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"The kind of doctor who doesn't believe doctor knows best": Doctors for Choice and the Medical Voice in Irish Abortion Politics, 2002-2018

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Abstract

This article examines how the physician advocacy organization Doctors for Choice articulated a collective pro-choice "medical voice" over the course of sixteen years. This voice was central to the successful 2018 campaign to repeal Ireland's Eighth Amendment, which had imposed a virtual ban on abortion in the Republic of Ireland since 1983. I examine how DfC set itself in opposition to the powerful cadre of anti-abortion Catholic physicians who had dominated Irish public discourse on abortion for decades. DfC not only had to provide a strong alternative argument, but also had to distance itself from a legacy of physicians as gatekeepers to abortion. Based on oral histories and documentary sources, I argue that DfC developed a collective pro-choice "medical voice" and a politics of physician advocacy by leveraging the cultural authority of physicians and using discourses of medical expertise and patient autonomy. Doctors have been called upon to use their social position to fight health-related social inequality. By providing a detailed case study based on individual experiences of and perspectives on physician advocacy, this article examines the framework of "physician advocacy" in practice. It identifies affective and structural barriers to physician engagement in abortion politics across medical specialties. Finally, it considers how, in the face of these barriers, a small group of physicians helped to set the terms of a movement for accessible and equitable abortion care in Ireland.

Introduction

In a 2018 referendum, Irish citizens voted overwhelmingly to repeal and replace the Eighth Amendment of Ireland's Constitution. Since 1983, The Eighth had imposed a virtual ban on abortion in the Republic of Ireland by granting equal protection to fetal and maternal life. It was replaced with a law protecting access to abortion up to 12 weeks, altering the legal landscape of abortion governance, particularly in Europe, where highly restrictive laws persist only in Poland and Malta (Remez et al., 2020; Mishtal and De Zordo, 2022). After many years of grassroots activism and political advocacy, the 2018 "Repeal" campaign intentionally framed abortion as a health issue rather than a moral one. Some of the campaign's most prominent spokespeople were physicians from Doctors for Choice (DfC),

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a small Irish physician advocacy group founded in 2002 to advocate for the integration of comprehensive reproductive health services, including abortion, into mainstream medicine. As the first and only pro-choice physician organization in Ireland, DfC was formed in opposition to the anti-abortion Catholic medical voices who had dominated public discourse on abortion for decades.

Doctors have historically functioned as gatekeepers to the medical means of exercising reproductive self-determination and bodily autonomy. Governing medical institutions have historically used legal and administrative abortion restrictions to secure clinical autonomy and financial advantage and to set boundaries around "legitimate" medical practice (Halfmann, 2019, 2003; Keown, 1988; McGuinness and Thomson, 2015). The feminist women's health movement of the late twentieth century challenged these restrictions, aiming to recast doctor-patient hierarchies by advocating for self-help, creating more democratic structures for healthcare provision, and agitating for legal reform (Nelson, 2015).

Despite the conservatism of their profession, pro-choice doctors have participated in the recent history of abortion politics in a range of cultural, legal, and political contexts. Globally, abortion has been unevenly incorporated into medical systems, with physicians making competing claims about their responsibility to provide abortion (Chavkin et al., 2017; De Zordo, 2016; Joffe, 1995; McGuinness and Thomson, 2015). Scholars have highlighted the stigmatization of abortion provision within mainstream medicine (De Zordo, 2018; Freedman, 2010; Joffe, 1995), the social contexts of physicians' political participation (De Zordo and Mishtal, 2011), and complex relationships between doctors and activists (Joffe et al., 2004). Recent qualitative work suggests that new frameworks of medical authority are needed to understand twenty-first century relationships between mainstream medicine and abortion politics. Lee et al. (2018) found that while British law frames doctors as gatekeepers of abortion, a "stratified subset" (p. 27) of pro-choice providers resent this position. They express strong personal commitments to patient autonomy and the ideal of conscientious provision. Building on these themes, I examine the articulation of a pro-choice "medical voice" as a collective political enterprise rather than an individual one.

DfC frames itself as a physician advocacy organization, drawing upon the idea that doctors should use their social position to advocate on issues of health-related inequality (Cantave et al., 2020; Kirmayer et al., 2018). Yet "physician advocacy" remains a loosely conceptualized framework (Earnest et al., 2010; Gruen et al., 2004) and there are no dedicated case studies of physician advocacy organizations in the social science literature. This article begins to fill that significant gap by using oral history to consider how multiple perspectives understand, interpret, and frame a collective physician advocacy effort.

DfC occupied an ambiguous position in the evolving landscape of twenty-first century Irish abortion politics. As physicians, DfC invoked a collective identity with considerable social power. Yet the group was marginalized within the medical profession by structural and affective barriers to widespread physician engagement with abortion politics. Simultaneously, as participants in a feminist-led social movement, DfC distanced itself from a legacy of physician authority over reproductive decision-making. Oral histories conducted with DfC committee members in 2019 reveal how the organization navigated

these tensions over the course of sixteen years. I argue that DfC developed a politics of pro-choice physician advocacy and mobilized a collective identity as the "medical voice" of pro-choice Irish doctors (Fominaya, 2010). This voice used discourses of medical expertise and patient autonomy to argue for safe, accessible, and equitable abortion care in Ireland.

