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(Ceannteidil an Bhille)

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Joint Committee on Health and Children

Report on

Protection of Life during Pregnancy Bill 2013
(Heads of)

Volume 1

May 2013

31/HHCN/012

Foreword by the Chairman of the Joint Committee on Health and Children, Jerry Buttimer TD.

At the request of Government **the Joint Committee convened a series of public hearings to discuss the Protection of Life during Pregnancy (Heads of) Bill 2013. These hearings were conducted over three days on the 17th, 20th and 21st May 2013.**

The purpose of this pre-legislative consultative process was to facilitate further consideration in advance of drafting the Bill which will be presented to the Oireachtas.

In carrying out this task the Joint Committee decided to concentrate on the legal and medical issues which arise from the Heads of Bill. In doing this we have been greatly assisted by many experts who have voluntarily given of their time so that they could share their knowledge, experience and views.
The expert witnesses highlighted many issues and made valuable contributions which were of significant benefit to the Joint Committee. Some of the issues highlighted need further consideration, others which require clarification but all were positive contributions in this difficult and sensitive area. In an effort to be open and inclusive the Joint Committee also invited written submissions from any interested members of the public.

This report provides an overview of the expert testimony given to the Joint Committee and it also takes into consideration the written submissions received. I hope that this report will be of valuable assistance to Government when drafting its proposed legislation.

I would also like to express my gratitude to my colleagues in both Houses of the Oireachtas, who are not Members of the Joint Committee on Health and Children, for the way they have discussed the issues and raised and shared their concerns. Their contributions have been deeply appreciated by the members of the Committee.

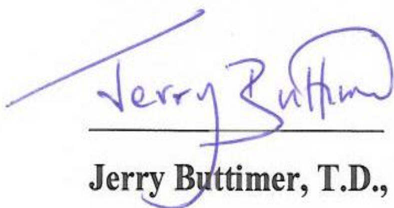
To my colleagues on the Joint Committee, I would like to express a sincere thank you. I appreciate your commitment and dedication in carrying out your duties as members of the Oireachtas. The conduct of our hearings reflects the professional approach which is consistently demonstrated at all of our Joint Committee meetings.

I would also like to record our appreciation to the Clerk of the Committee and his team, the wider staff of the Committee Secretariat; the Superintendent and Captain of the Guard and their team of

Ushers; the Editor of Debates and their staff, the Parliamentary Legal Advisors Office; all those involved in the recording and transmission of our hearings; and Mr. Michael O'Sullivan, without all of whom our hearings could not have run as smoothly as they did.

Lastly, I would like to thank Cathaoirleach of Seanad Eireann, Senator Paddy Burke, and the Leader of Seanad Eireann, Senator Maurice Cummins, for facilitating the Joint Committee by making the Chamber of Seanad Eireann available for our hearings.

I hope and I trust that our hearings and this report will provide assistance in the final drafting of the Government's proposed legislation.



Chairman,

Joint Committee on Health and Children.

30 May 2013.

Members of Joint Committee on Health and Children

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Regina Doherty TD (Fine Gael)	**Robert Dowds TD (Labour)**	**Peter Fitzpatrick TD (Fine Gael)**

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<tr><td> </td><td> </td><td> </td></tr>
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(Independent - WUAG)</td><td>Billy Kelleher TD
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Senators

Senator Colm Burke (Fine Gael)	**Senator John Crown (Independent)**	**Senator John Gilroy (Labour)**
Senator Imelda Henry (Fine Gael)	**Senator Marc MacSharry (Fianna Fáil)**	**Senator Jillian Van Turnhout (Independent)**

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Background and Purpose of the Heads of Bill

Implementation of the ABC judgment

At the opening session of the Committee's review on 19 May 2013, the **Minister for Health and Children, Dr James Reilly TD,** said that General Scheme of the Protection of Life During Pregnancy Bill 2013 was produced as a result of the Government's decision in December 2012 to legislate in relation to Article 40.3.3° as interpreted by the Supreme Court in the X Case[1] in order to implement the judgment of the European Court of Human Rights (ECtHR) in the case of A, B and C v Ireland.[2] In the latter case the ECtHR found that the State had failed to respect Ms C's right to have an accessible and effective procedure to establish whether she qualified for a lawful termination of her pregnancy in accordance with the laws of the State. The Minister commended the Heads of Bill to the Committee as providing such procedures. Heads 2, 3 and 4 set out clearly the circumstances in which termination of a pregnancy could be legally undertaken and the processes for deciding whether a woman qualified for one. Similarly, Heads 6, 7 and 8 provide an accessible, effective and timely review mechanism, as required by the ABC judgment, whereby a decision that a termination was not justified under Heads 2 or 4 could be reviewed at the request of the woman.

Elaborating on the Minister's opening statement, the **Chief Medical Officer, Dr Tony Holohan** said that the principles underlying the Heads of Bill are derived from the work of the Expert Group that had advised the Government on implementing the ABC judgment. These are intended to ensure that the Heads relate only to existing substantive rights to termination of pregnancy and did not create new ones; to uphold the right to life of the unborn; to restrict the legislation's applications to cases where termination was necessary to save the woman's life; to reflect the more subjective nature and clinical challenges of assessing suicidal intent; to uphold the principle of consent; and

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Attorney General v X, [1992] 1 IR 1.
A, B and C v Ireland, [2010] ECtHR 2032.

to provide an effective monitoring and reporting system. The scheme is designed to reflect and integrate with existing medical practices. In not prescribing specific referral pathways it acknowledges the complex and unpredictable ways in which termination under the scheme may become an issue, while still giving the clarity and definition required by the ABC judgment.

The requirement to legislate was disputed by **Mr Paul Brady BL** and **Dr Maria Cahill**. During oral presentations on legal issues on 21 May 2013 and their written submissions, they argued that the practice and precedents of the ECtHR are based on the principle of subsidiarity, leaving it up to the state party decide for itself the best and most appropriate means to remedy the breach identified by the Court. While legislation had been chosen by the Government, it was not the only option available. **Ms Caroline Simons** and **Dr Maria Cahill** argued in their presentations and submissions that, as a matter of Irish Constitutional law, there is no question of a requirement to implement in law an obligation that arose under an international convention.

Prof. William Binchy also disputed that the ABC judgment required legislation on the grounds proposed in the Heads of Bill, and said that the scheme proposed in them would not in any case satisfy it. In his oral presentation, he said that the use of legislation was a concession by the Government rather than a requirement of the Court. What the ECtHR requires is clarity in the law, and the Oireachtas has a range of options open to it. It could, for example, pass an Act enabling the Minister for Health and Children to issue regulations on safety considerations in pregnancy and guidance on best practice. There could be a non-statutory scheme implemented – with an appeal mechanism – by the Medical Council. Further, the Heads of Bill do not in fact give clarity on either the medical decisions that might be taken in cases where pregnant women's lives are threatened or the treatments that might be provided. In his oral presentation, **Mr Frank Callinan SC** disagreed, saying that an attempt to regulate abortion rights through pure medical regulation and guidelines of medical organisations had failed before the ECtHR in the case of *Tysiąc v Poland*.[3] Legislation and regulation are the appropriate means.

[3] *Tysiąc v. Poland*, ECtHR Application 5410/03, Judgment 20/02/2007

In his presentation, **Dr Peadar O'Grady** of Doctors for Choice suggested that the very limited nature of the proposed scheme and the restrictive measures governing access to it would fail to satisfy the requirement to give an effective and accessible procedure as required by the ECtHR. **Dr Seán Ó Domnhaill** said the State was required only to clarify existing law, not to write new law.

Mrs Justice Catherine McGuinness welcomed the move to legislate on the subject. She referred the Committee to the submission of the **Church of Ireland Working Group** on the Heads of Bill, of which she is a member: that submission states that the present position is unclear, unsatisfactory and unfair to pregnant women and medical professionals, and that the decision to seek to provide clarity is welcome. Summing up the Government position in the closing session, **Mr Alex White TD, Minister of State in the Department of Health**, stated the Government's view that it is the function of the Oireachtas to provide clarity of the law by means of legislation with appropriate regulations for technical aspects, a position that was supported by the **Institute of Obstetricians and Gynaecologists**.

The need to legislate for the X Case

Mr Frank Callanan SC told the Committee that the decision of the Supreme Court in the X Case is an indisputable part of the constitutional law of the State; it would remain so until that Court said otherwise or the Constitution was changed. While the Constitution does not force the Oireachtas to legislate to take account of the X Case, not doing so left "a fissure" between constitutional rights and the giving of legislative effect to them. Both the Irish Courts and the ECtHR in the ABC judgment had criticised the State for requiring the criteria for measuring eligibility for a termination to be determined on a case-by-case basis: this should not be the role of the Courts, nor was it appropriate to require women whose lives may be at risk to undertake such complex proceedings. **Mrs Justice Catherine McGuinness** agreed and said she did not think that the State could satisfy the ECtHR's judgment without legislating for the X Case. In her view the Government was "constitutionally constrained" to bring forward this legislation. The Oireachtas is not obliged to legislate, but she said it had been negligent in not doing so since the X Case judgment. Without

legislation, regulations would be unenforceable, particularly in the absence of consensus among professional bodies.

Opposing views focused on the status in Irish Constitutional law of the decision of the Supreme Court in the X Case. **Ms Sunniva McDonagh SC, Dr Maria Cahill** and **Mr Paul Brady BL** all emphasised that Counsel for the Attorney General in the X Case had chosen to concede – rather than argue and have determined by the Supreme Court – two issues. Those concessions were (a) that the intentional killing of an unborn child might be lawful in certain circumstances and (b) that, in certain circumstances, intentionally killing the unborn child might be the only way to avert the death of the pregnant woman from suicide and so might be lawful under Article 40.3.3°. It is a maxim of the doctrine of precedent, enunciated by Chief Justice Ó Dálaigh in *The State (Quinn and Ryan*[4] and subsequently affirmed by the Supreme Court in *Maguire v Ardagh*[5] that 'a point not argued is a point not decided'. The points conceded therefore did not establish a constitutional precedent and there is no compulsion – whether legal or moral – on the Oireachtas, or indeed a Court, to follow or apply them. Mr Brady pointed out in his written submission that Mr Justice Brian Walsh, in an extra-judicial speech in 1992,[6] had said that the claim that Article 40.3.3° allowed for direct termination of the life of the unborn had never been fully argued. He quoted Mr Justice Walsh concerning that claim:

> "In the X Case it was conceded. There was no *legitimus contradictor* to argue against such a construction and therefore the Court's decision can only bind the particular case as it was based on a conceded and unargued construction."

Prof. William Binchy told the Committee that the Supreme Court had stated in the case of *Best v Wellcome*[7] that, in matters involving scientific evidence, the Courts do not give definitive scientific judgments. Instead, they only adjudicate on the evidence as it is presented to them. It was the clearly stated view of psychiatrists that there was no evidence to show that termination of pregnancy was a treatment for suicidality. It is therefore open to the Oireachtas to proceed on the

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4 *The State (Quinn) v Ryan,* [1965] I.R. 70 at 120.
5 *Maguire v Ardagh,* [2002] 1 I.R. 385.
6 *"Justice and the Constitution"*, speech at University College Galway, 11 November 1992.
7 *Best v Wellcome Foundation Ltd*, [1996] 3 I.R. 378.

reasonable assumption that the Supreme Court would recognise that scientific evidence unavailable to it in 1992 would lead it to a different conclusion. Regardless of that, the decision in the X Case is incompatible with human rights and sound medicine and science. It is open to the Oireachtas to avoid legislating for it, and the Oireachtas would be right to do so.

Against these arguments, **Mr Frank Callanan SC** referred to the 1995 reference under Article 26 of the Constitution of the Bill that sought to prescribe conditions concerning provision of information on abortion services in other states.[8] In that case, Counsel for the unborn had specifically referred to the lack of medical evidence in the X Case. Mr Callanan pointed out the extent to which the Supreme Court relied on and affirmed its decision three years previously in the X Case. This and subsequent reliance on it established beyond question the status of the X Case judgment as a Constitutional precedent.

Dr Maria Cahill said that, apart from the status of the X Case as a precedent, a question arose concerning the need to legislate for it as a result of the ECtHR's judgment in the ABC case. The State's obligation is to prevent a recurrence of the breach that gave rise to the violation that was identified in the judgment. The issues in Ms C's case did not involve a threat of suicide. Giving effect to the judgement therefore requires action to address only her particular circumstances, not cases of threatened self-destruction.

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8 *In Re Article 26 of the Constitution and the Regulation of Information (Services outside the State for the Termination of Pregnancies) Bill 1995*, [1995] 1 I.R. 1.

Head 1: Interpretation

Terms Defined in Head 1

Appropriate location

The **Minister for Health and Children, Dr James Reilly TD** said that it was the intention that only public obstetric units perform terminations. This stems from the State's constitutional duties, the need to ensure the availability of obstetric and mental health services, appropriate specialists, and to allow for monitoring and investigation where required. However, medical contributors expressed concern about this restriction. **Prof. Fionnuala McAuliffe** of the Institute of Obstetricians and Gynaecologists proposed that this term be extended to cover all government-approved hospitals including the 19 maternity units. Pregnant women with serious illnesses are frequently treated in general hospitals because maternity units that are not co-located may not have appropriate specialists or facilities on site. In particular, the three main maternity units in Dublin do not at present have adult intensive care or coronary care units. This view was endorsed by contributors including **Dr Sam Coulter-Smith** of the Rotunda Maternity Hospital, **Drs Rhona Mahony** and **Peter Boylan** of the National Maternity Hospital, and **Prof. John Crowe**, President, Royal College of Physicians of Ireland.

Dr Sam Coulter-Smith pointed out that emergencies can also occur in private maternity hospitals, such as Mount Carmel Hospital in Dublin. In those cases a transfer might further imperil the patient's life. The definition should take account of the need for procedures under the Bill to take place in such cases without transferring the patient to an HSE hospital. Concerning the possible application of the Bill to clinics run by private organisations such as family-planning groups, **Dr Rhona Mahony** pointed out in her oral presentation that the focus of the proposals was on cases where the life of the pregnant woman was at risk. She thought it unlikely that women in such a position would be anywhere other than in a hospital. **Dr Peter Boylan** said that it seemed unlikely that any such clinic would be licenced to perform terminations of pregnancy under any

circumstances, though **Ms Sunniva McDonagh SC** observed that there is nothing in the Heads to prevent it. **Ms Orla Sheehan** proposed in her submission that emergency procedures covered by Head 3 be restricted to 'appropriate locations': she maintained that Head 3 would be open to abuse by abortion clinics otherwise.

In its submission, the **Institute of Obstetricians and Gynaecologists** also proposed that where a need for neonatal facilities may be anticipated, the location for any procedure under the legislation should take that into account. This was also proposed by **Ms Orla Sheehan** in her submission.

Obstetrician/gynaecologist

Prof. Fionnuala McAuliffe of the Institute of Obstetricians and Gynaecologists proposed that the definition be expanded to cover cases where an obstetrician who is registered only on the general Medical Register is acting in the role of a consultant (who would be on the Specialist Register). These situations occur commonly, such as over weekends. Requiring a fully registered consultant to intervene in such a case could cause harmful delays. This was endorsed by **Dr Rhona Mahony**. The term 'obstetrician/gynaecologist' could be used to cover cases where a specialist has simply chosen not to register or where a specialist registrar is covering for a registered consultant.

Psychiatrist

The **College of Psychiatry of Ireland** and **Mr John Saunders** of the Mental Health Commission suggested that this definition be expanded to encompass practitioners of all specialties of psychiatry registered under s. 43(2)(b) of the Medical Practitioners Act 2007. In his submission, **Dr Keith Holmes** pointed out the need to ensure that appropriately specialised psychiatrists are used to examine children and others who may come within the operation of the Bill.

Reasonable opinion

The **Irish Medical Organisation** and **Dr Peadar O'Grady** suggested that this term should be replaced by the term 'opinion'.

The **Institute of Obstetricians and Gynaecologists** suggested in relation to the Explanatory Note for this term that it be made clear that terminations under the Bill may be carried out only in accordance with approved HSE guidelines.

Dr John Monaghan proposed that this term be defined to mean "an opinion formed in good faith, and based on evidence that the intervention is an appropriate treatment for the medical condition in question and which has regard to the obligation to preserve the life of the child as far as practicable". Equivalent views were expressed by the **Pro-Life Campaign** (which stressed the use of the term 'obligation' instead of 'need'), **Ireland Stand Up**, **Doctors for Life**, **Dr Rachel Doyle**, and many other written submissions. **Prof. Veronica O'Keane** of Trinity College Dublin suggested in her written submission that this definition also refer to the risk to the life of the woman. Several written submissions from the public, including those from **Ms Martina Kealy** and **Mr Tarlach O'Donnachadha**, proposed that the interests of the father of the unborn should also be taken into account.

Prof. Joan Lalor of Trinity College, Dublin proposed that consideration of the right of the unborn should take account of its viability. She also submitted that the legal status of the unborn should not be such as to require a woman to undergo a procedure such as a caesarian section against her wishes.

In his submission, **Dr Simon Mills BL** suggested that it be made clear that it "is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate". While Heads 2 and 4 employ the 'real and substantial risk to life' test applied by the Supreme Court in the X Case, it might be useful to expressly set out this related aspect of it. He said the definition should also mention the right to life of the mother.

