stigmatization by colleagues.²¹⁰ A sense of doctors as the best managers of risk remains central to senior obstetricians’ understanding of Irish law. For example, in 2019, the Institute of Obstetricians & Gynaecologists published new post-Amendment clinical guidelines on termination of pregnancy, whether by abortion or induction, on grounds of risk to health or life.²¹¹ These merely suggest that women’s own assessment of the risk to their health ‘could’ be considered. Though the Amendment has been removed from the Constitution, many of the forces with which it intersected – including a heavily interventionist approach to pregnancy and birth and inherited Catholic medical ethos – continue to influence Irish reproductive health care. All pre-date the Amendment. Personal and social memory of Amendment legality probably still shapes women’s expectations of obstetric care even in the Amendment’s absence.

Outside Ireland, coercive obstetric interventions are increasingly recognized as obstetric violence,²¹² harms to health,²¹³ and gendered political violence.²¹⁴ In Ireland, no formal legal steps have been taken to reform the law as it applies to pregnancy and childbirth. The Amendment’s

²⁰⁴ Halliday and Morgan, op. cit., n. 14; F. d. S. e. Silva, ‘“Not Falling for That”: Law’s Detraction and Legal Consciousness in the Lives of Brazilian Anti-Torture Activists’ (2020) 16 *International J. of Law in Context* 39; K. M. Young and K. R. Billings, ‘Legal Consciousness and Cultural Capital’ (2020) 54 *Law & Society Rev.* 33.

²⁰⁵ R. Dukes and E. Kirk, ‘Law, Economy and Legal Consciousness at Work’ (2021) 72 *Northern Ireland Legal Q.* 741.

²⁰⁶ C. Delay and B. Sundstrom, ‘The Legacy of Symphysiotomy in Ireland: A Reproductive Justice Approach to Obstetric Violence’ in *Reproduction, Health, and Medicine, Volume 20*, eds E. M. Armstrong et al. (2019) 197.

²⁰⁷ Murphy-Lawless, op. cit., n. 200.

²⁰⁸ G. Scally, *Scoping Inquiry into the Cervical Check Screening Programme* (2018), at <<http://scallyreview.ie/wp-content/uploads/2018/09/Scoping-Inquiry-into-CervicalCheck-Final-Report.pdf>>.

²⁰⁹ Our Maternity Hospital, ‘The National Maternity Hospital Must Be 100% Publicly Owned’ *My Uplift*, at <<https://my.uplift.ie/petitions/make-the-national-maternity-hospital-ours>>.

²¹⁰ S. Power et al., ‘Fetal Medicine Specialist Experiences of Providing a New Service of Termination of Pregnancy for Fetal Fetal Anomaly: A Qualitative Study’ (2021) 128 *BJOG: An International J. of Obstetrics & Gynaecology* 676.

²¹¹ Institute of Obstetricians & Gynaecologists, *Interim Clinical Guidance: Risk to Life or Health of a Pregnant Woman in Relation to Termination of Pregnancy* (2019), at <<https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2019/05/FINAL-DRAFT-TOP-GUIDANCE-RISK-TO-LIFE-OR-HEALTH-OF-A-PREGNANT-WOMAN-220519-FOR-CIRCULATION.pdf>>.

²¹² E. Kukura, ‘Obstetric Violence’ (2017) 106 *Georgetown Law J.* 721.

²¹³ S. G. Diniz et al., ‘Abuse and Disrespect in Childbirth Care as a Public Health Issue in Brazil: Origins, Definitions, Impacts on Maternal Health, and Proposals for Its Prevention’ (2015) 25 *J. of Human Growth and Development* 377.

²¹⁴ Chadwick, op. cit., n. 83.

replacement, the 36th Amendment, makes no reference to positive rights in pregnancy and childbirth. The *National Consent Policy* was amended in June 2019 to recognize that interventions must be based on informed consent, but does not include any positive statement about women's rights in childbirth. There are no plans to legislate around obstetric violence.

This article builds on women's sense that the Amendment constructed Irish women as diminished, woundable subjects. It also puts the Amendment in its place. Krauss, writing of women's experiences under Mexican abortion law, values 'making explicit, while at the same time dissipating, an intractable moral-affective knot that might otherwise be ignored'.²¹⁵ The Amendment was part of a knot that no referendum, by itself, will undo.

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²¹⁵ A. Krauss, 'Luisa's Ghosts: Haunted Legality and Collective Expressions of Pain' (2018) 37 *Medical Anthropology* 688, at 690.