Methods

This paper is based primarily on oral history interviews conducted by the author, an American doctoral candidate in an interdisciplinary social science and public health program. During the summer and fall of 2019, I conducted nineteen sixty- to ninety-minute interviews: sixteen in-person in Dublin and Cork, Ireland; one in-person in New York City, and two via video conference. Interviewees included seven current and former DfC committee members, two part-time DfC staff members, and ten key informants from organizations involved in Irish abortion politics. Interviewees were selected through purposive sampling: potential subjects were identified during informational interviews with a DfC committee member. Introductions and an explanation of the author's background and research interests were followed by formal email invitations. Three invited participants were not interviewed due to scheduling conflicts. This study was reviewed by the author's institutional review board and informed consent was obtained from all interviewees following best practices in oral history research (Ritchie, 2015).

Interviews included a common set of open-ended ended questions about participants' professional and political backgrounds; how they became involved in reproductive rights advocacy; their impressions of the role of physicians in Irish abortion politics; their knowledge of DfC's changing strategies or priorities; and their subjective understanding of physician advocacy. Interviews then followed the course set by individual participants (Perks and Thomson, 2016; Ritchie, 2015). Three interviewees requested anonymity. All interviews were audio recorded, after which transcripts were produced by the author and reviewed by interviewees (Strong, 2018). Interview data was analyzed inductively to surface "common meanings" and themes within individual oral history narratives (Yow, 2005, p. 284). This article situates personal reflections within the history of Irish abortion politics using documentary archival sources, including newspaper articles, parliamentary proceedings, government reports, and DfC records.

These oral histories will be deposited with the Digital Repository of Ireland as part of their effort to document and preserve the history of abortion-related advocacy in Ireland (Irish Qualitative Data Archive, 2020). They will add to a small body of first-person accounts from pro-choice physicians (Furedi and Hume, Michael, 1997; Physicians for Reproductive Choice and Health, 2000a). This article contributes to oral history-based scholarship on Irish feminist health activism (Connolly, 2002; Kelly, 2019; Muldowney, 2015) and on health professionals more broadly (Bayer and Oppenheimer, 2000; Boschma, 2012; Walker, 2017).

Physicians and Abortion Politics Before DfC

In the weeks leading up to the 1983 referendum vote that had ushered in the Eighth Amendment, a group of "Doctors For the Amendment" confidently claimed the support

of “the vast majority of family doctors and specialists within the profession” (Irish Times Reporter, 1983). The pro-Amendment campaign was chaired by an obstetrician and former nun and was fully backed by prominent members of the Irish medical establishment (O’Reilly, 1992). Niall Behan, CEO of the Irish Family Planning Association (IFPA), remembered how the support of Catholic obstetricians strengthened the case for the Eighth Amendment: “How quickly they got traction for this idea of an Eighth Amendment and really what gave them that push…was the medical voices” (N.B. interview). One DfC committee member, who was in training at the time of the 1983 referendum, described a medical environment with a strong anti-abortion ethos:

> The consultant who was supervising me was a man called Professor Eamon de Valera, who was the son of one of the founders of the Irish State, also called Eamon de Valera…He would tell women to pray if they had excessive bleeding and pain.
>
> (Interview 1).

The pro-amendment campaign spoke with confidence on behalf of Irish physicians from the solid ground of a decades-long partnership between the Irish Catholic Church and organized medicine. In the years following Irish independence from Britain, a powerful “medico-religious alliance” used interconnected discourses of religious nationalism and sexual morality to institutionalize Catholic medical ethics in law and medical practice (Earner-Byrne, 2015, p. 109). Abortion had been illegal in Ireland under a British criminal statute since 1861, and by the mid-1930s, contraception was effectively banned under the law. Dedicated Catholic physician advocacy organizations championed these restrictions using moralistic arguments, while Irish women bore the physical and emotional toll of sexual surveillance and control (Earner-Byrne, 2015). By the 1970s, however, Ireland was in the midst of a sociocultural and economic transformation (Daly, 2016) that included feminist activism around reproductive health (Connolly, 2002; Muldowney, 2015) and the partial legalization of contraception (Earner-Byrne and Urquhart, 2019). Conservative Catholic political networks conceived of the Eighth Amendment in the late 1970s as a guardrail against threats to their perception of Ireland as a bastion of traditional Catholic values (Connolly, 2002; Oaks, 2002; O’Reilly, 1992).

In their arguments for the Eighth amendment, the pro-Amendment campaign asserted that the amendment would “not interfere with existing medical practice” (Solomons, 1992). In reality, the Eighth imposed a chilling silence on the medical profession. Cork-based general practitioner and DfC founder Mary Favier remembered that during medical training, “[Abortion] wasn't a subject of conversation. It wasn't acknowledged medically. It wasn't taught. It wasn't even discussed in the corridor. It was completely shamed and silenced” (M.F. interview). People seeking information about abortion in the 1980s and 1990s would have had to turn to the independent counselling services that grew out of the Irish women’s movement (Connolly, 2002). Among doctors, the absence of information about abortion in medical education and the threat of criminal penalties foreclosed the possibility of shared conversations that might build solidarity.