Dr Ciaran Craven BL told the Committee that the use in this definition of the term 'in good faith' was contrary to best medical, ethical and legal practice. The Medical Council and other supervisory bodies require the application of objective, evidence-based standards of conduct rather than subjective individual ones: a failure to require these undermined the relationship of trust that was required between medical practitioners and the public. The Courts also recognise the importance

of professional guidelines – which are increasingly driven by the requirement for objective justification – as a standard for assessing the duty of care owed by practitioners to their patients. Doctors owed their patients an affirmative duty to practice to objectively justifiable standards and to uphold their patients' Constitutional rights. Subjective standards could not suffice, particularly given the near impossibility of proving bad faith. Without using evidence-based standards, it would be impossible to fulfil the ethical requirement of 'primum non nocere' – that is, 'first, do no harm'.

Unborn

The **Irish Medical Organisation** and **Dr Peadar O'Grady** suggested that this term should be replaced by the medical term 'foetus'. **Dr Veronica O'Keane** of TCD suggested that the definition be altered to reflect viability, with 'foetal viability' being used as the appropriate "line of demarcation". She said this would allow for foetal life to be saved at an earlier stage of pregnancy as advances in obstetric and neonatal care emerge.

Dr Gerald Burke of the Mid-West Regional Maternity Hospital, Limerick told the Committee that, in approximately 1 in 2,500 cases, ectopic pregnancies occur within the uterus, for example in the cervix or in scars from earlier caesarian sections. These situations could pose extreme risks to the life of the mother. If the intention was to exclude the treatment of ectopic pregnancies from the scope of the legislation, account must be taken of this in the definition of the term 'unborn'.

Prof. William Binchy and **Paul Brady BL** said that the use of the words "until such time as it has completely proceeded in a living state from the body of the woman" meant that a child remained "unborn" until it had so proceeded. This left open the possibility of late or partial-birth abortions under the Bill.

The **Pro-Life Campaign** said that the definition of 'unborn' by reference to implantation could have unintended consequences if applied outside the intended remit of the Bill. It therefore proposed that the definition be qualified by the words "for the purposes of this Bill/Act, and for those purposes only".

Dr Ruth Fletcher of Keele University suggested that the moral duty to protect the unborn from implantation rests on its potential to develop to develop to personhood. This would not be the case where abnormalities were such as to remove any possibility of the unborn surviving outside the womb. The State itself had argued in D. v Ireland[9] that in such cases the right to life of the unborn under Article 40.3.3° might not be engaged. Accordingly, a pregnancy that was incapable of leading to independent life outside the womb due to foetal abnormalities need not be subject to the protections afforded by the Heads of Bill. This view was endorsed by contributors including **Ms Deirdre Conroy**, the **National Women's Council of Ireland**, **Dr Catherine Bates**, **Ms Marie-Louise O'Donnell,** the **Irish Council for Civil Liberties** (which suggested that this change wold be required to comply with the European Convention on Human Rights), **Galway Pro-Choice** and **Terminations for Medical Reasons** (TMFR), which proposed that the definition use the words "viable and compatible with life". However, in its submission **One Day More** expressed concern about misdiagnoses or inaccurate prognoses leading to the abortion of babies who might otherwise have lived. They argued that the availability of abortions will increase pressure on parents of unborn children diagnosed with fatal foetal abnormalities to terminate pregnancies.

Dr Ruth Fletcher also suggested that moral status was an attribute of sentience. Before attaining sentience, the unborn could be said to have potential rather than actual personhood, and to have moral value rather than moral status. She said the definition of 'unborn' should therefore extend only from the earliest moment at which sentience is possible. **Dr Ciaran Craven** described Dr Fletcher's analysis as "quite a novel proposition". He cautioned that lethal abnormalities are not necessarily wholly inconsistent with life: while that life may not be prolonged, it could last as long as months. The "unborn" in Article 40.3.3° should properly be understood as "the unborn child" – it was not an abstract noun.

9

D. v Ireland, [2006] ECHR Appl. No. 26499/02

A number of submissions, including those from the **Christian Medical Fellowship, Ms Eileen O'Connor** (Pro-Life Group, Killarney) and **Ireland Stand Up** said that conception, rather than implantation, was the appropriate time from which the term 'unborn' should apply.

Ms Orla Sheehan suggested that the term 'unborn' be replaced by 'unborn baby' or 'baby in the womb'.

Terms Not Defined in Head 1

Abortion

Dr Sam Coulter-Smith of the Rotunda Maternity Hospital welcomed the fact that the term 'abortion' was not used in the Heads of Bill. He said it is important that women who have a pregnancy terminated in any circumstances not be stigmatised in any way.

Appropriate qualifications and experience

The **Mental Health Commission** suggests that the use of this term in sub-head 6(4) may need clarification. It suggests that Regulations made under the Mental Health Act, specifically SI 55/2006, may provide guidance.

Child

In its written submission, the **College of Psychiatrists of Ireland** stressed the importance of including a definition of this term in the Bill rather that including all females regardless of age as was done in the definition of the term 'woman' for the purposes of the Bill. It points out the different ages of consent and capacity provided for in the Children Act, 2001, Mental Health Act, 2001 and the Non-Fatal Offences Against the Person Act, 1997.

Examination

Dr Simon Mills BL noted that this term is used without definition in Heads 2 and 4. As some forms of clinical review or assessment that may be required (such as blood tests) may not require a doctor to be in the physical presence of the patient, it may be appropriate to use another term or

give it a definition for the purposes of those Heads. The **Mental Health Commission** suggests that the definition used in Part 2 of the Mental Health Act, 2001 may be useful.

Immediate risk

Dr Simon Mills BL queried whether a threat of self-destruction could constitute a situation that came within the emergency treatment provisions of Head 3. **The Life Institute** suggested that the situations in which Head 3 were to apply needed to be clarified, saying that they could be open to abuse. The **Irish Council for Civil Liberties** proposed that the Bill expressly provide that Head 3 should apply to cases where the risk arises from suicidal intent.

Medical procedure

The **Pro-Life Campaign** suggested that this term, which is central to Heads 2, 3 and 4, should be defined to exclude any action or procedure that kills the unborn. **Dr John Monaghan** also proposed that the Bill include an express prohibition on such actions.

Patient

Mr Tony O'Connor SC said in his oral presentation that this term may need a definition. This is to accommodate cases where some other person may have an interest in the pregnant woman's decision, such as where surrogacy may be involved.

Self-destruction

The **Mental Health Commission** proposed that this term be defined and its relationship to 'suicidal intent' be clarified.

Suicide

In its written submission, the Institute of Obstetricians and Gynaecologists proposed the use of this term instead of 'self-destruction'.

Termination

The **Institute of Obstetricians and Gynaecologists** proposed adding a definition of this term. It should be applied to procedures whereby the pregnancy is ended before a foetus is viable.

Termination of pregnancy

Ms Caroline Simons noted that, while this term is used in Head 12, Head 1 refers to "a medical procedure that will end unborn human life", Heads 2, 3 and 4 refer to "medical procedures ... in the course of which or as a result of which unborn human life is ended ". The terms do not mean the same thing and the inconsistency could have profound effects on rights of conscientious objection under Head 12.

Head 2: Risk of loss of life from physical illness, not being a risk of self-destruction

Head 3: Risk of loss of life from physical illness in an emergency situation

General Observations

Observations and suggestions concerning Heads 2 and 3 generally applied to both Heads. They are considered together here except where a distinction is expressly made.

Protection and clarity

Obstetric and medical specialists who addressed the Committee generally welcomed the overall purpose and effect of these Heads. **Dr Sam Coulter Smith** reflected the views of many other contributors in saying that Heads 2 and 3 were necessary to give protection to medical personnel, that they would provide clarity and appropriate protection to those who care for pregnant women, and give reassurance to women and their families. Interventions to save mothers' lives should never be stigmatised by the use of the term 'abortion'. **Dr Gerard Burke** described the provisions as reflecting common sense and reflecting the manner in which obstetricians currently practise; to that extent, they would make little if any change to the way patients are treated. What was significant was the protection they afforded to medical personnel because, he said, an ambiguity currently existed and obstetricians feel vulnerable when dealing with marginal cases. **Dr Máire Milner** of Our Lady of Lourdes Hospital, Drogheda echoed this, saying that these provisions "will afford me a degree of protection and comfort and will give rise to an improved situation for our patients".

Nevertheless, **Dr John Monaghan** of Portiuncula Hospital, Ballinasloe queried whether Head 2 would give the degree of clarity required by the ECtHR in the case of Ms C, pointing out that the degree of risk to her life had not been medically assessed. He said that advances in cancer treatment meant that many conditions treated with abortion can now be dealt with without ending

the life of the unborn child, and referred to papers annexed to his written submission. He proposed that a national specialised unit to manage cancer in pregnancy be established, perhaps at an existing centre of excellence. He suggested that this, rather than legislation, would serve the objective of giving clarity to the treatment of potentially life-threatening cancers in pregnant women.

The need for statutory provision under these heads was questioned in a large number of written submissions sent to the Committee, including those from **Prof. William Binchy** and **Youth Defence**.

Oncology and cardiology

Dr Janice Walshe, a consultant medical oncologist, said that chemotherapy tended not to adversely affect foetuses, particularly after the first trimester. While data on the subject were scarce, cases in which a termination of pregnancy might be required to save the life of a pregnant cancer patient are exceedingly rare. The goal when treating pregnant women with cancer is always to attain foetal maturity rather than simply viability. She welcomed the scheme proposed, saying that legislation is definitely required in this area.

Dr Kevin Walsh, a consultant cardiologist who manages patients through pregnancy, said that advances in treatment meant that women who might previously have avoided pregnancy or died during it now had much better prospects of delivering. One study suggested that among women with congenital heart disease, the elective termination rate was 5%, but Dr Walsh's UK colleagues reported much lower rates. Terminations occurred either early in the pregnancy or late in it to save the mother's life. He said that he had personal experience two patients in the last few years "who were obliged to travel for terminations". He agreed that, while little would change in his practice, legislation was required.

Gestational limits

Dr Sam Coulter-Smith told the Committee that it was important that gestational limits for the application of Heads 2 and 3 were not set in legislation, as doing so might constrain doctors from taking steps that could save both lives. **Dr Rhona Mahony** agreed, pointing out that advances in

care meant premature babies born at increasingly early dates were surviving. She added in her written submission that where a life-threatening situation arises before there is any prospect of survival outside the uterus as a consequence of prematurity, a question of balancing the rights of the mother and the foetus does not arise. The issue is prevention of the mother's death because if she dies, her baby does too. **Dr John Monaghan** said that it was not uncommon for there to be uncertainty about dates: prescribing term limits might prejudice foetuses that were of greater gestational age than believed. For that reason, the Bill should contain an express prohibition on killing the foetus in the womb.

Obstetricians expressed extreme scepticism that that Heads 2 or 3 could or would permit late-term abortions of viable babies: **Dr Peter Boylan** said that such views are "extremist, have no basis in fact and are, quite frankly, insulting". Medical contributors stressed the importance of vindicating the life of the unborn as provided for in Article 40.3.3° of the Constitution as well as in the ethics and guidelines of the responsible medical bodies. **Prof. Fionnuala McAuliffe** stressed that in any case where there is a possibility of delivering a baby alive or prolonging a pregnancy to viability, every effort must be made, and is made, to do so. Where a prematurely born baby lived, it would receive all appropriate neonatal care. This was current medical practice and these Heads would not make any practical change. **Dr John Monaghan** proposed that the Bill contain a specific prohibition on killing a foetus in the womb as a means of avoiding these difficulties and vindicating the unborn child's right to life.

Resources

On the question of resources, there was a widely expressed view that obstetric are greatly under-resourced in Ireland compared to other advanced states. In this regard, the **Medical Council** expressed concern about the ability of women throughout the country to access services to be provided under Heads 2 and 4. The Committee heard that situations that would fall to be dealt with under Heads 2 or 3 were extremely rare: **Dr Gerald Burke** said that while it could be expected that there might be approximately 100 maternal deaths over the coming decade, only 1 to 3 of these cases were likely to be within the scope of these Heads. **Dr Mary McCaffrey** of Kerry General

Hospital, Tralee and **Dr Keelin O'Donoghue** of Cork University Maternity Hospital said that doctors who might be required to treat women whose lives are at risk and may be called upon to terminate pregnancies under the Bill would require training, clinical guidelines and care plans to ensure safe practices, a view that was echoed by the **Irish Medical Organisation** in its written submission, adding that appropriate physical and psychological follow-on care must also be assured. The **Institute of Obstetricians and Gynaecologists** also noted in its submission that referral pathways for terminations of pregnancies will need to be delineated through the development of HSE guidelines. The **National Women's Council of Ireland** said there was need to develop referral protocols and to ensure women have appropriate support and treatment after terminations.

Dr Mary McCaffrey suggested that a panel of experts in the major hospital might be set up to provide advice to obstetricians in smaller units who might faced with difficult emergency situations at night or over weekends when advice cannot be obtained locally.

Mr Brendan O'Connor proposed that doctors who refuse to carry out medical procedures under Heads 2 or 3 should be given immunity of an indemnity against civil liability for that refusal. He said that the availability of procedures under these Heads will create a bias in favour of terminations.

Choice Ireland submitted that compliance with the ABC judgment required guaranteed speedy access to all services.

Contributors' proposals

Merger of Heads 2 and 4

A number of contributors suggested that Heads 2 and 4 should be merged. The arguments concerning that proposal are outlined in the section of this report dealing with Head 4.

Capacity

Many contributors expressed concern as to the capacity of patients who may be affected by Heads 2, 3 and 4 or the review procedures in Heads 6 to 9. The views of contributors and their arguments are outlined in the section of this report dealing with the issue of capacity.

"Real and substantive risk"

Dr Gerald Burke said it was best not to be prescriptive as to clinical circumstances giving rise to 'a real and substantive risk'. These would have to be judged by the medical personnel involved in accordance with all the circumstances of the case and in light of best practice, which is subject to change as developments take place. He suggested that the Bill expressly state that this is not a question of percentages and is a matter for medical experts. Similarly, **Prof. John Crowe** of the Royal College of Physicians of Ireland said that best clinical practice is always evolving. It was important that legislation not seek to define treatment pathways that are more appropriately and safely dealt with through professional judgement.

Action on X submitted that the 'real and substantial risk' test should be qualified by the term "as a matter of probability".

Sub-heads 2(1) and 2(2)

The **Medical Council** proposed drafting changes to these sub-heads to ensure that specialists are registered on the Specialist Division of the register of medical practitioners under s. 43(2)(b) of the Medical Practitioners Act, 2007 under a relevant specialty, and so have completed specialist training recognised in Ireland. The proposed changes would render sub-head (2) redundant. It further proposed that it should not be necessary for one of the two specialists making a decision to be an obstetrician. Where neither of the deciding specialists is an obstetrician, at least one of them should then be required to consult with an obstetrician employed at the appropriate location. The **Irish Council for Civil Liberties** said that only two doctors should be required to certify under these Heads, of whom one should be an obstetrician. **Action on X** submitted that a single doctor should be sufficient.

Prof. John Crowe of the Royal College of Physicians of Ireland said that, where neither deciding specialist is an obstetrician, he or she should consult a colleague in his or her specialty for a second opinion and, where practicable, with a multi-disciplinary team. The **Institute of Obstetricians and Gynaecologists** suggested that, in a non-emergency situation, an obstetrician

faced with a potentially life-threatening situation should consult with a second obstetrician before consulting a specialist in another area. **Prof. John Crowe** said that, where possible, other specialists also should seek a second opinion and consider the issue within a multidisciplinary team. **Ms Eileen Lawrence** of the Irish Nurses and Midwives' Association said that the senior staff nurse should also be involved as part of a multi-disciplinary team.

Mt Brendan O'Connor suggested that there be an express provision in Heads 2 and 3 that procedures under these heads should be options of last resort.

The concerns of **Dr Ciaran Craven BL** relating to the term 'good faith' have been outlined in relation to the definition of 'reasonable opinion' under Head 1.

Head 2(3)

The **Irish College of General Practitioners** expressed concerns about the provision for consultation with the patient's GP. In particular, the GP might not be aware that the patient is pregnant, and the patient's confidentiality must be preserved. Further, it would be necessary for the GP to see the patient. The **National Women's Council of Ireland** submitted that requiring consultation with the woman's GP in this Head and Head 4 was not essential. Consultation should not occur without the woman's consent.

Head 2(4)

Dr Mary McCaffrey suggested that it would be likely that procedures under this sub-head would be carried out in tertiary centres, though circumstances may require them to be done in smaller ones. **Dr Sam Coulter-Smith** said it was important that the Bill should not prescribe particular techniques. The method of bringing a pregnancy to an end is based on a large number of factors, and the method that is safest for the mother will be chosen. **Dr Máire Milner** told the Committee that in early pregnancy the procedure would commonly involve chemical means, with surgical intervention only if required. After 12 weeks, medically induced labour may be the only way. **Dr John Monaghan** said that techniques such as vacuum extraction or lethal injection were not used

in Ireland. The **Institute of Obstetricians and Gynaecologists** said that the Bill should provide that procedures must always be undertaken in accordance with HSE guidelines.

Head 2(4)

The **Medical Council** said that the opinions of all registered medical practitioners certifying a procedure that will end unborn human life must be recorded in writing.

Head 2(5)

In its submission, **Amnesty International** said that the duty of medical personnel is to provide the highest standard of medical and mental health care, but the decision as to what constitutes the best care for her life and health is ultimately that of the woman or (in the case of a minor) her guardians.

Head 3(1)

Prof. John Crowe said that the provisions of Head 3 were appropriate for emergency situations where second opinions or consultation with colleagues may not be practicable.

The **Medical Council** proposed that sub-head 3(1)(a) refer to "a registered medical practitioner". Sub-head 3(1)(b) should, for the sake of consistency with phrasing used elsewhere, refer to "an immediate real and substantial risk". This Head should also require the registered medical practitioner to consult with another registered medical practitioner if practicable to do so.