Despite silence within the profession, doctors practicing under the Eighth witnessed bodily harms and compromised care. Marion Dyer, a Dublin-based general practitioner who joined

DfC's committee in 2013, remembered that soon after the Eighth had passed, "a young woman came into the hospital having just given birth and brought in a dead baby with her. This kind of thing wasn't very unusual back then." Dublin-based general practitioner and DfC founder Juliet Bressan told me that in the 1990s, doctors would not offer cervical cancer screenings to pregnant patients because cancer treatment might harm fetal development. Bressan remembered that the thinking was, "there's nothing I can do to treat her cancer till her baby's born" (J.B. interview).

Influential public and political events were catalysts to action for DfC's founders. Irish abortion politics after 1983 were punctuated by tragic cases that exemplified the toll of the Eighth on both mental and physical health. In 1992, a teenage rape victim was blocked from travelling to Britain for an abortion, and threatened to commit suicide if forced to continue with her pregnancy (Earner-Byrne and Urquhart, 2019). Public outcry followed the case, and in *Attorney General v. X*, the Supreme Court ruled that abortion would be legal when there was "real and substantial risk to the life, as distinct from the health, of the mother" (Earner-Byrne and Urquhart, 2019, p. 86). A pair of Constitutional amendments passed in the wake of the X case granted Irish citizens the right to obtain information about abortion and the right to travel abroad to access abortion services (notably, non-citizen Irish residents, including asylum-seekers, were often blocked from such travel).

By the end of the 1990s, polling revealed that the Irish public was moving away from an "absolutist" stance on abortion (Browne and Calkin, 2020). Pro-choice activists and civil society groups like the Irish Family Planning Association (IFPA) began to discuss abortion as a "health issue" rather than a moral one (Oaks, 2002).This was a powerful rhetorical shift in a context where anti-abortion activists continued to claim the support of "the Irish medical profession" writ large (Oaks, 2002, p. 326). Julie F. Kay, an American lawyer who worked with the IFPA in the early 2000s, recalled an urgent sense that the pro-choice community needed doctors on their side. Kay's previous employment had been with the U.S. Center for Reproductive Rights; as she explained to me, "I had never done abortion rights or sued without a doctor or two. I knew the credibility doctors bring to the abortion rights position" (J.F.K. interview). An opportunity to engage pro-choice doctors arrived with the 2001 visit of Women on Waves (WoW), a Dutch project led by Dr. Rebecca Gomperts that sought to bring a "floating women's reproductive health clinic" to places where abortion was illegal or inaccessible (Gomperts, 2002). The boat docked in Dublin and Cork, and among the small group who attended a seminar for medical professionals were Drs. Mary Favier, Juliet Bressan, and Peadar O'Grady, the founding members of DfC.

After the WoW visit, Bressan wrote in an op-ed that foreign reporters had been confused about how Irish doctors could "put up with being dictated to by the misogynistic rules of a discredited religious hierarchy" (Bressan, 2001). Bressan was referring to recent scandals within the Irish Catholic Church, including reports that it had concealed decades of physical and sexual abuse of children at religious institutions (Commission to Inquire into Child Abuse, 2001). The diminishing moral authority of the Church in the 1990s ran parallel to other "secularizing" (Mishtal, 2017, p. 197) developments in Ireland, including an economic boom, increased female labor force participation, and a growing immigrant population (Oaks, 2002). The doctors who eventually joined DfC's committee were active in the

left-wing political and social movements of this era: in interviews, they described voting to repeal the national prohibition on divorce; canvassing for the Labour party; campaigning for the right to abortion information; and volunteering for local feminist organizations.

Defining the Pro-Choice Physician Voice

O'Grady, Favier, and Bressan publicly launched DfC in 2002 (O'Regan, 2002a). Recalling the impetus behind the name "Doctors for Choice," Favier remembered:

> All the organizations in Ireland were "for choice" …and we decided that that's what we would go for because it was really clear. We weren't waffling around…Doctors for Choice. You can't miss what we're about
>
> (M.F. interview).

At the same time, the Irish government announced a referendum on another proposed constitutional amendment. It would remove suicide as legal grounds for an abortion, implying that acute mental distress did not constitute a sufficient "risk to life" (Oaks, 2002). As part of a broad Anti-Amendment Coalition, DfC gathered and published the signatures of 50 doctors urging a "No" vote in the referendum (O'Regan, 2002b). Other doctors also spoke out against the amendment. A group of psychiatrists published a statement arguing against the spurious distinction between mental and physical health being made by some of their anti-abortion colleagues (O'Keane et al., 2002). While the studiously apolitical Irish College of General Practitioners (ICGP) did not take a position on the referendum, the Institute of Obstetrics and Gynaecology publicly endorsed a "Yes" vote in the campaign. In response, a group of twenty-five obstetricians and gynecologists broke with their professional organization, saying that the new amendment would infringe upon the doctor-patient relationship (McCafferty, 2002).