The **Institute of Obstetricians and Gynaecologists, Dr Keelin O'Donoghue** and **Dr Sam Coulter-Smith** submitted it would be desirable for an obstetrician in an emergency situation to consult another, as well as any other relevant specialist (such as a microbiologist, haematologist or anaesthetist), if the circumstances permit.

Ms Loretto Browne RGN proposed that procedures under Head 3 should be carried out only by a suitably qualified obstetrician, and not by a junior doctor.

Mr Ken Igoe submitted that every procedure under Head 3 should be subject to review. A doctors who was shown to have failed to protect both the woman and the unborn to requisite standard should be subject to disciplinary measures.

Head 4: Risk of loss of life from self-destruction

Capacity

Many of the experts who contributed to the Committee's review expressed concerns about the capacity of patients who might fall to be dealt with under Head 4. An outline of their concerns and opinions is give separately in the section of this report dealing with capacity.

Views of psychiatrists

Assessing suicidality

Dr Anthony McCarthy President of the College of Psychiatrists of Ireland, said that suicide in pregnancy is a real risk. Too much had been made of a UK study which suggested that predictions of suicide by psychiatrists were accurate in only 3% of cases. Psychiatrists had to rely on clinical evidence, not just statistical evidence. The role of the psychiatrist is not to predict but to assess the patient's mental state, mental health and risk of killing herself. While there are uncertainties, there are well-understood clinical markers and symptoms that can be and are regularly used.

Prof. Veronica O'Keane of Trinity College, Dublin, explained that suicidal ideation is measured using parameters of risk such as sudden onset of suicidal ideation, previous attempts, family history and whether the patient had made plans to kill herself. **Dr Anne Jeffers** of the College of Psychiatrists of Ireland explained that the focus of assessment is not to predict the risk of suicide but to manage that risk in the context of ongoing care and to find a way to keep the patient safe. Similarly, **Dr Joanne Fenton** said that the role of the psychiatrist is not simply to perform what she termed a "box-ticking" exercise: every woman or girl who presented with suicidal ideation must be properly treated to the best of the psychiatrist's ability. Psychiatrists do not predict the future, but they do assess probabilities and provide the best available care. **Dr Eamon Moloney** of University College Hospital, Cork, told the Committee that self-harm in young women is a strong indicator of risk. He said that exact calculation of the risk posed by suicidal ideation in pregnancy is impossible because of its rarity and the inability to determine the number who had been saved by appropriate

assistance and interventions. It would be neither practicable nor ethical to conduct a statistically reliable trial on this group. The UK study concerning prediction to could not be applied to Ireland because of the ready availability of abortion in Great Britain.

Dr John Sheehan, a perinatal psychiatrists attached to the Rotunda Maternity Hospital, said that assessment is not prediction. UK studies on suicide among pregnant women suggested that the risk was between 1 and 2 for every 500,000 pregnancies, and that these cases were likely to to have serious mental illnesses. While psychiatrists have useful tools such as a 'hopelessness index' to help assess risk of suicide, it is impossible for any psychiatrist to accurately predict which women will die from suicide in pregnancy. Any attempt to make such predictions must lead to a high rate of false positives. A similar statement was made by **Prof. James Lucey** of St. Patrick's University Hospital. **Dr Bernie McCabe** of Navan Hospital said that psychiatrists are competent at assessing intent and risk factors, but it is impossible to to predict when and whether intent will be acted on. In relation to women who are suicidal because of their pregnancy rather than an underlying mental illness, there is no scientific data on that group to assist in predicting suicide. The X Case test proposed in Head 4 is therefore unworkable by psychiatric means, as it requires prediction that a woman would commit suicide unless, and only unless, her pregnancy was terminated. That the test does not require the risk to be inevitable or immediate only served to remove it further from the role of proper psychiatric practice.

Termination of pregnancy and aversion of the risk of suicide

Dr Anthony McCarthy said that there is no treatment for suicide. The objective of a psychiatrist with a suicidal patient is to prevent the loss of the patient's life by looking at the causes of suicidality and, if possible, removing them. **Prof. Veronica O'Keane** described this process as "dismantling the causes of suicidality"; in some rare cases, pregnancy itself is the cause. Dr McCarthy said that patients who present with suicidality must be treated with compassion and respect and holistically, taking account of all their circumstances. Suicidal ideation can arise in patients without mental illness due to life stresses which can be very serious, such as rape. It can be difficult to distinguish distress from mental illness. Where the patient is not mentally ill, refuses

all interventions except a termination of her pregnancy, and remains suicidal, it is hard to see alternatives. The Mental Health Act, 2001 will not permit a treatment to be imposed on a patient who is not mentally unwell. **Dr Joanne Fenton** of the College of Psychiatrists in Ireland told the Committee that she had seen many pregnant women with psychiatric conditions in her practice as a perinatal psychiatrist in the Coombe Hospital, and many women who had had terminations of their pregnancies. While she had not seen a woman where termination of her pregnancy was the treatment for her mental illness, and she did not believe termination to be a treatment for mental illness, she could not say that there will never be a situation where a woman is in such a state of distress and turmoil that for her, termination of pregnancy is a life-saving option. **Dr Anne Jeffers** said that assessment itself is therapeutic in helping to relieve stresses. A psychiatrist would never counsel a patient to seek a termination of her pregnancy as a treatment, but will instead seek to avoid and advise the patient that there are always better options. Only in very rare cases could a termination of pregnancy be a realistic option for a suicidal woman. **Dr Maeve Doyle** of the College of Psychiatrists of Ireland added that the possibility of psychological harm being caused to a woman by a termination of her pregnancy would be an integral part of any assessment. **Dr Peadar O'Grady** and **Prof. Veronica O'Keane** both referred to research to propose that restricting or denying abortion services increases the risk of suicide. Dr O'Grady said that, in an Irish context, this would be likely to affect those who lack the ability to travel abroad, whether because of age, lack of capacity, disability, financial reasons or social ones such as stigma. Prof. O'Keane also noted that, as outlined in Head 4, the woman's consent is central, and it was she who applied to have the termination, and the psychiatrists who certified her eligibility for it. For that reason, it was not an issue of the psychiatrist prescribing the termination as a treatment. **Dr Peadar O'Grady** said that ideally, termination would be performed early, before viability was an issue. In the USA, only 1 termination in 1000 involved an issue of viability.

Prof. Kevin Malone of University College Dublin told the Committee that he could not say how the risk assessment 20 years ago in the X Case would relate to modern psychiatric practice. He was clear that abortion is not a treatment in any textbook of psychiatry, and no case of it being required

in Ireland for treatment of suicidality over the last 20 had been identified. He asked how it could become a recommended treatment by means of legislation. Similarly, **Prof. James Lucey** wrote that neither the work of St. Patrick's Hospital nor evidence in the literature indicated that termination of pregnancy is an effective treatment for any mental health disorder or difficulty. In her written submission, **Prof. Patricia Casey** cited a recent statement by Prof. David Fergusson of Otago University, New Zealand: based on his studies of suicide and abortion, the lack of evidence on benefits of abortion for suicidality permits at most a neutral attitude to be taken on the subject. Prof. Casey suggested that suicidal intent is almost always due to mental illness and should be treated the same way during pregnancy as in other cases. She added that no research has been performed on those who are suicidal simply due to pregnancy. **Drs John Sheehan** and **Bernie McCabe** said that in psychiatric emergencies, the approach is usually to try to avoid irrevocable decisions while the patient is distressed or has impaired capacity. Dr McCabe said Head 4 gave the impression of trying to rush the woman into a decision rather than giving time for for consideration and adjustment. **Dr Jacqueline Montwill** of Mayo Mental Health Services said that there is no situation where risk of suicide can be averted only by a termination of pregnancy. Mental illnesses and distress caused by life crises respond to treatment. The appropriate treatment for a suicidal patient is to ensure her safety, provide psychological support and counselling, and prescribe any appropriate medication. It would be unethical to impose a treatment that is not best practice; that is compounded by the ethical problem raised by the small to medium increase in risk of mental health problems – including suicidality – that can be caused by termination of pregnancy. Dr Montwill pointed out that there was no time-frame within which the patient's decision under sub-head 4(4) was to be made. She said that, as suicidal thoughts can change and disappear over time, and it was possible that they might have gone by the time the procedure was to be carried out. That might render the procedure unlawful under the terms of Head 4 as the woman's life was no longer at risk.

Dr Seán Ó Domhnail described abortion as a mediaeval solution to crisis pregnancy which has no place as a treatment in modern medicine.

Consequences of enacting Head 4

Dr Anthony McCarthy told the Committee that this Bill is about saving lives. It is essential to do everything possible to prevent the small but real possibility of suicide in pregnancy. All pregnant women should have appropriate and specialist mental health services. The proposed scheme is very restrictive and applicable only to rare circumstances, but every woman with suicidal ideation in pregnancy must be provided with expert psychological assessment. There are genuine concerns arising from ethical or religious viewpoints, questions about resource implications and clinical dilemmas, all of which must be fully dealt with. Psychiatrists don't want to be placed in a position of social policing. However, this scheme may help to improve psychiatric provision to pregnant women, reduce the numbers who currently travel abroad for terminations and encourage them to seek help at home, and ultimately to save lives. There was always a possibility of abuse of the law by a psychiatrist, but doing so put one at risk of a criminal charge as well as professional sanctions. Nobody wants their profession discredited. **Dr Joanne Fenton** said that the Bill was restrictive and that many women would continue to travel abroad. In her role as a perinatal psychiatrist she saw it as her responsibility to continue to assess pregnant women in distress and to aim to provide the best and most compassionate care to them. **Dr Maeve Doyle** stressed the importance of dealing with the issue of capacity and children in the Bill, particularly as many of the cases likely to come under Head 4 would involve children in care of the HSE.

Dr Jacqueline Montwill pointed out that termination up to 38 week into pregnancy could be permitted under Head 4. She said that late-term abortions can have serious mental health outcomes for the woman. The right to life of the unborn required that early live delivery should be undertaken as the most ethical way of terminating the pregnancy. Claims that it would save lives are based on the assumption that some of the women who currently travel abroad for abortions are suicidal. There is no evidence to support this assumption. If, as had been proposed, only specialists willing to implement Head 4 were empanelled to certify and review cases, the system would be open to abuse. Head 4 was contrary to evidence based and ethical medical practice: if enacted, it profoundly damage the doctor-patient relationship.

Dr John Sheehan said that perinatal psychiatrists know of no cases where a termination had been the treatment for a mental disorder in the last 20 years but it seems likely to him that this will change if Head 4 is enacted. The new cases coming to psychiatrists are likely to be drawn from those who currently travel abroad for terminations. Their number and the extent of mental health and suicidality among them are unknown. Anything that encourages these women to seek help at home is to be welcomed. However, the test under Head 4 will change psychiatric practice from assessing and treating to assessing and adjudicating. Further, the lack of term limits in Head 4 could lead to late-term abortions, with very deleterious effects on the mental health of the women concerned.

Prof. Kevin Malone expressed concern that Head 4 that Head 4, which was based on a 20-year old risk assessment, excluded consideration of the 50% of the population comprised by males. Suicide rates among young men were considerably higher than reported rate of 2 per million among pregnant women. He said Head 4 could accelerate the already high rates of suicide among young Irish men by legitimising it for women and girls who suffer a crisis pregnancy. Overall, Head 4 could cost more lives than it saves. Prof. Malone also said that Head 4 compromises the therapeutic alliance between a psychiatrist and his or her patient by pre-selecting an outcome without proven therapeutic value. This would be contrary to the ethics of the doctor-patient relationship, as would involving any kind of fee for the certifying psychiatrist.

Dr Bernie McCabe and **Prof. Patricia Casey** said that the proposal of abortion as a treatment without an evidence base was an abuse of the psychiatric profession and psychiatrists should have no role in the process. Head 4 would bring the psychiatric profession into disrepute in a way similar to the use of mental institutions in earlier times.

Dr Seán Ó Domhnaill maintained that some psychiatrists support abortion ideologically and believe it should be available on demand in Ireland. He said it "stretches the boundaries of credibility" to suggest that these would not be more likely to approve of abortions under Head 4. The experience of mental health and suicide grounds for abortion in other countries supports this.

He said abortion cannot prevent suicide, but the harm it can cause can lead to it. He described the proposed scheme as being about killing babies, not saving lives.

Prof. Veronica O'Keane said that this Bill did not add any new rights. She told the Committee that 'floodgates' arguments are premised on "deeply problematic assumptions" about the credibility of women, the reliability of psychiatry, the nature and effect of suicidal ideation, and the idea that doctors and legislators have the power to control women's reproductive autonomy.

Contributors' Proposals

The requirement in sub-head 4(1)(b) that one certifying psychiatrist be employed at a centre registered by the Mental Health Commission, and that the other be attached to an institution where the termination was to be carried out, was criticised by **Dr Anthony McCarthy**, **Dr Yolande Ferguson**, **Dr Peadar O'Grady** and **Dr Eamon Moloney.** There are only three perinatal psychiatrists in the country whose combined work roster amounts to less than one full-time position. Many other obstetric units have only on-call emergency psychiatric cover. As it could be expected that GPs will be the first point of contact for many crisis pregnancies, community psychiatric services should be used as part of this process and the central role of the GP in managing the care of the woman recognised.

An alternative certification process modelled on that used in the Mental Health Act, 2001 was proposed in their submissions by **Drs Yolande Ferguson** and **Eamon Moloney**: a GP should be able to certify the mental state of the patient after confirming her pregnancy and providing counselling. A consultant psychiatrist (who need not be attached to an institution) could then examine the woman and confirm the certification if appropriate. Dr Ferguson suggested that a panel of doctors prepared to consider cases under Head 4 could be organised along the lines of those used by the Mental Health Commission so as to ensure that lack of resources or conscientious objection did not result in services not being available throughout the country.

Dr Peadar O'Grady suggested that either a GP or a consultant psychiatrist should be able to certify without the need for a second doctor.

Doctors who favoured Head 4 generally took the view that if an obstetrician was required to form part of the certification process, his or her role should be confined to obstetrical aspects of the patient's case, and the opinion of the two psychiatrists (or, as might be, the GP and psychiatrist) should not be subject to a veto.

Dr Bernie McCabe and **Prof. Patricia Casey** recommended that Head 4 be replaced by a clinical pathway for suicidal pregnant women that does not include abortion.

Views of other doctors

Dr Rhona Mahony told the Committee that she supported the inclusion of Head 4 as giving effect to the decision in the X Case and providing a way of saving lives. A woman at risk of suicide is at risk of dying and killing her baby. In almost all cases, the woman would seek treatment of their suicidal feelings but the possibility could not be excluded that a termination of pregnancy would be the only option of last resort to prevent the loss of both her and her unborn child. She accepted that there was no evidence to show that abortion was a treatment for suicidality, but said that such evidence would be impossible to obtain, as the number of cases was extremely small and it would be impossible and possibly unethical to conduct a randomised trial of such women. The fact was that a small number of women do commit suicide when pregnant. Suicidal women needed to be listened to sympathetically and believed. She trusted the views of her psychiatric colleagues: if they told her that a woman would die unless her pregnancy was terminated, she would defer to their judgement. If there was a possibility of saving the life of the unborn child, she had an ethical and legal duty to do so in the same way as in any other aspect of her practice. **Dr Peter Boylan** expressed similar views, adding that the proposals in the Heads of Bill were very restrictive by international standards. His concern was at all times to save life, not to take it. He credited psychiatrists with being able to tell when a patient was feigning suicidality.

Dr John Monaghan said it was a matter of grave concern that no evidence had been produced to show a medical benefit to a suicidal patient of terminating her pregnancy. In his oral presentation and written submission, he said that treatment should be evidence based. While assessment of a

woman's mental state was a matter for psychiatrists, an obstetrician who is aware of a lack of evidence to support a termination would be in "an impossibly conflicted situation ethically". If evidence was produced to show that such a termination was harmful or of no benefit, Head 4 should not be permitted to stand as it is. He also criticised the gloss on the X Case judgment in the Explanatory Note to the effect that the risk need not be inevitable or immediate, which he said left the procedure open to exploitation and abuse.

A similar criticism of Head 4 based on the lack of evidence for termination as a treatment for suicidality was made by **Dr Sam Coulter-Smith.** While obstetricians would defer to psychiatrists' assessment of patients' mental states, the lack of evidence for termination in cases of suicidality created "an ethical dilemma" for the obstetrician. The absence of gestational limits raised further problems. If this Head was invoked by a suicidal woman who unborn child was the delivered prematurely, the doctors involved could be liable for inducing harms to the child - such as cerebral palsy or blindness - that are attributable to the premature delivery it would not otherwise have had. It could not be predicted how many of the estimated 5000 Irish women who avail of abortion services in Britain would come within the terms of Head 4: there was a possibility that this could affect the resources of an already over-stretched obstetric service.

Prof. Fionnuala McAuliffe told the Committee that an obstetrician should be centrally involved in any decision on termination in a suicidality case. The woman may suffer from co-morbidities that might render her unsuitable for the procedure. The obstetrician should examine the patient and sign if appropriate, but should seek a second opinion from another obstetrician.

Dr Margaret O'Riordan of the Irish College of General Practitioners stressed that GPs have expertise in assessing suicidal intent and should have a clearly defined role in the decision process under this Head. She suggested that the practicality of organising appointments for a suicidal woman with three different doctors should be considered, particularly given problems of access and confidentiality. There should be a specific and well-resourced referral pathway from GPs, who will in many cases be the first person a woman with a crisis pregnancy will consult.

Dr Matthew Sadlier of the Irish Medical Organisation said that, while his organisation's policy was opposed to abortion, it was necessary to respect the law. He said the requirement for certification by three doctors would cause unnecessary delay. The certification process should be undertaken by two psychiatrists and the woman's GP: obstetricians should not be required to certify a patient's mental state. Clear clinical guidelines would be required as would additional resources to ensure no diminution of mental health services.

Dr Gerald Burke said there had been a degree of "hysteria" about cases that would be dealt with under Head 4. In his view, most doctors would not see one in their career. He doubted that there would be psychiatrists who would write "abortion tickets", and said that obstetricians would be vigilant to ensure that procedures would be medically and ethically sound.

Merger of Heads 2 and 4

A number of contributors suggested that Heads 2 and 4 should be merged so that all risks to the life of a pregnant woman, whether arising from mental or physical causes, would be dealt with under a single set of criteria and procedures. This proposal was made in the submission of the **Medical Council**, which also suggested that the review procedures in Heads 7 and 8 be amalgamated for the same reasons. The Council's written submission contains suggested amendments to the sub-heads dealing with the numbers and qualifications of the medical personnel required to certify and to review cases under the scheme proposed in the Heads of Bill.

This proposal was endorsed by, among others, the **Institute of Obstetricians and Gynaecologists**, **Dr Gerald Burke**, **Dr Eamon Moloney**, **Dr Peadar O'Grady** and **Dr Sam Coulter-Smith**, who said that the distinction in the Heads between suicidality and other causes of risk was not warranted on medical grounds. **Dr Yolande Ferguson** of Tallaght Hospital also recommended this approach, referring to the "long and sad history of psychiatry being seen as somehow outside of medicine".

In its submission, **Choice Ireland** proposes that Heads 2, 3 and 4 should all be merged and governed by single procedure.

Views of lawyers

Dr Simon Mills BL asked whether the more onerous procedures for certification under Head 4 (i.e. three doctors rather than two under Head 2) amounted to an impermissible form of discrimination. The requirement to consult with the woman's GP may raise issues of confidentiality. He further queried whether a failure to consult the woman's GP would invalidate a decision under this Head or Head 2. Lastly, Dr Mills suggested that a definition of the term 'examination' be added to avoid doubt as to procedures required to comply with this Head and Head 2.

Mr Paul Brady BL said that Head 4 creates a new and unprecedented statutory basis in Irish law for the direct and intentional termination of an unborn child's life. This was also novel in medical practice. The logical conclusion of Head 4 was that even late-term abortions may be required under it. Regardless of the intentions of doctors and legislators, if the cause of the woman's suicidal ideation was the very existence of the child (as distinct from the fact of the pregnancy), then it was hard to see how the risk could be averted under Head 4 without terminating that life, however advanced the stage of pregnancy. (**Sunniva McDonagh** SC made the same point, and questioned how this can be reconciled with the unborn's right to life. **Ms Caroline Simons** and **Dr Maria Cahill** argued that it is a necessary understanding of the X Case judgment.) Head 4 also included nothing to require that termination of a pregnancy should be a last resort or a treatment for a recognised medical condition. Mr Brady also suggested that the certification process outlined in sub-head 4(1)(b) gave effective control of the procedure to the first psychiatrist consulted, who would be in a position to decide which colleague to ask to jointly certify the case.

Ms Sunniva McDonagh SC argues that if a late-term abortion as discussed above is untenable having regard to the unborn's right to life, then it might also be possible to delay termination until a foetus has a prospect of survival outside the womb. Delaying termination until viability would be considered in any case under Head 2, and she found it hard to see why the same should not be the case with Head 4. Ms McDonagh also pointed out that sub-head 4(2)(b) provides that at least one of the doctors "should" examine the woman. This contrasts with sub-head 4(2)(a), which provides that, where practicable, one of the doctors "shall" consult the woman's GP. (Equivalent

provisions are also found in sub-head 2(3).) There is therefore no requirement to examine the woman, only an exhortation to do so. This may encourage what she termed "forum shopping" by both patients and doctors. In her oral presentation, she said that in light of the absence of evidence to support termination of pregnancy as a treatment for suicidality, she believed Head 4 was medicalising a social issue.

Prof. William Binchy made the same point as Mr Paul Brady BL concerning the possibility of Head 4 requiring the destruction of the unborn child's life rather than just the termination of the pregnancy. He pointed to the absence of time limits in Head 4. If Head 4 does not mandate the taking of a viable foetus' life, the question arises of how a child, possibly disabled by early delivery, should be cared for.

Ms Caroline Simons argued in her submission that, in the absence of evidence to support its use to treat suicidal ideation, termination of pregnancy must be regarded as an untested and experimental treatment. Using it as proposed in Head 4 breaches the usual criteria for using experimental treatments, namely that conventional treatment must have proved unsuccessful; potential patient benefit must exceed risks; and the treatment should not increase the patient's suffering.

Dr Maria Cahill referred the Committee to the decision of the High Court in Cosma v Minister for Justice.[10] In that case, the High Court had rejected the evidence presented to it in support of a claim that a threatened suicide could be averted only by overturning a deportation order against the applicant. The Court had firstly found that the applicant had no treatment plan and was not undergoing therapy; without this, the Court could not find that there was a 'real and substantial risk' to her life as required by the X Case. Secondly, the Court applied strictly the X Case test that the

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10 Cosma v Minister for Justice, [2006] IEHC 345.

risk should be such that it could be averted only by the relief sought, in that case, the quashing of the deportation order. Other options, such as treatment that might reduce her suicidal ideation, must also be considered before it could be said that the relief sought was the only way to avoid the risk. Dr Cahill said the Oireachtas should use this precedent to develop sound tests for the criteria expounded in the X Case. Further, she pointed out that Counsel for the Minister had adverted to the consequences if arguments of suicidality could be invoked to frustrate administrative decisions; in her written submission, Dr Cahill characterised this as "a floodgates argument" and noted that in this and a later case, the issue of feigned suicidality as a means of avoiding the application of the law had been flagged as a genuine concern.

Dr Cahill also questioned the treatment of a woman's right of equality under Head 4 as, despite being diagnosed as suicidal, she is offered no psychiatric treatment, whereas a woman with a life-threatening physical condition is offered treatment under Heads 2 and 3, and one with a non-life threatening mental condition is offered treatment under the Mental Health Act 2001.

Mr Frank Callanan SC disputed that the Cosma case could be seen as modifying the judgement of the Supreme Court in the X Case. Concerning Heads 2 and 4, he said in his submission that consultation with the woman's GP should in all cases be subject to her consent.

Dr Ruth Fletcher said that the 'risk to life' grounds employed in Heads 2 and 4 are too narrow. While the rights of the mother and the unborn may be equal, they are not the same. True equality requires accommodating actual differences. The interests of the mother, as a conscious, sentient being with moral views and responsibilities to to others, are different from those of a foetus. The test should have regard not only to risks to the mother's life, but also to her life interests in mental and bodily integrity.

Mrs Justice Catherine McGuinness said that the absence of time limits was due to the difficulty in qualifying Constitutional rights. However, it was important to bear in mind the X Case had not involved an advanced pregnancy, so the question of term limits had not been an issue decided by the Court. It might be possible to build them into the legislation and see how the Courts dealt with the matter.

Dr Ciaran Craven BL said that, by prescribing an outcome not mandated by evidence or bast medical practice, Head 4 was illogical and adopted an inverted approach to how laws should be formulated to comply with the Constitution and vindicate rights under it. The provision did not respect the ethical imperative of proper professional practice, the legal imperative of evidence-based practice that vindicates constitutional rights, disregarded the two-patient model that applies in every other aspect of care of pregnancy, and inverts the normal ethical and legal principles of treatment of patients.

Other submissions

The provisions of Head 4 were the focus of the great majority of submissions received from members of the public, advocacy groups and other organisations in response to the Committee's invitation. Among these, most criticised the provisions of Head 4 and disputed the need to include it in the Bill. Most also cited statements by psychiatrists at the Committee's public hearings in January 2013 concerning the lack of evidence to support the use of termination of pregnancy when dealing with suicidality, suggested that it could never be best medical practice when doing so, and said that Head 4 should be dropped. Other arguments against Head 4 commonly made in these submissions were based on concerns regarding:

- psychological harm being caused to women who have abortions;
- the potential for abuse of the terms of Head 4 by pregnant women, doctors or certain organisations;
- social effects of condoning or 'normalising' abortion;
- religious or moral objections;
- the absence of term limits or an express requirement to deliver a viable foetus alive;
- increases in abortion rates in jurisdictions such as Great Britain, California and Spain following removal or reduction of restrictions on the availability of abortion, and claims of abuse of the laws by doctors in those jurisdictions.

Submissions from members of the public that made these arguments are too numerous to detail in this report. Organisations and advocacy groups that criticised Head 4 on some or all these grounds included the **Christian Medical Fellowship**, **the Iona Institute**, **Ireland Stand Up**, the **Life**

Institute, the **Pro-Life Campaign**, **Pro-Life Group Killarney**, **Women Hurt** and **Waterford Concerned Citizens.**

A minority of submissions were from individuals and organisations who favoured the retention of Head 4 but suggested changes to it on various grounds. Several maintained that the criteria in the Heads of Bill provided too limited a basis for performing a termination on grounds permitted under the X Case judgment: these included **Global Doctors for Choice** and **Amnesty International**, which argued that the Bill should recognise that suicidality is caused by a perception of limited choices, and the decision as to what care is appropriate should be the woman's, not her doctor's. Dealing with specific aspects of Head 4, the **Irish Council for Civil Liberties**, the **Association for Improvement of Maternity Services in Ireland**, **Action on X**, **Pro-Choice Ireland** and **Galway Pro-Choice** all proposed reductions in the number of doctors required to certify eligibility. Similarly to its submission concerning Head 2, **Action on X** said that examination of the woman by all the certifying doctors should be an option, not a requirement.

Capacity

The **Medical Council's** submission noted the absence of provisions in the Heads of Bill to deal with cases where a woman's capacity is impaired. It asks how decisions on treatment will be made and how a woman with impaired or limited will be supported and enabled to participate in them.

The **Irish Medical Organisation** said in its submission that it is essential to deal with questions of capacity concerning consent to treatment and the exercise of the various rights and choices provided for in the Heads of Bill. A woman may lack capacity to make a medical decision, perhaps temporarily due to mental health problems or physical illness. The submission points out that the Non-Fatal Offences Against the Person Act, 1997 sets the age of consent to medical examinations at 16, while the Mental Health Act, 2001 sets it at 18 for mental health issues.

Mr John Saunders of the Mental Health Commission also pointed to the need to deal with women under the age of consent, as well as children detained in approved centres under the Mental Health Act.

In his written submission, **Dr Keith Holmes** of The Lucena Clinic outlined concerns relating to the assessment and treatment of children including the interaction of the scheme outlined in the Heads of Bill with the Children First guidance and the Bill that proposes to give it statutory effect.

Dr Maeve Doyle of the College of Psychiatry of Ireland referred to the College's detailed submission, which discusses the problems of capacity and consent as they relate to children. She stressed the importance of including a definition of the term 'child' in light of the differing ages and circumstances dealt with by the Non-Fatal Offences Against the Person Act, 1997, the Children Act, 2001 and the Mental Health Act, 2001. Dr Doyle also noted the importance of dealing with the issue of confidentiality where children are concerned, as well as the manner in which children in the care of the HSE ill be dealt with, including consent to care as well as applications for terminations and reviews. In some cases it may be appropriate to appoint a guardian *ad litem*.

Mr Tony O'Connor SC considered in his written submission the question of consent to treatment under Heads 2(5) and 4(4). He outlined the existing law on substituted decisions as set forth in the judgement of Laffoy J in Fitzpatrick v F.K.[11] He suggested the possibility of adopting in the Bill proposals that appeared in the recent Assisted Decision-Making (Capacity) Bill, and that consideration be given to how they might interact with the existing law and the provisions and procedures outlined in the Heads of Bill. He also suggested a revised form of wording to deal with consent to treatment under Heads 2 and 4.

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11 Fitzpatrick v F.K. [2009] 2 I.R. 7.

Heads 6 - 9: Reviews

General

The Medical Council recommended that Heads 7 and 8 be merged with the procedures in Head 8 being employed with modifications suggested in its written submission. It suggested that there should be clarity as to which practitioner is responsible for informing the woman of her right to a review, and an express requirement that she be given information in a timely and effective manner. It queries the need for the psychiatrist referred to in Head 8 to be attached to the location where the procedure is carried out. There should be a set timeframe for notifying the woman of the committee's decision.

The Irish College of General Practitioners said it may be appropriate to include the woman's GP in the review process if he or she is not already involved. In relation to the HSE convenor, it suggested strict controls of confidential information concerning the woman and the review. It asked how the woman's GP will be informed of the result of the review, and whether the woman must attend the review.

The Institute of Obstetricians and Gynaecologists proposed that all specialties organise suitably qualified consultants to volunteer to serve on reviews. Funding and organisational resources to operate the review system must be provided. The HSE convenor should serve as the primary contact point for the woman during the review process. The panel should have access to legal advice and be legally indemnified. There should be a mechanism for appealing decision to a Court. Head 9(4)(a) should not apply to voluntary members of a committee. The **Irish Council for Civil Liberties** said that appointments to the panel must be open and transparent.

Dr Peter Boylan said said a request for a review should not have to be in writing. He suggested that a practitioner who decides that a termination is not necessary under Heads 2 or 4 should be obliged facilitate the initiation of a review. **Prof. Joan Lalor** also proposed that the review should be initiated in every case by the HSE.

Dr Rhona Mahony submitted that the review process must be accessible. Reviewing practitioners should belong to relevant specialties, so that, for example, obstetricians are not called on to review a decision to decline a termination on psychiatric grounds.

The **Irish Medical Organisation** said in its submission that practitioners who declare a conscientious objection must be excluded from review panels, as did the **Irish Council for Civil Liberties** and **Galway Pro-Choice**. The IMO also said that resources should be provided for the care and support of the woman during the review.

Dr Veronica O'Keane noted that Head 6(2) mentions the possibility of a woman who requested a termination not being given a decision. She said the woman in that case should not have to appeal to get a decision and suggested that a practitioner who was unwilling or unable to decide should refer the woman to another. She also proposed that Head 8 provide that members of a review committee should receive an allowance for expenses but not be remunerated.

Dr Eamon Moloney said that decisions of a review committee should be by majority vote, along the lines of mental health review committees.

The **College of Psychiatrists of Ireland** said that the HSE should be responsible for informing the woman of her right to a review.

The **Mental Health Commission** suggested that a mechanism for appealing decisions of a review committee to the Courts might be added.

Mr Frank Callanan SC submitted that where a committee decides in favour of a termination, its certificate should be phrased in terms equivalent to those under Heads 2(4) and 3(4), expressly mentioning the real and substantial risk that can be averted only by a termination. Practitioners could then be able to rely on the certificates in the same way.

Dr Simon Mills BL suggested that there should be a legal representation scheme for reviews. Apart from helping to put the woman's case, if required, it would so help to overcome issues relating to capacity. One possible model would be the guaranteed representation form used for

reviews of detention under the Mental Health Act, 2001. Alternatively it could be by way of a general right to representation if the woman chose to exercise it. The **National Women's Council of Ireland** also proposed a means of advocacy and representation for women.

A number of written submissions proposed providing representation for the unborn. **Mr Paul Brady BL** told the Committee during his oral presentation that there may be justification for doing so but this is ultimately a political decision.

Time Limits

Contributors expressed a range of views on the time limits for convening committees and reviews of decisions under Heads 2 and 4. **Drs Rhona Mahony** and Mary McCaffrey found the 7-day limits reasonable as maxima, while the **Irish Medical Organisation** and **Dr Peter Boylan** suggested they were too long. **Drs Yolande Ferguson**, **Eamon Moloney** and the **College of Psychiatrists of Ireland** suggested limits of 72 hours for convening a committee and a further 72 to give its decision, while **Prof. Veronica O'Keane** suggested these should be reduced to 48 hours each. **Action on X** suggested a maximum of 72 hours for both convening the panel and issuing a decision. **Amnesty International**, the **Association for the Improvement of Maternity Services in** Ireland and **Galway Pro-**Choice all suggested reductions in the time limits for reviews.

In his closing remarks, **Mr Alex White TD, Minister of State at the Department of Health** said that the 7-day limits were to be regarded as maxima rather than setting a norm of 14 days for convening and issuing a decision.

Heads 10 and 11: Formal review reports and notifications

Dr Tony Holohan, the Chief Medical Officer, said that reports and notifications were essential for ensuring accountability under the Bill. The Department had no difficulty with giving the Oireachtas a role in review of the operation of the legislation once enacted.

The Irish Medical Organisation suggested that the formal medical review reports under Head 10 were unnecessary. Hospital returns under the HIPE system could be used without creating a new reporting requirement. **Dr Simon Mills BL** also queried the need for duplicate returns of information that the HSE would receive in any event.

Contributors who expressed opinions on these heads generally stressed the importance of accuracy and confidentiality of both patients and doctors. **Prof. Joan Lalor** highlighted the importance of monitoring this data to identify trends that may need review. The **Institute of Obstetricians and Gynaecologists** and most medical contributors who expressed an opinion on the matter said that anonymity of both doctors and the women involved was essential. The Institute suggested that meaningful annual statistics could be generated without contravening the Freedom of Information Acts. The HSE should set up and run a properly resourced and user-friendly review system.