These physicians entered the public debate surrounding abortion on the narrow terms set by the proposed reform. This perspective was reminiscent of the 1982 "Doctors Against the Amendment" group, who were not pro-choice (they actively objected to abortion "on demand") but argued that the Eighth would impede their ability to practice good medicine and exercise clinical discretion (Solomons, 1992). While DfC agreed that the Eighth Amendment compromised a doctor's ability to do their job, their definition of the doctor-patient relationship explicitly framed doctors as facilitators of the *patient's* right to choose. Strong commitments to bodily autonomy and equity underpinned DfC's mission: to advocate for "comprehensive reproductive health services, which includes abortion and contraception, as an integral and respected part of mainstream medicine in Ireland" (Doctors for Choice, 2002).

When the 2002 referendum failed, DfC used the energy of the victory to continue their advocacy efforts, successfully lobbying the Medical Council of Ireland to remove a clause that made it medical malpractice to counsel or refer a woman for an abortion (J.B. interview). Although official DfC publications in the early 2000s cited a total membership between 100 and 200, a handful of committee members sustained the organization. DfC's tenacity was a tribute to its clearly articulated collective identity. As Favier explained to me:

> I think I was very aware that the brand of Doctors for Choice was way stronger than the membership…You can't ring up the national radio broadcaster and say I'm X, an individual, please let me talk on the radio, but you can ring up as Doctors for Choice, even if there's only two of you
>
> (M.F. interview).

From its earliest days, DfC depended on the administrative support and expertise of other organizations, including the IFPA, the British Pregnancy Advisory Service (BPAS) and U.S.-based Physicians for Reproductive Health and Choice (PRCH). In fact, DfC drew directly upon PRCH language to draft its own first mission statements and organizational objectives (Physicians for Reproductive Choice and Health, 2000b). In 2008, DfC, PRCH, and a group of international doctors formed Global Doctors for Choice to support pro-choice physician advocacy around the world, connecting DfC with an international network of pro-choice physicians.

In collaboration with BPAS, DfC submitted observations to the European Court of Human Rights (ECHR) in the 2010 case of *A, B and C v Ireland* (so named to shield the identities of the three women who had been forced to travel to Britain to obtain abortions). The submission exemplified DfC's interest in connecting the health outcomes of the Eighth to fundamental inequalities in Irish society; they summarized medical issues associated with abortion restrictions and highlighted the disproportionate burden on low-income, migrant, and asylum-seeking women who could not travel to Britain (Furedi et al., 2009). The submission from BPAS and DfC was cited in the ECHR's influential decision that Ireland had not established effective mechanisms to facilitate the right to a life-saving abortion. The Court noted in particular that this status quo constituted "a significant chilling factor for both women and doctors" (European Court of Human Rights, 2010).

Favier remembered the years following the ECHR decision as demoralizing: "There was nothing happening politically. I mean the whole thing had just gone into abeyance, whether it was people had run out of energy, or there wasn't anything to be energetic about. You can't just go agitating into a vacuum" (M.F. interview). By the end of 2011, Favier was on the verge of shutting the group down. Then in 2012, married dentist Savita Halappanavar died of septicemia during a miscarriage in a Galway maternity unit. An inquest found that the presence of a fetal heartbeat had prompted her doctors to withhold care until it was too late to save her life (Boylan, 2013). The case prompted domestic and international outrage and is considered a turning point in Irish abortion politics (Earner-Byrne and Urquhart 2019). In the aftermath of Halappanavar's death, five physicians joined DfC's committee—four general practitioners and a psychiatrist. In interviews, all five used Savita's name to mark a before and after. As Mark Murphy, a Dublin-based general practitioner and one of DfC's new committee members, told me: "Savita happened, and things just changed drastically after that…it was just this absolutely shuddering, stark, case study, that was right in front of us, you couldn't not look at it" (M.M. interview).

The Irish government was finally pressured to move forward with legislation that would regulate access to life-saving abortion. The Protection of Life During Pregnancy Act (PLPDA) was signed into law in 2013 and legalized abortion under extremely narrow

medico-legal terms (Enright et al., 2015; Murray, 2016). The PLPDA required multiple medical practitioners to certify a physical or mental "risk to life," framing abortion entirely in terms of medical authority. Yet it did little to resolve the ambiguities of the Eighth for physicians (Enright et al., 2015; McDonnell and Allison, 2006). One feminist activist told me that in the wake of Savita's death and the disappointment of the PLPDA, "we felt that the time was right to kind of shift focus to be more *proactive* and try and set the agenda rather than simply reacting to increasingly horrific cases where despite all these promises there [was] no actual progress" (Interview 2).

The Irish pro-choice movement mobilized with new energy around the shared goal of repealing the Eighth. In 2012, the volunteer-led, grassroots Abortion Rights Campaign (ARC) was founded and held its first annual March for Choice. In 2013, a group of twelve organizations, including DfC, launched the Coalition to Repeal the Eighth Amendment. The Coalition would eventually grow to include over 100 organizations. As a pro-choice coalition in Ireland coalesced, DfC became a fixture at public events, domestic and international conferences, and in the media alongside left-wing politicians and pro-Repeal organizations.