Mr John Saunders of the Mental Health Commission noted that the Freedom of Information Acts contained strict controls on the storage and use of sensitive personal data. If the Head was to be altered to permit it to be applied to this information, that would have to be borne in mind. The exclusion of application of the Freedom of Information Acts was condemned by the **Pro-Life Campaign**, **Waterford Concerned Citizens**, **Doctors for Life** and **Ms Loretto Browne RGN.**

Dr Bernie McCabe and **Prof. Patricia Casey** asked whether practitioners would be named in annual reports. They said it was important that the age, level of suicidal intent, prior treatments, gestation at the time of abortion and other relevant information be provided in annual reports. They also suggested that advocates of the Bill who maintained that levels of demand were likely to be

very low should suggest the probable figures so that the the effects of the legislation could be properly assessed over time.

Head 12: Conscientious Objection

Medical views

The **Medical Council** said that the term 'conscientious objection' should be expressly used in sub-head 12(1). It should also clarify whether it applies to assessments of risks, certifying and reviews. Head 12(2) needed to be clarified.

Prof. Joan Lalor suggested that the Bill should contain a whistleblower provision similar to that in the Children First Bill.

There was general acceptance of the practitioner's obligation to tell a patient of a conscientious objection. However, **Prof. Veronica O'Keane** said that medical experts who volunteer to serve on review panels should also be required to state whether they are prepared to make available the service to be provided under the Bill. **Drs Matthew Sadlier** and **Mary McCaffrey** expressed concerns about employment discrimination and pressure to declare one's position when applying for a position.

Concerning emergency situations, the **Medical Council** submitted that a statement similar to that in section 10.3 of its Guide to Ethics be inserted to the effect that a conscientious objection does not absolve a practitioner from his or her duty to a patient in an emergency situation.[12] However, **Dr John Monaghan** queried the note to that effect in the Explanatory Note. He said that the rightness or wrongness of a situation does not depend on whether an emergency situation exists. A doctor will always treat a patient whose life is in danger: if she dies, so too does her baby. To act otherwise would be professional misconduct. He submitted that the idea of 'conscientious objection' was misnamed: it was more appropriate to refer to 'conscience', and a doctor must always act conscientiously, even thought idea of conscience was under attack in medical literature.

12 It may have been intended that Head 12(2) refer to 'Head 3', concerning emergency situations, rather than 'Head 4'.

Dr Monaghan also said that the provision should extend to persons including counsellors, social workers, clerical staff and porters.

The **College of Psychiatrists of Ireland** and **Dr Mary McCaffrey** asked for clarification of the meaning and purpose of the term 'third party' in sub-head 12(3).

Concerning sub-head 12(4), the **Irish College of General** Practitioners asked how a doctor who has a conscientious objection identify a colleague to whom he or she can refer a case. In its submission, the **Irish Medical Organisation** said that there must be a system to allow practitioners to declare a conscientious objection and protocols to deal with situations of conscientious objection as they arise, including referrals to colleagues. On a wider concern, **Dr Bernie McCabe** asked how a situation could be avoided whereby a doctor who is asked to certify eligibility for a termination always calls on colleagues with similar views, whether to facilitate or obstruct. Similarly, **Dr Peadar O'Grady** voiced concerns about the possibility of what he termed "conscientious obstruction".

Legal views

In his written submission, **Dr Simon Mills BL** queried the use of the verb 'assist' in sub-head 12(1). He pointed out that the verb 'participate' – which he suggested may have a wider sense than 'assist' – had been at issue in the Doogan case in Scotland.[13]

In relation to sub-head 12(3), Dr Mills asked whether the intention was that institutions be obliged to ensure they have sufficient numbers of non-objectors to be able to provide the relevant services. He queried the effect of equality legislation on this sub-head, as well as the use of the term 'third party'. He noted that the Council of Europe Guideline[14] requires a balance between the exercise right of conscientious objection (including that of institutions) and the interests of others – particularly women on low incomes and in rural areas – who may be vulnerable as a result of that exercise.

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13 *Doogan and Anor. v NHS Greater Glasgow & Clyde Health Board*, [2013] CSIH 36.

14 Parliamentary Assembly of the Council of Europe, Resolution 1763 (2010) 1[1].

Concerning sub-head 12(4), Dr Mills queried whether there should be a duty to refer to someone who will provide the service in question. He also asked whether the right of conscientious objection extends to giving an opinion under Heads 2 - 4 or sitting on review panels. Finally, he queried the exclusion of pharmacists from this Head even though they are referred to in the Explanatory Note.

Ms Caroline Simons argued in her submission that the rights of conscientious objection should extend to any person likely to participate formally or materially in abortion as part of their work or occupation. She cited the Doogan case as an example of the wide scope of the right under the European Convention on Human Rights, and pointed to other jurisdictions that have well-developed conscientious objections regimes that should be used as models for this country.

Ms Simons described the exclusion of hospitals, organisation and third parties under sub-head 12(3) as illogical and not grounded in law. She cited the 2010 resolution of the Parliamentary Assembly of the Council of Europe as well as extensive case law of the ECtHR.

Ms Simons noted inconsistencies in terminology throughout the Heads of Bill that could have a material effect on rights of conscientious objection. While Head 12 refers to 'termination of pregnancy', Head 1 refers to 'medical procedure ... that will end unborn human life", while Heads 2, 3, and 4 refer to "medical procedure ... in the course of which or as a result of which unborn human life is ended". She noted that Explanatory Note states that rights of conscientious objection must be balanced against competing rights. The X Case created a legal test for abortion which is not supported by medical evidence. The right to conscientious objection should therefore be recognised as a right to conduct best medical practice even against the rights recognised in the X Case.

Dr Ruth Fletcher submitted that the right to conscientious objection should apply to individuals only, and only if alternative provision of services are available. The right is limited by the duty not to harm others. Dr Fletcher suggested that the recognition of the consciences of medical personnel was inconsistent with the lack of legal recognition of the consciences of pregnant women. If conscientious objection to abortion is legally acceptable, so too should be conscientious objection

to sustenance of an embryo or foetus within one's body. If a woman's conscience tells her that termination of her pregnancy is the best moral resolution of a situation, the law should accommodate that decision.

Dr Maria Cahill argued in her written submission that the exclusion in sub-head 12(2) of a right to conscientious objection to procedures under Head 4 was clearly unconstitutional.[15]

Concerning sub-head 12(2), Dr Cahill cited case law of the ECtHR and 2010 resolution of the Parliamentary Assembly of the Council of Europe discussed by Mr Simon Mills and Ms Caroline Simons above. She argued on that basis that the sub-head would not withstand a challenge before the ECtHR.

Other views

A considerable number of written submissions expressed concern about Head 12. The most common concerns related to sub-heads 12(1) and 12(3). In relation to 12(1), many submissions demanded that all personnel, whatever their role in a health facility, be allowed to claim conscientious objection to any form of cooperation or involvement with the termination of pregnancies. Many of these referred to the Doogan case and/or provisions of the European Convention on Human Rights. Concerning sub-head 12(3), many cited the 2010 resolution of the Parliamentary Assemble of the Council of Europe referred to above. Submissions from individuals making these arguments are too numerous to name here. Those from organisations include **The Iona Institute**, the **Christian Medical Fellowship**, **Ireland Stand Up**, **Doctors for Life** (which also objected to sub-head 12(4)) and the **Pro-Life Campaign**.

A different perspective was evident in the submissions of **the National Women's Council of Ireland**, **Prof. Joan Lalor**, the **Irish Council for Civil Liberties** and **Amnesty International**, all of which argued that conscientious objection should not prevent provision of services under the Bill.

15 See however fn. 12 above.

Head 18: Repeals and consequential amendments

Head 19: Offence

Dr John Monaghan told the Committee that the criminalising of any act done with the intent to destroy unborn human life was "a most important statement vindicating the right to life of the unborn child under the Irish Constitution". He suggested this be reinforced by inserting a provision in the Bill prohibiting practitioners from killing the child in the womb, even though it may be necessary to deliver the child to save the mother's life.

A number of contributors expressed concern about the severity of the penalty and the very wide range of persons and circumstances that could be covered by the offence as outlined in this Head. **Dr Rhona Mahony** said it would be wrong to threaten the woman involved with conviction and imprisonment. **Dr Peter Boylan** agreed, particularly in cases where the woman had been following medical advice. Other contributors cited cases where women or girls self-administered drugs or medication bought over the Internet: they argued that these should not be treated in the same way as someone who operated an unlicenced abortion clinic.

Dr Simon Mills BL said that the references to "a person" and "any act" in sub-head 19(1) were so broad as to possibly encompass procedures under Heads 2, 3 and 4 that were intended to be exempt from the offence. He suggested that a saving provision be added to the definition of the offence to specifically exempt procedures properly undertaken in compliance with those Heads. There should be a separate offence for where a person other than a registered medical practitioner carries out a termination that is purported to be otherwise in accordance with Heads 2, 3 or 4.

Dr Ruth Fletcher said that criminalising women's decisions to end their pregnancies was a disproportionate and unfair implementation of Article 40.3.3°. Criminalisation

does not protect foetal life, as evidenced by the numbers of Irish women who have abortions abroad. It adds stigma and increases the distress of the women involved. A better approach to vindicating unborn life would be to invest in pregnancy-related care and research into miscarriage. Criminalising abortion made pregnant women, rather than the State, bear the responsibility of vindicating the unborn's right.

Mrs Justice Catherine McGuinness told the Committee that the offence and penalties should differentiate between the circumstances in which it might occur. The case of a single woman and her doctor was not equivalent to an illegal clinic, and it would not be right to rely on prosecutorial discretion.

Among written submissions sent to the Committee, a number, including those from **the Christian Medical Fellowship** and the **Pro-Life Campaign** disagreed with the proposal to repeal sections 58 and 59 of the Offences Against the Person Act, 1861.

Submissions that opposed the application of new offence in Head 19 to women who had or had attempted to terminate their pregnancy included those from **the National Women's Council of Ireland**, the **Irish Council for Civil Liberties**, **Action on Maternity Services in Ireland**, **Action on X**, **Choice Ireland** and **Galway Pro-Choice**. Calls for repeal of all abortion-related offences were made in submissions from **Dr Catherine Bates** and **Amnesty International**.

Head 20: Commencement

Mr John D Walsh of Waterford Concerned Citizens suggested that operation of the Bill be time limited to one year, after which it would cease to have effect and its operation during the preceding three months be subject to a review. Against that, **Amnesty International** argued against any 'sunset' clause.

Action on X proposed that the Bill should take effect immediately upon enactment.

List of those who presented to the Committee

<u>Day 1 Policy Medical and Obstetrics</u>
Minister for Health
Dr Tony Holohan
Institute of Obstetricians and Gynaecologists
Irish College of General Practitioners
Irish Medical Council
Irish Medical Organisation
Royal College of Physicians of Ireland
Dr Peter Boylan
Dr Sam Coulter Smith
Dr Rhona Mahony
Dr Gerard Burke
Dr Mary McCaffrey
Dr Máire Milner
Dr John Monaghan
<u>Day 2 Psychiatry and Other Medical Specialities</u>
College of Psychiatrists of Ireland
Dr John Sheehan
Dr Yolande Ferguson
Dr Peadar O'Grady
Professor Veronica O'Keane
Dr Eamonn Moloney
Professor Kevin Malone
Dr Bernie McCabe
Dr Jacqueline Montwill
Dr Sean O'Domhnaill
Irish Nurses and Midwives Organisation
Mental Health Commission
Dr Kevin Walsh
Dr Janice Walshe
<u>Day 3 Legal Hearings</u>
Mr Paul Brady
Dr Simon Mills
Mr Tony O'Connor
Ms Caroline Simons
Professor William Binchy
Dr Maria Cahill
Mr Frank Callanan
Mrs Justice Catherine McGuinness
Dr Ciaran Craven
Dr Ruth Fletcher
Ms Sunniva McDonagh
Minister of State Alex White TD

Appendix 1

Oral Presentations and Submissions

Day 1 Policy, Medical and Obstetrics

ORAL HEARINGS –

JOINT COMMITTEE ON HEALTH AND CHILDREN

17th May 2013

Opening Statement

Good morning Chairman and members of the Committee,

I am pleased to be here today to open these hearings on the General Scheme of the Protection of Life during Pregnancy Bill.

I look forward to the presentations of your invited guests, and I am confident that these hearings will provide very useful input as we come to finalise drafting of the terms of the Bill. I was struck by the balanced and respectful approach taken by all during the last three days of hearings held by the Committee in January, and hope that the present hearings will be as productive.

Background

As you are all aware, on 30th April the Government approved the drafting of the Protection of Life during Pregnancy Bill 2013 subject to any technical amendments that may be deemed necessary following consultation with the Attorney General, and the publication of the General Scheme of the Bill. The General Scheme aims to give effect to the Government's decision in December 2012to legislate in this area within the parameters of Article 40.3.3 of the Constitution as interpreted by the Supreme Court in the *X* case, in order to implement the judgment of the European Court of Human Rights in the *A, B and C v Ireland* case.

Before I proceed I think it is worth reminding ourselves of the findings of this judgment. Three applicants, A, B and C, all of whom had crisis pregnancies, brought proceedings against Ireland before the European Court of Human Rights claiming violations of Articles 2, 3, 8, 14 and 13 of the European Convention on Human Rights. In its judgment delivered on 16 December 2010 the Grand Chamber determined that there had been no violation of the Convention in relation to the first and second applicants, Ms. A and Ms. B. The Grand Chamber determined that there had been a violation of Article 8 of the Convention in relation to applicant Ms. C. The Court found that Ireland had failed to respect the Ms. C's private life contrary to Article 8 of the Convention, as there was noaccessible and effective procedure to enable her to establish whether she qualified for a lawful termination of pregnancy in accordance with Irish law.

The aim of General Scheme being discussed is to provide such a procedure. However, it is worth noting again that the issues at stake here are extremely complex, and engage with fundamental rights.

Overview of the General Scheme

I will now take you through the General Scheme head by head. I do not wish to pre-empt your discussion but I am mindful that there might be issues still to be dealt with and my own Department has already identified some provisions that might need to be revisited from a technical perspective. Furthermore, some of the participants in these hearing might also have identified additional technical issues that may need examination and I look forward to any suggestions that will lead to the improvement of the operation of this legislation.

Head 1of the Scheme deals with the interpretation of the Bill; it defines the meanings of some of the terms used for the purposes of the Bill, including *appropriate location, reasonable opinion,* and *unborn*.

Head 2deals with the risk of loss of life from physical illness. It provides that it is not an offence for a registered medical practitioner to carry out a medical procedure in the course of which or as result of which unborn human life is ended under certain circumstances. These are that the procedure is carried out in an appropriate location and two

medical practitioners registered on the Specialist Division of the Medical Council Register have certified that in their reasonable opinion there is a real and substantial risk to the life, as opposed to the health, of a pregnant woman arising from a physical illness that can only be averted by a termination of pregnancy.

The process requires an assessment on medical grounds to determine if the test set out in the Supreme Court judgment in the *X* case is met. The Supreme Court held that the correct test was that a termination of pregnancy was permissible if it was established as a matter of probability that:

1) there is a real and substantial risk to the life of the mother; and
2) this risk can only be averted by the termination of her pregnancy.

It is **not necessary** for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate.

The definition of "reasonable opinion" requires that this opinion must be formed in good faith and must have regard to the need to protect the right to life of the unborn and preserve unborn human life where practicable. The emphasis on preserving unborn human life means that a doctor will be obliged to make every effort to safeguard the unborn and, where it is potentially viable outside the womb, to make all efforts to sustain its life after delivery.

The registered medical practitioner(s) will be obliged to record this opinion in writing if certifying a procedure that will end unborn human life.

One of the two medical practitioners involved in the certification process will always be an obstetrician/gynaecologist and the other

will be a medical practitioner in a specialty relevant to the risk to the life of the woman, e.g. oncologist, cardiologist, etc. As indicated in the definition of reasonable opinion, the test requires a clinical diagnosis in relation to the risk to the life of the pregnant woman and a foetal assessment. Therefore the expertise of an obstetrician will always be required. Secondly, a termination of pregnancy will most likely be carried out by, or under the care of, an obstetrician/gynaecologist, and therefore their inclusion here should be central in accessing services and ensuring patient safety.

During the process of assessment it may also be appropriate that the pregnant woman's GP is consulted with her permission and where practicable and feasible.

In relation to appropriate locations, it is intended that these will be public obstetric units only. I believe that the State's constitutional obligation and its responsibility to act in the common good demand that, provision of terminations of pregnancy be only allowed in health care facilities providing obstetric and mental health services and where relevant specialists are attached, that can be duly monitored and investigated, should the need arise.

Head 3 deals with emergency situations, where there is an immediate risk of loss of life arising from physical health conditions only. In an

emergency situation, the opinion of one registered medical practitioner will be sufficient for the termination to be lawful.

Doctors should not be prevented from saving a woman's life in a situation of acute emergency, because, for example, the required numbers of doctors are not available to certify or the woman in question arrives at a health facility that is not covered as an appropriate location under this Bill i.e. not a public obstetric unit. Therefore, in emergency circumstances, the reasonable opinion of one medical practitioner is required to certify that the termination is immediately necessary to save the life of a pregnant woman, but the medical practitioner who carries out the procedure will be required to certify the reasons for his/her actions, and notification of all emergency terminations will be sent to my Department.

Again, this opinion must be formed in good faith and have regard to the need to preserve unborn life where practicable. The emergency 'exception' **will not apply in the case of a risk to life from self-destruction** because of the more subjective nature of the diagnosis due to the absence of objective clinical markers.

Head 4 deals with a risk to the life of the pregnant woman from self-destruction. Assessment of self-destruction is more subjective and there are recognised clinical challenges in accurately assessing suicidal ideation, for example, the absence of objective clinical

markers. Therefore, this assessment requires more safeguards to be put in place. In these cases, three medical practitioners registered on the Specialist Division of the Medical Council Register must certify that in their reasonable opinion there is a real and substantial risk to the life of a pregnant woman arising from self-destruction that can only be averted by a termination of pregnancy. One of them must be an obstetrician/gynaecologist and the other two must be psychiatrists.

I am aware that the role of the obstetrician in this assessment has been raised, however, the test in this case will always be a multidisciplinary test as it requires a clinical diagnosis in relation to the risk to the life of the pregnant woman and a foetal assessment. Therefore the expertise of an obstetrician will always be required.

Head 5 provides for the notification to the Minister of the certified medical opinions referred to in heads 3, 4 and 5. It is undoubtedly important to record the number and nature of terminations of pregnancy carried out under this Bill, in order to monitor its correct implementation and detect any potential abuse of its provisions. Therefore, the legislation includes a clear requirement on providers to notify for all terminations carried out under this legislation within 28 days.

Head 6 provides for the establishment of a formal process to allow a woman to seek a medical review of her case. The establishment of a

formal framework providing for an accessible, effective and timely review mechanism is one of Ireland's obligations under the judgment in *A, B and C v Ireland.* The purpose of this formal medical review process is to provide a mechanism for the woman, where she so requests, to have access to a review of the clinical assessment made by the original doctor or team of doctors. In practice, this will only arise where the woman's request for a termination in line with the *X* case criteria has not been granted, or when she has been unable to obtain an opinion in this regard.

It is important to note that this formal review pathway is in addition to and not in substitution for the option of a woman seeking a second opinion as with normal medical practice.

It is intended that the Health Service Executive will act as the Convenor for the purpose of the formal medical review process and will appoint authorised persons to establish and convene a Review Committee drawn from a Review Panel. It will also establish a panel of relevant experts for the purposes of this formal medical review. Members will be nominated by the Institute of Obstetricians and Gynaecologists, the Irish College of Psychiatry, the Royal College of Surgeons in Ireland, and the Royal College of Physicians of Ireland. The HSE will draw from this panel when it needs to establish a review committee to consider an application made under this Head.

As soon as possible but no later than 7 days after receiving a written request from the pregnant woman the HSE shall establish and convene the committee drawn from a panel maintained by the executive. The Committee shall complete its review as soon as possible but in any event no later than 7 days after the HSE has formed the Review Committee.

Head 7 sets out of the functions of the Review Committee in physical illness matters. These provisions precisely mirror the provisions in Head 2 for the initial assessment in both the number and specialties of the doctors involved.

Head 8 sets out the function of the Review Committee in the case of risk of loss of life through self-destruction. These provisions precisely mirror the provisions in Head 4 for the initial assessment in both the number and specialties of the doctors involved.

Head 9 sets out the general provisions for the Committee for both physical risk and risk from self-destruction. It aims to empower the review committee to obtain whatever manner of clinical evidence it requires to reach a decision, and to call any relevant medical practitioners to give evidence in person and to vindicate a woman's right to present her case at the meeting of the Review Committee or someone authorised on her behalf.

Head 10 sets out that reports from all review committees must be reported to the Minister by the Executive.Information that will have to beprovided includes:

a) the total number of applications received

(b) the number of reviews carried out

(c) in the case of reviews carried out, the reason why the review was sought and

(d) the outcome of the review.

Again, this information is required to monitor the implementation of the legislation to ensure that the principles and requirements of the system are being upheld.

Head 11 provides for a notification system in relation to all terminations of pregnancy carried out under the terms of this Bill. I consider it very important to record the number and nature of terminations of pregnancy, in order to monitor the Bill's correct implementation and to detect any potential abuse of its provisions. Therefore, the legislation includes a clear requirement on providers to notify me, as Minister for Health, of all terminations carried out under this legislation within 28 days. This will be done without disclosing the names of the women involved.

Head 12 deals with conscientious objection. In this regard, professional health personnel (namely medical and nursing personnel)will not be obliged to carry out or assist in carrying out

lawful terminations of pregnancy if they have a conscientious objection, unless the risk to the life of the pregnant woman is immediate. Where a doctor or other health professional has a difficulty in undertaking a required medical procedure, he or she will have a duty to ensure that another colleague takes over the care of the patient, as is normal in current medical ethics.

I should note that the right to conscientious objection is a human right, which is limited to persons only and which cannot be invoked by institutions.

Head 13 reaffirms the freedom to travel and freedom to information as per the Thirteen and Fourteenth Amendment to the Constitution, for the avoidance of doubt.

Head 14 on regulations, is a standard provision in regard to Ministerial powers to make regulations.

Head 15 states that certain regulations must be made to provide for prescribed forms listed in Heads 2, 3 and 4. In this regard, I will be making regulations to set out the way in which medical practitioners will certify their opinions regarding the risk of loss of life to the woman, and whether a termination of pregnancy is required. These regulations will require, for example, certificates to indicate the clinical grounds for the opinion and other relevant details of the case

at hand. Under this Head I will also be making regulations regarding the functioning of the Review Committee.

Head 16 also deals with regulations, this time on the prescribed notification form to be filled in under the terms of Head 11 (on Notifications).

Head 17 is a standard provision for the laying of the regulations before the Houses of the Oireachtas.

Head 18 repeals sections 58 and 59 of the Offences Against the Person Act 1861, as they are replaced by the provisions made in Head 19 of the Bill. Consequential amendments may need to be inserted in existing Acts subject to legal advice from the Attorney General and these are currently being explored.

Head 19 specifies the offence of performing or effecting, or attempting to perform or effect, a termination of pregnancy. This updates the law in this area. The penalty for the offence is up to 14 years imprisonment or fine or both.

Head 20 contains a standard provision dealing with the short title and commencement date of the Bill.

Concluding Remarks

In conclusion, Mr Chairman, I wish to reassure you again that the only purpose of the legislation I will be bringing before the Houses of the Oireachtas is to clarify what is lawfully available by way of treatment in cases where there is a real and substantial threat to the life of a pregnant woman, and to set out clearly defined and specific circumstances in which this treatment can be lawfully provided.

As you will be aware a very significant amount of work was involved in producing the heads of this legislation. Over 50 drafts were composed as we moved to produce what we believe to be balanced proposals that meet our obligations. I commend the heads of the bill to the Committee and I now look forward to hearing your discussion and deliberation on its proposals.

Mr Chairman I am joined at the Committee by the Chief Medical Officer, Dr Tony Holohan, who was closely involved in all of the work on the heads of the bill. I am also joined by the Secretary General of the Department of Health Dr Ambrose McLoughlin who is fully conversant with the detail of the proposals.

Dr Holohan and Dr McLoughlin will remain with you to be of assistance in ensuring that the proposals in the heads are fully understood and to answer questions on areas where members require explanation.

I think it is important in the first instance for the Committee to have an opportunity to satisfy itself that there is no ambiguity as to what the heads mean.

Of course as the Committee knows the next phase is the drafting of the legislation followed by Committee stage in the Dáil. I look forward to working closely with colleagues in the chamber as we discuss the final legislation and any amendments that it may require.

Finally, Mr Chairman, I wish to again publicly state my gratitude to the committee for your earlier hearings which informed the composition of these heads and I'd like thank you and all of those participating in **these** public hearings, for the invaluable contribution you are making to this issue and for the assistance you will provide to me and my officials. I wish to acknowledge deputies on both sides of the house who have discussed these matters with me and I'd like to thank all those persons who recognise the great sensitivities involved and the need for our discourse to be respectful of differing views.

I now hand over to the Chief Medical Officer, Dr. Tony Holohan, who will be provide further details on the principles underpinning this General Scheme.

JOINT COMMITTEE ON HEALTH AND CHILDREN

17th May 2013

Statement from

Dr Tony Holohan MB BCh BAO DCH MPH MICGP FFPHMI FRCPI (Hon)

Chief Medical Officer

Good morning Chairman and members of the Committee,

I am pleased to be here today to contribute to these hearings on the General Scheme of the Protection of Life during Pregnancy Bill.

The Minister has already provided the background and a detailed presentation on the Heads of this Bill. I would like to begin by setting out the principles that underpin this legislation and to comment on matters of professional medical practice that arise in the context of these Heads. These guiding principles are derived from the work of the Expert Group chaired by Mr Justice Sean Ryan of which I was a member. I think it is important that the committee would understand these and how they guided the drafting of the Heads.

The **first Principle** behind the General Scheme is that it should provide legal clarity by way of legislation and regulations on the circumstances in which a termination of pregnancy is permissible – that is, where there is a real and substantial risk to the life, as opposed to the health, of a woman. The aim of the General Scheme is to bring clarity to the **existing** situation. As the Minister has already alluded to in his presentation the Scheme **does not** confer any **new** substantive rights to termination of pregnancy. Rather, it provides for rights which already exist, within Constitutional provisions and the Supreme Court judgment in the *X* case. Its purpose is to confer procedural rights on a woman who believes she has a life-threatening condition, so that she can have certainty as to whether she requires this treatment or not.

The **second Principle** underpinning the legislation is that the State will uphold the right to life of the unborn as far as practicable, as per the Constitutional obligations in Article 40.3.3.

This means that where a woman has a pregnancy that places her life at risk and her foetus is or may be viable, she may have a right to have the pregnancy brought to an end but **not** a right to deliberately end the life of the foetus.

The **third Principle** is that termination of a pregnancy must be necessary to save the woman's life. In these circumstances, termination of pregnancy will always be considered a medical intervention that operates within all the existing arrangements that pertain to other medical services, and standard medical practice should be adhered to as much as possible in its delivery.

I should note, however, that certain additional requirements are considered appropriate due to the fundamental Constitutional rights at stake here - the right to life of the pregnant woman, and the right to life of the unborn. The requirements provided for in the legislation include a process for assessment, the number of doctors required for assessment, the process of

certification, the locations where terminations might take place, a formal medical review process, and a notification system.

The **fourth Principle** deals with the issue of suicide, and states that given the more subjective process and recognised clinical challenges involved in the evaluation of suicidal ideation, the legislation should reflect this in the "checks and balances" which it provides for.

Principle number 5 deals with the issue of consent which is enshrined in ethical standards for doctors. This Principle provides that it is always a matter for the patient to decide if she wishes to proceed with a termination of pregnancy following a decision that it is the only intervention that will save her life.

Finally, the **sixth Principle** provides that there must be an ability to monitor the impact and operation of the legislation, so therefore it provides for a mandatory monitoring and reporting system. It specifies that, in order to ensure that the general constitutional prohibition on abortion is maintained; the State will regulate and monitor the exercise of a woman's right to lawful termination of pregnancy as stipulated by the Supreme Court in the X Case.

I would now like to expand on the issue raised in Principle 3 regarding adhering to standard medical practice. To reiterate the Principle involved, where termination of a pregnancy is necessary to save the woman's life, the procedure is to be considered a medical intervention, and standard medical practice should be adhered to as much as possible in its delivery.

The General Scheme has put this Principle into practice by ensuring as far as possible that the processes it sets out for assessing the risk of loss of life do not go beyond what normally occur in clinical practice. For example, in terms of setting out the assessment process, the General Scheme provides for more than one medical practitioner to be involved. This reflects the fact that it increasingly the case that doctors do not act alone in assessing and managing patients where the complexity is of a similar order to that of a pregnant women who has a real and substantial risk to her life. Evidence based practice in many disciplines provides more and more that doctors work as part of a team or consult with colleagues as a matter of course. Emergency situations are the exception here, of course, and these are considered separately by the General Scheme, with different requirements made where the risk of loss of the woman's life is immediate.

In addition, the General Scheme does not preclude patients from seeking a second or subsequent opinion in relation to any/all members of their treating team, as per standard practice. This is a routine feature of everyday medical practice.

Although the General Scheme sets out the process to follow in assessing whether a termination of pregnancy is required, I must note that it is silent on how the certification may come about. This was deemed appropriate since clinical scenarios where the *X* case criteria might apply are bound to be complex and possibly unpredictable, and therefore attempting to predict and set out specific referral pathways in legislation would be unsafe. Instead, the General Scheme expects and indeed necessitates that standard medical practice would apply as in all other aspects of medical practice.

I am the Chief Medical Officer. I have confidence in the medical profession in this country. I believe in the integrity and professionalism of our doctors. We have highly trained and motivated doctors working in this country. They have a track record of high quality patient centred care which puts patients first. While none of us is blind to the fact that today's

standards of service would not necessarily deem the practices and behaviours of the past as appropriate, I think it is absolutely fair to say that the Medical Colleges have shown a consistent commitment to the public interest in the work they do- for many years they have relied on voluntary altruistic endeavour in the training of the next generation and in the pursuit of research knowledge and understanding which is the bedrock of evolving evidence based care. They are showing leadership in every aspect of the major health reforms that are underway- at a scale and pace that would simply be impossible without their active engagement. This is true of doctors right across the spectrum- whether GPs, obstetricians, psychiatrists or any other speciality.

It is my hope and expectation that the doctors who give evidence to this Committee will do so in a manner that reflects their duty of professionalism and respect for one another as colleagues **and** that remembers their responsibility to ensuring that this Committee and the wider public are informed through evidence and science.

It is perfectly rational and reasonable that society would seek to place limits and boundaries upon certain services provided by doctors where there is a public interest to do so and to provide clear oversight and accountability arrangements for the doctors in the delivery of these services. That is precisely what these heads seek to do while recognising and respecting the latitude there must be for medical practitioners to carry out their duties in the interests of their patients with clarity and certainty about the legal framework within which they must operate. It is vitally important, therefore, that guidance is developed for doctors on the appropriate operation of this legislation. That is best done by the doctors themselves through the professional College and the Medical Council who have a strong track record in this regard. The Department has a very good working relationship with the colleges and professional bodies and I plan to work with them in preparing guidance to their members on the operation of the Bill. I will be meeting with them in the very near future to commence this process.

In conclusion, Mr Chairman, I wish to thank you and your fellow Committee members for the opportunity to address you today. I would like to wish you well with your work, and look forward to your report.

ENDS

Opening statement of The Institute of Obstetricians and Gynaecologists on the protection of life during pregnancy bill 2013

Chairman Buttimer, members of the committee,

The Institute of Obstetricians and Gynaecologists (IOG), Royal College of Physicians of Ireland is the body that officially represents and advises on Obstetrical and Gynaecological opinion, professional standards, patient care, education and research in Ireland. As such the IOG has a compelling interest in the contents of the final Bill. We have a responsibility to ensure that it will be the best way to protect women's' health, and also allow for the necessary flexibility to cater for future advances in Obstetrics.

Maternal health services in Ireland are amongst the best in the world and pregnant women and their families should be reassured that they are receiving the very best of care during pregnancy.
Recent accurate figures have been collected in Ireland over the past 3 years and these show that approx. 1 mother dies for every 12,000 pregnancies. These low rates compare very well with UK and the rest of Europe.

However we are never complacent and it is our absolute priority to ensure that pregnant women receive the very best of care. In order to maintain these high standards and indeed to improve on them, we need to continue to adequately resource maternity services.

The situation where termination of pregnancy or delivery of a very premature baby is required in order to avert a substantial threat to the life of the mother is rare, though these situations do occur.
The Heads of Bill provides a process that can be accessed for this rare clinical situation when there is a concern about maternal life. This process will then require underpinning with robust multidisciplinary guidelines from the Department of Health and HSE, input will be required from the Royal college of physicians, Royal college of surgeons, College of Psychiatrists of Ireland, college of anaesthetists of Ireland, Irish College of General Practitioners, an Bord Altranais, Irish Nurses and Midwives organisation to mention a few. Robust Medical council guidelines will also be required

At all times we remain acutely aware of the potential negative consequences for the unborn when cessation of pregnancy is necessary to protect maternal life. We highlight the fact that enormous additional challenges to clinical management arise when termination is being considered at gestations approaching foetal viability but still extreme prematurity. In current practice, all efforts are exhausted within medical margins of safety to prolong the pregnancy in the foetal interest.
Additionally once the baby reaches a stage when it can survive it is current practice that every effort is made to support the life of that baby after birth if medically appropriate.
We do not see this bill in any way providing for late terminations nor destruction of the baby, and our members would not support this.

These are complex difficult cases and a multidisciplinary team approach is required, however obstetricians who are the experienced clinicians in the care of pregnant women should be central to the assessment of sick pregnant women and to any decision making process when there is a substantial risk to the mother's life.

In this submission we represent the majority view within Obstetrics and Gynaecology in Ireland following a planned structured consultative process.
In preparation of this opinion on the Heads of Bill we used the content of our positional paper from Jan 2013 whose final text had been approved by the Institute of O+G and circulated to all our members.
Following request for an opinion on the protection of life during pregnancy bill an initial draft was considered and discussed in detail by the executive of the Institute and final text approved at a meeting on May 17th. The final version has been circulated to all members.
In addition direct contact was made with representatives from all maternity units for comments directly on this document. The response was overall supportive of the Institutes written submission.

Specific comments on the protection of life during pregnancy bill 2013
A number of areas requirement amendment and these are detailed below.