Structural and Discursive Barriers to Pro-Choice Physician Advocacy

In countries like the United States and Portugal, doctors had become politicized by direct exposure to medical emergencies caused by unsafe, illegal abortions (Joffe, 1995; Stifani et al., 2018). In contrast, Irish doctors encountered abortion in far more limited and circumscribed ways. Long before the Eighth, Irish women had travelled to Great Britain and mainland Europe to obtain abortions. In 1967, Great Britain legalized abortion and the practice of travel became more common, reaching a peak in 2001 when 6,000 women reported Irish addresses at clinics abroad (Earner-Byrne and Urquhart, 2019). By the 2010s, these numbers had dropped by half, as people were increasingly self-managing their abortions with medications purchased via online pharmacies and international telemedicine services (Shelton, 2018; Aiken, Gomperts and Trussell, 2017).

While the abortion pill brought abortion onto Irish soil, it remained outside the formal channels of the medical system. Behan recalled that "doctors here really didn't have to engage [with abortion]" (N.B. interview). Indeed, some physicians did not have to engage with abortion because they simply never encountered it. But other doctors did encounter abortion in their clinical practice: they counselled patients with unwanted pregnancies on their limited options, treated patients for post-abortion complications when they returned to Ireland (ICGP 2004) and performed abortions when it was necessary to save a patient's life (Aitken et al., 2017; Murphy et al., 2012). For these doctors, Behan's point remains true: structural and discursive barriers discouraged physicians from engaging with abortion as a matter of politics, and by extension, as a cause for physician advocacy.

DfC was marginalized within the broader medical profession. As Favier explained to me, "I don't think you can understand quite fully how toxic a brand Doctors for Choice was seen as…we were just considered, for so long, way too radical, way too extreme" (M.F. interview). Interviewees explained this in terms of a class-bound, cultural conservatism

within Irish medicine: in DfC committee member and Dublin-based GP Tiernan Murray's words, “Doctors are innately conservative. Doctors come from comfortable middle-class backgrounds…every force is, don't stand out, don't upset your patients, don't upset the Church, don't upset anybody” (T.M. interview). These forces were only strengthened by the long history of abortion provider stigma in Ireland. In the twentieth century, highly publicized criminal trials labeled “abortionists” as quacks motivated by profit and distanced abortion from professional medicine (Delay and Liger, 2020). The stigma of provision extended into the twenty-first century, fueled by physicians’ fears of criminal penalties (Duffy et al., 2018). Inspired by the U.S. anti-abortion movement (Oaks, 2002), militant Irish anti-abortion groups also perpetuated the stigma of abortion provision as “dirty work” (O’Donnell et al., 2011) by using what Favier remembered as “quite extreme language…that ‘murderer’, ‘abortionist’ language” (M.F. interview).

There were also structural barriers to physician advocacy for Irish doctors. In the years following the 2008 financial crash, Ireland entered a period of austerity governance. This translated into spending cuts across the healthcare system, including reductions in rates of pay for physicians (Mercille, 2018; Nolan et al., 2014). The late 2000s and early 2010s were therefore a precarious time to consider pro-choice advocacy in a field where leading figures were still openly anti-choice. This was particularly true for obstetricians, who faced institutional barriers to public advocacy. In contrast to the decentralized structure of Irish general practice, in which over 3,000 physicians work primarily out of financially independent medical offices, Irish obstetrician-gynecologists work in a hospital system still peppered with historically Catholic maternity units (Foley, 2019). Interviewees brought up the power of hospital leadership in this context. Favier remembered one example:

> In Galway, where Savita Halappanavar died, that has historically been a strongly pro-life hospital. Careful appointments by the lead doctor ensured it stayed that way…Everyone knew this. And so when Savita died in Galway other doctors weren't surprised that it was Galway. Gynecologist friends of mine here in Cork would have said to me, it would never have happened in Cork
>
> (M.F. interview).

Many interviewees noted that obstetricians were not a presence in pro-choice advocacy until the final weeks of the 2018 referendum campaign. Until then, their participation in Irish abortion politics had been limited to formal settings like parliamentary hearings, where contributions were always framed narrowly. During parliamentary hearings to inform the PLPDA, master of the National Maternity Hospital Rhona Mahony said, “doctors are simply looking for adequate protection to make proper clinical decisions to save mothers’ lives and nothing else.” (Oireachtas, 2013). Behan recalled remarks like these and was struck by the professional boundaries obstetricians seemed to be drawing: “I really got the sense of this divide there, and that's really a sense of: well, we’re the obstetricians…we're doing the *good* abortions” (N.B. interview).

Kimport et al (2016) describe the “stratified legitimacy of abortions” that emerges when “medically indicated” abortions are viewed as more legitimate than elective procedures. When providers make these distinctions, they reinforce moralistic, gendered, and classed

ideas about responsible sexual behavior and perpetuate disparities in access to care (Beynon-Jones 2012; De Zordo 2018). But when telling me about past experiences with emergency terminations, Irish obstetricians highlighted their own vulnerability, not judgements of their patients. As obstetrician and gynecologist Nóirín Russell explained to me, “Nobody called it abortion. Just a few people got together and said look, this is the right thing to do here” (N.B. interview). Chair of the Institute of Obstetrics and Gynaecology Cliona Murphy used the same language to describe her experience: “We never called it abortion. It was that, I don't know, cognitive dissonance or something” (C.M. interview). Avoiding the word “abortion” formed a discursive shield against the criminal threat of the Eighth and the stigma of abortion provision, but also silently reinforced a hierarchy of legitimacy. Further, the state of exception that defined obstetricians’ engagement with abortion isolated them from a broader pro-choice politics.

Articulating a Pro-Choice Healthcare Message

By the mid-2010s, a consensus had emerged among those working to repeal the Eighth that their campaign should frame abortion as healthcare. Extensive research and in-house polling conducted by advocacy groups revealed that, as Behan explained, “the most trusted people on the abortion issue were women who had abortions, followed very closely by medical professionals” (N.B. interview). By that time, public discourse around abortion in Ireland had moved away from Catholic-dominated discussions of religious ethics and into the realm of medico-legal expertise (McAvoy, 2013), not least because the most public cruelties of the Eighth Amendment involved formal adjudication of physical and mental suffering. Framing abortion as healthcare extended the existing medical frame of abortion politics but changed its scale by focusing more on the patient experience. While organizations like Terminations for Medical Reasons offered the perspectives of people forced to travel to end desired pregnancies, advocacy groups promoted the message of abortion as “just one choice” in a lifetime of normal reproductive healthcare (Irish Family Planning Association, 2013).

DfC’s longstanding commitment to full reproductive choice was well-suited to this framework. As Murray explained to me: “We wouldn't just talk about the ‘hard cases.’ Our message was safe, legal, free, as early as possible, as late as necessary…We're not saying she's sick, we're not saying it's a fatal abnormality, were saying it's a women's choice” (T.M. interview). DfC committee members expressed a reflexive understanding of their cultural authority as physicians. As Murray said to me, “If they say X and I say X is wrong, they're going to believe me. People trust doctors” (T.M. interview). While this principle lay at the heart of DfC’s ability to command attention, it was also a source of discomfort for some committee members. Mark Murphy remembered, “you’re going to the meetings and giving the half hour speech and you're just looking at women looking back at you who know so much more about this” (M.M. interview). Indeed, a longstanding feminist critique of abortion politics in Ireland has been the exclusion of women’s experiences and perspectives from formal sites of power and decision-making (McAvoy, 2013).

Furthermore, “People trust doctors” was a truism that was just as easily leveraged by anti-choice campaigners. DfC was therefore very intentional about how *their* “medical voice” differed from that of anti-choice physicians. Murray explained the rhetorical and affective

approach DfC adopted: “if the anti-choice side go low, we go high…The best we could do is represent your typical sort of middle-class, middle age, reasonable doctor” (T.M. interview). DfC tried to avoid “arrogant people, people who would say offensive things, be radical beyond reasonable, [and who] would say things that weren't evidence-based” (M.F. interview). This approach mirrored that of the broader pro-choice community, who aimed “set the tone as informative, reasoned, calm, and non-confrontational” (Griffin et al., 2019). DfC’s underlying message was, as Dyer remembered it, “I'm a doctor…I’m not strange, I'm not radical, and I think we need to get rid of this horrible Eighth Amendment” (M.D. interview).

DfC committee members framed their pro-choice advocacy in terms of medical expertise and evidence. In practice, this meant that scientific language suffused DfC’s public messages: when Dyer spoke in public venues, she told me her aim was “to clearly explain that [the Eighth Amendment] meant that from the moment of fertilization, [an] adult woman’s right to exist was equal to no more and no less than the right of a fertilized egg to exist.” DfC reinforced their assertion of expertise by explicitly citing their sources: as Favier recalled, “we quoted the WHO right left and center, because they'll always respect that” (M.F. interview). By the 2010s, anti-abortion physicians had also adopted the language of evidence-based healthcare, but this discursive turn was tied to flawed evidence and misleading interpretations of data. For example, anti-abortion physicians frequently referred to Ireland as one of the “safest places in the world to have a baby,” intending to undermine the pro-choice argument that the Eighth Amendment harmed women’s health (The Life Institute, 2013; Save the 8th, 2018). As DfC and other pro-choice advocates pointed out, the refrain erroneously suggested a correlation between restrictive abortion laws and lower maternal mortality rates (Abortion Rights Campaign, 2014; Doctors for Choice, 2018). Further, the maternal mortality data these claims referenced was under-reported and criticized as misleading (O’Toole, 2012).

DfC directly countered anti-choice arguments by sharing “reputable research” (M.D. interview). For example, in 2016, the Irish government announced that a Citizens Assembly would consider evidence about the Eighth Amendment and make a formal recommendation to the state. The Assembly solicited submissions from a wide range of sources, primarily “experts” in law, medicine, and bioethics, but also advocacy groups like DfC (Citizens’ Assembly, 2017a). In a presentation on behalf of DfC, psychiatrist and committee member Veronica O’Keane couched her argument in unambiguously “reputable research,” citing longitudinal data from *The Lancet*, government statistics on women who obtained abortions abroad, and clinical recommendations from the Royal College of Obstetricians and Gynaecologists (Citizens Assembly, 2017b).

O’Keane also argued for a “woman-centered” model of abortion care rather than a “medical-centered” one (Citizens’ Assembly, 2017b). O’Keane was not suggesting the demedicalization of abortion, but a paradigm of care guided by patient autonomy. In interviews, DfC committee members acknowledged but held themselves apart from the legacy of medical authority. Dyer remembered that at meetings with other pro-choice organizations,

> (I tried) to represent the kind of doctor who doesn't believe doctor knows best… because some women…have had negative experiences of the medical profession, and it's totally understandable that they would assume that doctors might want to be controlling
>
> (M.D. interview).