HEAD 1. INTERPRETATION

- We propose adding a definition for termination. When a real and substantive threat to the life of a pregnant woman occurs, the gestation at which the pregnancy is interrupted is the critical factor influencing outcome for the unborn. We suggest restricting the use of the term "Termination" to situations where there is no chance of survival after birth ie when a pregnancy is ended before a foetus is viable
- The definition of Obstetrician/Gynaecologist for pragmatic reasons will need to expand to include those acting in the role of consultant obstetrician & gynaecologist who may be on the "General" Medical Register rather than in the "specialist registration" division.
- All Government approved General Hospitals including the 19 maternity hospitals will need to be regarded as suitable venues to provide these procedures as necessary. Pregnant women with severe illness requiring specialised in-patient treatment are often cared for in a general hospital setting with access to coronary care and intensive care units, therefore general hospitals must be included.
- Failure to make the above two changes could result in delays in the access of life saving treatments during pregnancy.

HEAD 2. RISK OF LOSS OF LIFE FROM PHYSICAL ILLNESS, NOT BEING A RISK OF SELF DESTRUCTION.

- In non-emergency situations whatever the indication two obstetricians/gynaecologists must be involved in the decision making process; one Obstetrician would be required to examine the patient and sign the documentation, and the support of a second obstetrical opinion sought. In addition where the condition warrants ,but only then, other consultants on their own specialist register

HEAD3. RISK OF LOSS OF LIFE IN A MEDICAL EMERGENCY

- We accept that although consultation between two Obstetricians/Gynaecologists is desirable in the acute emergency case this may not always be possible and that a single opinion would be sufficient.

- It is the institutes view that emergency procedures should only be carried out in a hospital setting

HEAD4. RISK OF LOSS OF LIFE FROM SELF-DESTRUCTION
The institute of O+G does not differentiate in terms of logistical arrangements between physical or mental reasons for considering a termination. One Obstetrician would be required to examine the patient and sign the documentation, and the support of a second obstetrical opinion sought. We accept there is need for two psychiatrists however, as it will be their expertise that the obstetricians will rely on to determine whether suicide ideation is true intent and poses a real and substantive risk to the life of the woman.

Heads 6-11
We support the review process and would like to emphasise the importance of accurate documentation and of regular audit of cases

Head 12 conscientious objection
We endorse the current Medical Council Guidelines 10: 1-3. 2009 regarding the options and responsibilities for clinicians with a conscientious objection to participating in certain clinical treatments.

HEAD 14. REGULATIONS
The Institute of Obstetricians and Gynaecologists RCPI support the legislative option of Legislation plus regulations suggested by the Expert Group on the Judgment on A,B and C V Ireland. We believe this option best addresses the need to protect women as well as the Health Professionals involved. The Regulation aspect of this option should allow the necessary flexibility to incorporate future developments in best obstetric practice.
We ask the minister in developing Regulations with the Department of Health that they are initiated without delay so that robust safe guidelines of practice can be enacted promptly by the HSE on this issue. This will necessitate appropriate funding and infrastructure provision. Any changes in regulation should be put before the Oireachtas before enactment.

Our full opinion on the Heads of Bill is contained in the written submission from The Institute of Obstetricians & Gynaecologists, we would appreciate careful attention be paid to it.

Conclusion
In conclusion detailed multidisciplinary guidelines will be required, the location should include all government approved hospitals and the definition of Obstetrician & Gynaecologist expanded.

We are grateful for the opportunity to participate in this discussion. We request that obstetricians have input into the final wording, as we are the doctors most intimately connected with this issue and who will need to deliver the service.

AN OPINION ON THE PROTECTION OF LIFE DURING PREGNANCY (HEADS Of) BILL 2013
SUBMISSION BY
THE EXECUTIVE COMMITTEE OF THE INSTITUTE OF OBSTETRICIANS AND GYNAECOLOGISTS OF THE ROYAL COLLEGE OF PHYSICIANS OF IRELAND

1. INTRODUCTION. The Institute of Obstetricians and Gynaecologists (IOG) Royal College of Physicians of Ireland is the body that officially represents and advises on Obstetrical and Gynaecological opinion, professional standards, patient care, education and research in Ireland. As such the Institute and its members has a compelling interest in the contents of the final Bill. We have a responsibility to try to ensure that it will be the best way to protect women and health professionals and also allow for the necessary flexibility to cater for future advances in Obstetrics.
The IOG contributed by invitation to the debate on this issue to the Oireachtas Joint Committee on Health and Children Public Hearings following the publication of the Expert Group Report into matters relating to A, B, C vs. Ireland on 8th January 2013.We also met with the Department of Health and the Minister informally last week (26th April) and re-enforced this position. We note that we are also referred to in this Draft Heads of Bill a number of times.
As outlined above we feel it essential to make comment as invited by the Joint Committee on Health and Children in their email of the 2nd May on the text of Heads of the Protection of Life During Pregnancy Bill 2013. We would also be prepared to appear and discuss our submission with the Committee in Public Session at a future Committee meeting.
2. PRE-EVALUATION. The Protection of Life during Pregnancy (Heads of) Bill 2013 publication on 1st May was acknowledged by the Institute in a press release on 2nd May.
We will review this Bill carefully. Our intention is to make the conclusions of these deliberations known directly to the relevant forum of the legislature at the appropriate time. Our current stated position as presented to the Oireachtas Joint Committee on Health and Children in January 2013 remains unchanged.
3. MODUS OPERANDI. Because of the severe time constraints brought on by short notice a small group prepared an initial draft which was then considered by the whole of the executive at an emergency meeting and this final text approved.
We used the content of our positional paper (copy enclosed Appendix 1) for comparative purposes. Our discussions and this Text this reflects our considerations as requested on a Head by Head basis as set out in the document as published entitled "General Scheme of the Protection of Life During Pregnancy Bill 2013. Some of which we have linked together as necessary. Final conclusions and recommendations are drawn at the end.
4. COMMENTS ON CONTENT OF THE BILL.p1-33.
4.1. THE REPORT IN GENERAL. The comprehensive nature of the content was acknowledged. It was found to be very readable but complex with interlinking Heads. We have to say that the very short time given to prepare a majority consensus submission of Institute Members on such an important issue created unfair albeit not insurmountable difficulties.
4.2. HEAD 1. INTERPRETATION. P3-5.
We comment on three issues. One is adding a definition, the latter two relate to situational changes to what is established practice already currently in place.
4.2.1. Termination
When a real and substantive threat to the life of a pregnant woman occurs, the gestation at which the pregnancy is interrupted is the critical factor influencing outcome for the unborn.

We suggest restricting the use of the term "Termination" to situations where there is no chance of survival after birth ie when a pregnancy is ended before a foetus is viable.

4.2.2. Obstetrician/Gynaecologist.p3

Our stated position on this issue in terms of the Qualifications of doctors involved was that they should be "Consultants on the Specialist register". However it is inevitable that sometimes the Obstetricians involved may instead be on the General Register.

We therefore suggest a pragmatic change of definition of Obstetrician/Gynaecologist to be used as necessary through-out the text of all the Heads where the term Obstetrician/Gynaecologist is used that reflects reality:-

"Obstetrician/Gynaecologist" means a medical practitioner who is registered in the specialist Division of the register of Medical Practitioners established under section 43(2) (b) of the Medical Practitioners act 2007 under obstetrics and gynaecology or, if on the general medical council register, is acting in the role of Consultant Obstetrician/Gynaecologist at the time of specific need when a termination of pregnancy needs to be contemplated.

4.2.3. Appropriate Location.p3-4 The Institute opinion on this subject continues to be that "all public General Hospitals including public maternity units and not just the 19 providing obstetrical services should participate in providing these procedures as necessary." The Private Maternity facility in Mount Carmel Hospital Dublin and other such private institutions delivering in-patient maternity care also needs to be included in this regard. Pregnant women with severe illness requiring specialised in-patient treatment are often cared for in a general hospital setting with access to coronary care or intensive care units. To have to transfer them to an obstetric facility for termination would not be medically safe. We feel strongly that the statement (Para3 p4) "The Relevant medical treatment, therefore may only be provided in public obstetric units except in emergencies …" is insufficient and needs revision along the lines we suggest so that all Public General Hospitals and public maternity units are included. This would then acknowledge clearly what the situation is in reality and ensure greater patient safety. The vague "except in emergencies "in our opinion is insufficient.

In addition we feel comment on the neonatal facilities should form part of this section. Again we use our previous comments: - "Where the need for a neonatal input is anticipated due to potentially viable gestational age but is not on-site, provided that the women's health allows, in-uteri transfer pre-delivery to a unit that has the appropriate facilities should be considered"

4.2.4. Explanatory Notes –Reasonable opinion p5.

We feel that the first sentence "The Bill provides that terminations permitted under the Bill may only be carried out by registered medical practitioners" should have added to it:-in accordance with approved HSE guidelines.

Referral pathways for termination of pregnancy will need to be delineated through the development of HSE guidelines.

4.3. HEAD 2. RISK OF LOSS FROM PHYSICAL ILLNESS, NOT BEING A RISK OF SELF DESTRUCTION p6-8.

We comment on two issues

4.3.1. Number of Medical Practitioners. p6. (sec2)

Our original opinion in this area was for two consultant specialist registered Obstetricians and Gynaecologists plus where the condition warrants ,but only then ,other consultants on their own specialist register. (see also definition change ss4.2.1.)

We feel that this should still be the case in terms of Head 2. Although we accept that only one Obstetrician is needed to examine the patient and sign the documentation best current practice dictates that the support of a second obstetrical opinion should be sought.

4.3.2. Explanatory Notes p6

We assume typographical error and that these relate to head 2 not 3 as stated.

Under sub head 2 (last line p6) we wish the sentence to read: - the procedure is undertaken by a registered medical practitioner...in accordance with HSE guidelines.
Sec3 para 6 should read The Institute of Obstetricians and Gynaecologists.
4.3.3 Page 8 Para 4 We feel this should read "in circumstances where the unborn may be potentially viable outside the womb, doctors would make all efforts to sustain its life after delivery if medically appropriate". However .... stays as is.
4.4. HEAD3. RISK OF LIFE IN A MEDICAL EMERGENCY P9
We have two comments.
4.4.1. Medical Emergencies.p9
In our past submission on the Medical Emergency situation, our position was that there should be "no special provisions. Use established clinical practice."
We accept that although consultation between two Obstetricians/Gynaecologists is desirable in the acute emergency case this may not always be possible and that a single opinion would be sufficient.
It should be noted that In terms Section 1(a) ie carrying out the Termination as apposed to making the decision, a doctor other than that described in our definition of Obstetrician/Gynaecologist may be involved such as a doctor still in training in Obstetrics and Gynaecology.
4.4.2 Explanatory Notes p9 Final paragraph Line 3 "health facility"
We suggest this be replaced by "general hospital or maternity unit" as these emergency procedures should be carried out in a hospital setting but this may be at a hospital not covered as an appropriate location under the Bill.
4.5. HEAD4. RISK OF LOSS OF LIFE FROM SELF-DESTRUCTION.p9-11
We favour the term suicide rather than self-destruction.
The need for two Obstetricians and Gynaecologists as we define them (ss 4.2.1) to be involved remains our position for best practice, one obstetrician required to examine the patient and sign the documentation and, the support of a second obstetrical opinion sought.
We accept there is need for two psychiatrists however, as it will be their expertise that the obstetricians will rely on to determine whether suicide ideation is true intent and poses a real and substantive risk to the life of the woman. In our view, whatever the reason, physical or mental for considering a termination the same logistical arrangements should be in place.

4.6. HEAD 5. MEDICAL OPINION TO BE IN THE FORM AND MANNER PRESCRIBED BY THE MINISTER p13
We comment only of the need to put in place, via the HSE, funding for the considerable support, medical and administrator that will undoubtedly be needed to implement and ensure the running of the service that is envisaged and depicted here and in Heads 7-11.

4.7 HEAD 6. FORMAL MEDICAL REVIEW PROCEDURES P14-16
HEAD7. REVIEW WHERE RISK ARISES FROM PHYSICAL ILLNESS, NOT BEING A RISK
OF SELF-DESTRUCTION p17 (see also 4.5)

HEAD 8.REVIEW IN CASE OF RISK OF LOSS OF LIFE THROUGH SELF DESTRUCTIONp18 (see also 4.5)
4.8. HEAD 9. GENERAL PROVISIONS FOR COMMITTEE p20
Although discussed separately we have drawn these four Heads together as they appear to us to address a common theme: - Appeal Mechanism...
The contents concur with our own position.

In terms of the composition of the review panel we say: - All appropriate specialities are to source and provide from within their own appropriately qualified ranks consultant volunteers practicing in Ireland to form a panel that can be called on for a second opinion. There should be a minimum of 2 obstetricians/Gynaecologists plus other specialties similarly qualified as appropriate. In obstetrics and Gynaecology the Institute would act as list provider. The Convenor would be a nominated person in the DOH/HSE to whom the woman can access directly who would then be fully responsible to convene the appropriately constituted panel from the lists supplied already by the professional bodies.
We also made comment that the Panel should have" formal access to legal expertise, that the chair could be recruited from the medical or legal professions". These we feel should be reintroduced into the appropriate sections of the final Bill as should the statement that" the Panel should be indemnified against possible legal proceedings"
Germane to this issue, in light of the threat of proceedings being taken and a summary conviction on a failure or refusal to attend or send documentation when so requested HEAD 9 (p20 s4) we would ask at least that section a if it applies to a panel member (it is not clear who) to be removed as all are Volunteers.
Finally in this section we acknowledged as we assume the final bill will of a final appeal via the courts.
As previously stated (ss4.5) we see no need to differentiate between HEADS 7 p17 and 8 p18.

4.9. HEAD10. FORMAL MEDICAL REVIEW REPORTS TO MINISTER>p21

HEAD11. NOTIFICATIONS.p22
We have linked these two Heads together. We previously stated before under a section in the expert report entitled Monitoring System/Monitoring Review Panel that we "Felt this aspect of the provisions and working of the act "important especially as trends may develop in indications, for terminations which may need close monitoring and review. Anonymity must be preserved on both sides. However we feel that this can be achieved and we urge the generation of meaningful annual statistics'. These we feel can and should still be generated without contravention of the FOI act 1997 which we agree should apply.
Proper documentation and data collection is essential. There is also the need for a review system to be put in place and run by the HSE that is user friendly and fully and adequately staffed and funded. (See ss4.6 comment).

4.10. HEAD12.CONSCIENCIOUS OBJECTION p23-4.
We endorse the current Medical Council Guidelines 10: 1-3. 2009 regarding the options and responsibilities for clinicians with a conscientious objection to participating in certain clinical treatments.

4.11. HEAD 13. TRAVEL AND INFORMATION, p25
No comment

4.12. HEAD 14. REGULATIONS p26
The Institute of Obstetricians and Gynaecologists RCPI support the legislative option of Legislation plus regulations suggested by the Expert Group on the Judgment on A,B and C V Ireland. We believe this option best addresses the need to protect women as well as the Health Professionals involved. The Regulation aspect of this option should allow the necessary flexibility to incorporate future developments in best obstetric practice.

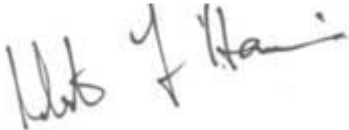
Our views on the proposed Legislation are stated in this document. We ask the minister in developing Regulations with the Department of Health that they are initiated without delay so that robust safe guidelines of practice can be enacted promptly by the HSE on this issue. This will necessitate appropriate funding and infrastructure provision.
Any changes in regulation should be put before the Oireachtas before enactment.

4.13. HEAD 15. p27 HEAD 16 p28, HEAD 17.p29
No Further comment needed.

4.14. HEAD 18.REPEAL AND CONSEQUENTIAL AMENDMENTS p30
HEAD 19. OFFENCE p31-2
Our opinion is to favour repeal of the 1861 act and full replacement. We applaud HEADS 18-19 in this. In terms of HEADS 19 this is the act that it is suggested replaces HEAD 18. We have no legal expertise to comment. We however feel it wise and are reserving the right on behalf of our Membership to seek counsel's opinion on this issue before making any (if any) comment.

HEAD 20. COMMENT
No Comment is needed.

5. CONCLUSIONS.
The Institute of Obstetricians and Gynaecologists as a corporate body acknowledges the need for the action that is to be taken to help "Protect Life during Pregnancy". We have indicated a number of areas in the HEADS that we feel need change if, as Obstetricians and Gynaecologists we are not to be handicapped in ensuring as much as is possible the safety of all the pregnant women who we will be serving in the future.
As obstetricians we are expected to practise evidence based interventions and first and foremost do no harm. This legislation should help to provide clarity and reassurance to professionals and patients alike. However, to enact and underpin the idea that termination of pregnancy is a solution or a treatment for a patient at risk of committing suicide when there is at present a lack of evidence to support that intervention, does create a dilemma for our profession.
Additionally, at all times we remain acutely aware of the potential negative consequences for the unborn when cessation of pregnancy is necessary to protect maternal life. We highlight the fact that enormous additional challenges to the clinical management plan arise when termination is being considered at gestations approaching foetal viability but still extreme prematurity. In current practice, all efforts are exhausted within medical margins of safety to prolong the pregnancy in the foetal interest.
We submit that on the basis of this report, that more dialogue is needed and our further advice sought before the bill is finalised as we are the doctors most intimately connected with this issue and who will need to deliver the service.