Mark Murphy explained this idea in terms of medical ethics: "Doctors always learn about ethical principles and a fundamental one is autonomy…You have to really care, and you have to really accept what they want" (M.D. interview). These sentiments echo themes from 2018 research on abortion providers in England and Wales, wherein doctors understood abortion in terms of a "notably anti-paternalistic" ethic and viewed the decision-making authority of the patient as a component of good medical care (Lee et al., 2018). Modern terms like "shared decision-making" and "patient-centered care" express a similar ideal of the patient-provider encounter as a space that incorporates individual preferences and values alongside clinical expertise (Tanenbaum, 2015).

The prominence of patient autonomy within DfC's "medical voice" was a legacy of late twentieth-century health social movements. For example, in 1970s Ireland, radical groups like Irishwomen United criticized the medicalization of contraception, emphasized the class and geographic stratification of birth control access, and circumvented medical control through direct action by distributing contraceptives directly (Cloatre and Enright, 2017; Kelly, 2019). Similarly intersectional themes have persisted in the twenty-first century pro-choice activism of groups like ARC, the Abortion Support Network, and Disabled People for Choice, which have consistently argued for equitable and inclusive access to legal abortion (Carnegie and Roth, 2019).

Tensions, Concessions, and Advocacy After Victory

The Citizens' Assembly recommendations to the Irish government were far more liberal than many in the pro-choice movement had expected (Citizens' Assembly, 2017a). The Assembly overwhelmingly recommended that the Eighth be removed from the constitution. Further, a majority of the Assembly suggested that abortion before 12 weeks should be lawful without restriction. After a parliamentary committee held lengthy hearings on these recommendations (Joint Committee on the Eighth Amendment of the Constitution, 2017), the government announced that there would be a referendum on the Eighth Amendment and released a proposed framework for legislation should it be repealed (Department of Health, 2018). In response to the referendum announcement, ARC, the Coalition to Repeal the Eighth, and the National Women's Council of Ireland came together as the Together for Yes (TfY) campaign.

TfY sharpened the existing consensus that abortion should be framed as healthcare and launched a targeted political campaign to achieve a majority vote in the referendum (Griffin et al., 2019). In service of this goal, TfY endorsed the proposed legislative framework as "reasonable" (Cullen and Korolczuk, 2019; Together for Yes, 2018). However, the framework included several restrictions that DfC took issue with, including a three-day waiting period and a gestational limit for elective abortion. Sarah Maloney, DfC's part-time

coordinator from 2016 to 2019, observed how the DfC committee adjusted the scope of their advocacy messaging despite these concerns.

> By the time legislation on the table…it was very, 'Everyone just keep it together.'…Maybe this doesn't go far enough, but we are only talking about the positives
>
> (S.M. interview).

This instance reflected a tension that DfC navigated as it became more embedded in the network of organizations working to repeal the Eighth. DfC gained new committee members in 2013, and with new voices and a new advocacy landscape, DfC had many internal debates about how and when it was reasonable for the group to compromise on their ideal of abortion without legislative restrictions. Disagreements were at times acrimonious and threatened DfC's claim to a unified collective identity. In 2016, after a founding member exited the group, DfC embraced a more flexible and responsive approach to advocacy. Mark Murphy remembered that "the remaining members did what the rest of the abortion rights community judged, and floated along and kept an open mind" (M.M. interview).

During the few months of the TfY campaign, DfC found itself with unprecedented support from the medical community. Favier explained this to me in terms of "the momentum of [the campaign], the sense that it was going to win, feeling the safety of it, people making tentative forays and getting away with it and saying I'll do it again" (M.F. interview). During the campaign, physician advocacy had its home in the campaign group "Doctors for Repeal." DfC helped to organize a petition for physicians, which quickly gained over one thousand signatures. "It's funny, Doctors for Repeal was somehow more respectable than Doctors for Choice," Dyer recalled. "If that had been a Doctor for Choice petition many doctors wouldn't have signed it" (M.D. interview). Cliona Murphy explained that she and her obstetrician colleagues joined TfY and Doctors for Repeal out of a sense of duty to their patients, but that their participation was distinct from DfC's broad advocacy goals. As she remembered, "as medics, when the referendum came out, we felt we didn't really sit that well with the group that would have been maybe social activist as regards, 'My body my choice'" (C.M. interview). Instead, physicians like Murphy hewed closely to the narrow message of TfY: that the Eighth Amendment was dangerous to women's health and should be repealed. DfC committee members delivered this narrower message in their positions as campaign spokespeople. As Ross Kelly, a Dublin-based GP who joined DfC in 2013, remembered the experience, "suddenly [you] aren't just Doctors for Choice anymore, you are Doctors for Choice as part of a broader campaign" (R.K. interview).

In May of 2018, the referendum to repeal the Eighth Amendment passed with an overwhelming margin of support. "After the vote, everybody fell across the line exhausted, whereas we had to pick ourselves up and not just go on but do *more*," Favier remembered. DfC committee members were key stakeholders in designing formal systems for abortion provision, managing the vocal countermovement of anti-abortion physicians who mobilized around conscientious objection, and addressing concerns that physicians would be unprepared to begin service provision on January 1, 2019 (Cullen, 2018). In May of 2018, Favier was elected Vice President of the ICGP and in the winter of 2018,

Mark Murphy helped to negotiate a contract between the state and GPs on behalf of the Irish Medical Organization. The ICGP had taken no formal position on the referendum (Irish College of General Practitioners, 2018). But in the aftermath of the Yes vote, the pro-choice commitments of the organization's new leadership made a difference. As Favier remembered of this period:

> In all the many meetings [that] have had to take place between the Department of Health and the Irish College of GPs trying to tease out the service and structure it, I always went as the Vice President of the ICGP. I never went in my Doctors for Choice hat, even though everybody knew that that's really why I was there due to my knowledge of the area, and that kept everybody happy
>
> (M.F. interview).

Health systems and professional bodies have frequently been unprepared for the implementation of abortion services in the aftermath of legal reform (Favier et al., 2018; Joffe, 1995; McGuinness and Thomson, 2015). As a result, abortion care is not effectively integrated into mainstream medical services; in the United States, for example, abortion services are siloed in reproductive health clinics and provision remains stigmatized (Freedman, 2010). Ireland was able to avoid some of these pitfalls because experienced pro-choice advocates were involved in designing the service from the start. In fact, several interviewees credited DfC with the model of abortion care that Ireland has adopted, wherein early medical abortion is provided primarily by general practitioners in community settings. DfC began publicly advocating for this design as early as 2013 (Favier, 2013) and was founded on the principle that abortion should be integrated into mainstream medical care as one essential service within a model of comprehensive reproductive healthcare.

Limitations

As a case study of a single organization, this article is necessarily limited in the perspectives it offers. DfC committee members are not representative of Irish doctors in general, nor are physicians the only health service workers who were impacted by the Eighth Amendment or participated in the Together for Yes campaign. In an effort to identify the organizational dynamics of DfC and its role in the broader context of Irish abortion politics, important elements of the relationship between abortion provision and personal ethics were not addressed, such as conscientious objection. In this article's discussion of patient-centered medicine, the patient perspective is notably absent. This article should be read alongside scholarship highlighting the experiences of people who obtained abortions under the Eighth Amendment (Broussard 2020).

Conclusion

In the presence of considerable obstacles, including abortion provider stigma and structural barriers to physician engagement in abortion politics, DfC committee members successfully established a strong pro-choice "medical voice" in Irish abortion politics. For DfC committee members, that voice was based on a shared commitment to the value of medical expertise and an understanding of patient autonomy as a pillar of medical ethics. DfC entered the mainstream as part of a broad coalition to repeal the Eighth Amendment. By that

point, DfC had established a clearly defined collective identity as the voice of pro-choice, pro-provision Irish physicians. It is impossible to know how many minds DfC changed during these years of political action. But notwithstanding their powers of persuasion, DfC's most critical intervention was their ability to provide a coherent discursive framework to physicians who decided to enter the political fray.

As members of a broad coalition, DfC's specific advocacy goals were reoriented around the needs of TfY, and DfC was joined by a cadre of physicians who were willing to tread on safe political terrain by criticizing the Eighth Amendment, but did not connect its harms to DfC's expansive, pro-choice political vision. Commentators have pointed out that the campaign's focus on healthcare—and its corresponding emphasis on physician voices—overshadowed rights-based arguments for abortion reform (Taylor et al., 2019). DfC inevitably reinforced a medical framework through its messaging, but it worked to change the terms of that framework: even during the TfY campaign, DfC committee members actively sought to distance themselves from a legacy of physician control by framing healthcare messages in terms of patient autonomy.

The repercussions of political compromises made during and after the campaign are unfolding in real time. The possibilities for patient-centered care of the kind DfC advocated throughout the campaign are constrained in practice. Irish law still positions physicians as gatekeepers: for instance, they must certify that a patient's gestational age is within the legal limit of 12 weeks for elective procedures (Taylor et al., 2019). Legal abortion in Ireland requires a three-day waiting period and retains harsh sanctions on abortion provision outside of the law's confines. Pro-choice activists have identified these and many other ways that legal and medical practice are falling short of the ideal of free, safe, and legal abortion care in Ireland (Grimes and Abortion Rights Campaign, 2021). Righting these wrongs will require continued advocacy from pro-choice physicians willing to use their inherited positions of cultural authority to push the boundaries of abortion access instead of setting them.

By examining pro-choice physician advocacy in practice, this article adds a new dimension to the rich social science literature on physicians and reproductive politics. Future scholarship should consider how pro-choice physician advocacy has been operationalized across diverse historical, political, and geographic settings. Despite its narrow focus, this case study has broad implications in a global context where reproductive autonomy remains a field of fierce political contest. DfC's example demonstrates that pro-choice physician advocates can work alongside feminist stakeholders to destabilize the seemingly static conservative politics of organized medicine. Further, this article identifies barriers to physician advocacy that extend far beyond the Irish context, including abortion provider stigma, divisions between medical specializations, and health system austerity. These findings are of critical importance to pro-choice health professionals who are, or one day hope to be, involved in the provision of safe and equitable abortion care.

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