ROBERT F HARRISON.MA.MD.DSC.FRCS(ED).FRCOG.FRCP(I).DCH.
INSTITUTE CHAIRMAN.
WEDNESDAY 8 MAY 2013

APPENDIX 1

AN OPINION ON THE REPORT OF THE GOVERNMENT COMMISSIONED EXPERT GROUP ON THE JUDGMENT IN A, B AND C v IRELAND BY THE EXECUTIVE OF THE INSTITUTE OF OBSTETRICIANS AND GYNAECOLOGISTS OF THE ROYAL COLLEGE OF PHYSICIANS OF IRELAND,

1. BACKGROUND. This report was published by government 27th Nov 2012.
The Terms of Reference *were "To examine the Judgement in A, B and C versus Ireland of the European Court of Human Rights. Secondly, to elucidate its implications for the provision of health care services to pregnant women in Ireland. Thirdly, to recommend a series of options on how to implement the judgment taking into account the constitutional, legal, medical, and ethical considerations involved in the formulation of public policy in this area and the over-riding need for speedy action."*
The contents of any report on abortion (Termination of Pregnancy) and recommendations as to future practice in this area are of obvious concern to practicing obstetricians and Gynaecologists and the patients they serve.
The Institute are the body that officially represents Obstetrical and Gynaecological opinion in Ireland, acts as the advisory body and strives to promote excellence in the area of patient care and professional standards.
Therefore, while acknowledging the right of individual members to have their own opinions on this issue, it was felt important that the Institute as a corporate whole (the Executive) should examine the report in depth and come to an opinion on the contents as it has the potential to affect their practice, mindful of the patients they serve.

2. MODUS OPERANDI. Following Consultation with others, on 28TH Nov the Institute issued an initial statement following the Report release as follows:-
"Maternal health services in Ireland are amongst the best in the world and pregnant women and their families should be reassured that they are receiving the very best of care during pregnancy.
We are currently reviewing the expert Group report on the Judgment in A, B and C v Ireland and are consulting with our members on its findings and recommendations.
We are also awaiting the Government's response to this report. It is important, from the perspectives of mothers and the medical profession, to clarify what intervention in pregnancy, including termination of pregnancy is permitted if a mother's life is in danger. This important issue requires the utmost care and sensitivity."
I as Chairman of the Institute, again with advice of other committee members, convened a meeting for 4th December 2012 at the Royal College of Physicians of Ireland (RCPI) to discuss the Report. Members of the Institute Standing Committee and other Institute members, representative of differing parts of the country were invited.
Copies of the report were made available to allow fully informed discussion and decision making on the salient points relevant to Obstetrical practice. This meant in reality an agenda set primarily on consideration of the alternatives for practice and legislation contained in Chapter 6*, Procedures for determining entitlement and access to TOP* and Chapter7 *Options for Implementation.* A draft document on these key aspects of the report was prepared from the deliberations for consideration by the Institute Executive Council. The final document outlining our response to the expert group report was agreed unanimously at the meeting of the Institute Executive on December 14th 2012.

3. ACCOUNT OF THE MEETING.12 of the invitees attended. I acted as chair and Rapporteur.

3.1. AIM The aim of the Meeting to prepare a document for the Executive of the Institute to consider was agreed.
It was agreed, that while the focus of the Expert report was narrow, we would confine our findings solely to those contained in the report itself pertaining to our practice and patients. However, we have recorded opinions on legal issues, such the need to repeal the 1861"Offenses Against the Person Act" so that the possibility of the doctor or patient being convicted of a felony is eliminated. (Expert Report ss.3.1.1: 7.7.4)

3.2. THE REPORT IN GENERAL. The Timeliness of its appearance, the comprehensive nature and readability of the report as a whole were acknowledged and commended by all.

3.3. THE INITIAL CHAPTERS. The usefulness of chapters 1-3 in setting-out the chronology of the law and initiatives taken at various times since 1861 to date on this issue was thought very helpful and salutary in terms of lessons to be learned by those who govern us.
Chapter 4 discusses the European case and legal implications. The need for action and the state's obligations in this regard were made very plain to see.
In Chapter 5 the principles for implementation of the A, B, C judgments were stated. We all agreed it is the duty of the government to respond to the European court.

3.4. CHAPTER 6. This was discussed in chronological order.' ss' alludes to each specific procedural option as in the report text (ss 6.1-10). Decisions as to the group's opinion on each were considered from the alternatives set out in the document or our own alternative as formulated at the meeting (depicted in italics). From now on in this account of what happened, our written opinions follow the questions being asked. All decisions were unanimous.

ss.6.2 Test to Be Applied?
This can only be an expeditious Medical Decision with the appropriate documentation.

ss.6.3 Qualifications of Doctors involved?
Consultant on the Specialist Register (strengthening option 2)

ss.6.4.1-4 Number and Role of Doctors > Number Options and Branches of Medicine?
Two consultant specialist registered Obstetricians/Gynaecologists plus where the condition under review warrants, but only then, other consultants on their own specialist register as a team assessment.

ss.6.5 Emergencies?
Option2. No special provisions. Use established clinical practice, (This answer links with ss. 6.6).

ss.6.6 Locations?
The considerations listed were acknowledged but, it was considered that all General Hospitals and, not just recognised maternity units should participate in providing these procedures as necessary. Where the need for a neonatal input is anticipated due to

potentially viable gestational age but is not on-site, provided that the woman's health allows, in-utero transfer pre-delivery to a unit that has the appropriate facilities should be considered. This is the established practice already currently in place.

ss.6.7.1-3 Formal Review Process?
Option 1. Medical Model at the woman's request by her or another person acting on her behalf.

ss.6.7.4 Composition of review panel?
All appropriate specialties are to source and provide from within their appropriately qualified ranks (ss 6.3) consultant volunteers practicing in Ireland to form a panel that can be called upon for a second opinion. There should be as per ss 6.4 a minimum of 2 obstetricians/gynaecologists plus other specialities similarly qualified as appropriate. In Obstetrics and Gynaecology the Institute would Act as list provider. This panel should be indemnified against possible subsequent legal proceedings and should have Formal Access to Legal Expertise (option 2). *The chair could be recruited from the medical or legal professions.*

ss.6.7.5 Convenor?
A nominated person/Department in the Department of Health to whom the woman can access directly would then convene the panel from the lists supplied by the professional bodies.

ss.6.8 -6.9 Access to Courts for appeals and Conscientious objection?
These were acknowledged as read. In the latter case it was noted that this may extend to other Health Professionals.

ss.6.10 Monitoring System/Monitoring Review Panel.
This was felt important especially as trends may develop in indications for TOP's which may need close monitoring and review. Anonymity must be preserved on both sides.

3.5. CHAPTER 7.IMPLEMENTATION? We agree statutory legal protection is needed.
ss.7.2-7.4.3 Alternatives for Implementation?
We felt this section was more in the province of the lawmakers than Institute members. Nevertheless, of the 4 alternatives put forward, we felt that the one which best fitted the need to protect women and the Health Professionals involved was Option 7.4.3. Legislation plus Regulations.
This we felt also could provide the necessary flexibility to cater for the possibility that there will be future improvements in obstetric practice which will need to be factored in to whatever method is chosen to achieve legal clarity.

7.4.4 New Legislation or Amendment of the 1861Act?
As previously stated (ss. 4.1) we favour Repeal. We bow to the superior knowledge of our law colleagues' opinions in this matter who will be advising the government on this but, unless we have misinterpreted the trend of the argument expressed in the Report, the Review report itself seems to make a stronger case for Choice 1 a Repeal of 1861 act and a full Replacement of the Law on Abortion rather than choice 2:- Retention and amendment by legislation provided by the X case.

Opening Statement from the Irish College of General Practitioners to the Oireachtas Joint Committee on Health and Children on the General Scheme of the Protection of Life during Pregnancy Bill 2013

Deputy Buttimer, Members of the Joint Committee on Health and Children, Ladies and Gentlemen I would like to thank you for your invitation to the Irish College of General Practitioners to present on the Protection of Life during Pregnancy Bill. This is an extremely important piece of legislation and the college welcomes the opportunity to be involved in the legislative discussions. The General Practitioner has a key role in supporting women during pregnancy.

By way of introduction I am a General Practitioner and Medical Director of the Irish College of General Practitioners.

Established in 1984, The Irish College of General Practitioners (ICGP) is responsible for post graduate specialist medical education, training and research in the specialty of General Practice. The ICGP also provides an extensive range of practice management services focussed on the effective organisation of General Practice. The College has a national advisory role in relation to clinical standards and interacts regularly with a number of bodies including the Medical Council, Department of Health and Children, the Health Service Executive and the Health Information & Quality Authority amongst others. As a membership organisation the ICGP is responsible for providing continuing medical education (CME) for established GPs numbering over 2,500 at present.

The mission of the ICGP is to serve the patient, and its members / general practitioners by encouraging and maintaining the highest standards of general medical practice.

The core values of the College are quality, equity, access and service to the patient.

The ICGP has provided guidance for its members on the management of Crisis Pregnancy since 1995 and the latest guidance is available on open access on the ICGP Website.

In the vast majority of cases, a termination of pregnancy is a decision taken as a last resort and in great distress. The college believes that the structures, resources and systems to support women during a crisis pregnancy should be enhanced.

There is a need to improve access to social supports, counselling and psychology services. Peri-natal psychiatry should be a priority for government in supporting women in crisis pregnancy.

The GP is usually the first point of contact a pregnant woman has with the health service. The General Practitioner has a key role in supporting women during pregnancy. All pregnant women are entitled to free antenatal care under the Mother and Infant Scheme.

Current obstetric practice does not place a patient in the care of an obstetrician until 16 to 20 weeks gestation. GP care is immediately available to every pregnant woman and GPs routinely play a supportive role to women through the provision of antenatal and post natal care. The GP has knowledge of the woman's past medical and psychological health and of her social supports. In many instances this knowledge extends over a number of years. GPs view every patient as an individual and care for them in their unique circumstances. Therefore the GP has a vital role in the assessment of risk.

This role is supported by the Expert Group's Report which suggested that "it may be appropriate that GPs are consulted as a matter of best practice in the course of the diagnostic process. This would provide access to their knowledge of the patient and establish continuity of care for the woman after the treatment has been delivered".

Consultation with her GP should take place only with the woman's consent and the importance of confidentiality should be emphasised in all aspects of the Bill. The current Heads of Bill could be strengthened in this regard. The legislation should not be enacted until a specific, well defined referral pathway is in place with appropriate professional support. GPs will usually be the first person that a woman with a crisis pregnancy presents to and will need to know exactly how to refer the woman in a timely manner.

The GP has an important ongoing role as patient advocate and in providing non-judgemental support to women who have been involved in this process – whether or not they have had a termination.

The ICGP recommend that the Department of Health commission an independent guideline consortium to develop evidence-based national clinical guidelines to underpin implementation of the legislation. Following the guidance provided by the National Clinical Effectiveness Committee this process should involve healthcare professionals and patients in the guideline development process and employ internationally agreed standards of guideline development methodology. The ICGP has experience in this area and is willing to take an active role in the development of these guidelines.

Dr Margaret O'Riordan

Medical Director ICGP

Submission from the Irish College of General Practitioners to the Oireachtas Joint Committee on Health and Children on the General Scheme of the Protection of Life during Pregnancy Bill 2013

Introduction

Established in 1984, The Irish College of General Practitioners (ICGP) is responsible for post graduate specialist medical education, training and research in the specialty of General Practice. The ICGP also provides an extensive range of practice management services focussed on the effective organisation of General Practice. The College has a national advisory role in relation to clinical standards and interacts regularly with a number of bodies including the Medical Council, Department of Health and Children, the Health Service Executive and the Health Information & Quality Authority amongst others. As a membership organisation the ICGP is responsible for providing continuing medical education (CME) for established GPs numbering over 2,500 at present.

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The ICGP has provided guidance for its members on the management of Crisis Pregnancy since 1995. The latest guidance can be accessed at www.icgp.ie
(http://www.icgp.ie/library_catalogue/index.cfm/id/134924/event/catalogue.item.view.html)

Summary of recommendations

In the vast majority of cases, a termination of pregnancy is a decision taken as a last resort and often in great distress. The college believes that the structures, resources and systems to support women during a crisis pregnancy should be enhanced. There is a need to improve access to social supports, counselling and psychology services. Peri-natal psychiatry should be a priority for government in supporting women in crisis pregnancy.

The GP is usually the first point of contact a pregnant woman has with the health service. The General Practitioner has a key role in supporting women

during pregnancy. All pregnant women are entitled to free antenatal care under the Mother and Infant Scheme.

Current obstetric practice does not place a patient in the care of an obstetrician until 16 to 20 weeks gestation. GP care is immediately available to every pregnant woman and GPs routinely play a supportive role to women through the provision of antenatal and post natal care. The GP has knowledge of the woman's past medical and psychological health and of her social supports. In many instances this knowledge extends over a number of years. GPs view every patient as an individual and care for them in their unique circumstances. Therefore the GP has a vital role in the assessment of risk. This is supported by the Expert Group's Report which suggested that "it may be appropriate that GPs are consulted as a matter of best practice in the course of the diagnostic process. This would provide access to their knowledge of the patient and establish continuity of care for the woman after the treatment has been delivered".

Consultation with her GP should take place with the woman's consent and the importance of confidentiality should be emphasised in all aspects of the Bill.
The legislation should not be enacted until a specific, well defined referral pathway is in place with appropriate professional support. GPs will usually be the first person that a woman with a crisis pregnancy presents to and will need to know exactly how to refer the woman in a timely manner.

The GP has an important ongoing role as patient advocate and in providing non-judgemental support to women who have been involved in this process – whether or not they have had a termination.

The ICGP recommend that the Department of Health commission an independent guideline consortium to develop evidence-based national clinical guidelines to underpin implementation of the legislation. Following the guidance provided by the National Clinical Effectiveness Committee this process should involve healthcare professionals and patients in the guideline development process and employ internationally agreed standards of guideline development methodology. The ICGP has experience in this area and is willing to take an active role in the development of these guidelines.

Comments on specific heads of the bill

Head 2: Risk of loss of life from physical illness

Head 2 recommends that hospital specialists "*shall consult with a woman's general practitioner where practicable".*
The details of the consultation are not clear and raise concerns about patient autonomy and confidentiality as to whether a consultant can request information from a GP without the patients consent. For instance the GP may not be aware that the patient is pregnant. The GP would need to see the patient in order to form an opinion.

Head 4: Risk of loss of life from self-destruction

Head 4 specifies that the decision requires an obstetrician, two psychiatrists and consultation with GP. GPs have expertise in assessing suicidal intent and will have prior knowledge of the patient and their background including supports. The GP can assist in the decision making process.

Page 11 The bill does not specify that the three doctors examine the woman together or that they examine the woman at the same location, it is expected that …….

The practicality of organising an appointment for the woman with three different doctors merits consideration. The practicalities of setting up these interviews in a local hospital and keeping the reason for the appointments confidential should also be considered.

Page 11 *It was not felt desirable to provide in legislation for a specific referral pathway.*

The legislation should not be enacted until a specific, well defined referral pathway is in place with appropriate professional support. GPs will usually be the first person that a woman with a crisis pregnancy presents to and will need to know exactly how to refer the woman in a timely manner.

GP should be consulted as a matter of best practice

Possibly need to add in here to the sentence *GP should be consulted as a matter of best practice, with the woman's consent.*

Head 6: Formal medical review procedures

Head 6 refers to the review process of decisions to refuse a termination. It may be appropriate to include the GP at this stage if he/she has not been part of the initial decision making process.

Page 14 . A pregnant woman ……may apply in writing to the HSE..to have her case reviewed..

This will be very difficult for a woman with poor literacy skills.

Who is this letter sent to and how can the HSE ensure that her letter will be dealt with confidentially?

Page 14. *The executive shall establish and maintain a panel of medical practitioners*

There should be a nominee from the ICGP included here.

The executive shall appoint or authorise one or more of its employees

There are serious concerns about confidentiality in this review panel. The very nature of applying for review means that the administrative staff involved in receiving the letter, setting up the review panel and corresponding with the doctors and the patient will have access to very sensitive patient information.

Page 14 ……*the outcome of the committee's review shall be given to*

a. *The woman…*
b. *The executive.*

Again issues of confidentiality need to be addressed here. Will the woman's GP be informed of the outcome with her consent? What supports will be put in place for the woman afterwards?

Page 15 …..*guarantee to a pregnant woman at least the possibility to be heard in person*
Does this mean the woman will be interviewed by the review panel? This would be a daunting process for a patient and would discriminate against those with poor social skills and low educational attainment.

Head 7: Review in physical illness matters

The woman's GP may be able to contribute an informed medical opinion to the obstetrician/gynaecologist on the patient's current physical illness and therefore should also be included in this head.

Head 12: Conscientious Objection

According to Irish Medical Council Guidelines doctors may have conscientious objections but must refer to another doctor who may provide the service. How will doctors who are willing to refer patients requesting a termination in these circumstances be identified?

Submitted on behalf of the Irish College of General Practitioners by Dr Mary Sheehan Chairman, Dr Seamus Cryan President and Professor Bill Shannon Immediate Past President.

Medical Council Presentation to the Joint Committee on Health and Children on the Protection of Life During Pregnancy (Heads of) Bill 2013.

Professor Kieran Murphy, President, Medical Council

Chairman and members, on behalf of the Medical Council, I welcome the opportunity to provide the Joint Committee on Health and Children with views to assist the Committee in formulating its report to Government on the Protection of Life During Pregnancy (Heads of) Bill 2013.

As you know, the Medical Council is the statutory body responsible for the regulation of doctors in Ireland. Its purpose is to protect the public by promoting and ensuring the highest standards among doctors.

In the interests of patient safety and the protection of the public, the Council has been vested by the Oireachtas with responsibility to ensure that only those doctors with the necessary education, training and skills are registered to practise in Ireland. The Council also specifies standards of practice for doctors in the areas of professional conduct and ethics.

The Medical Council provides principles based guidance to doctors on matters relating to conduct and ethics through its Guide to Professional Conduct and Ethics for Registered Medical Practitioners. The seventh edition of the Guide was published in 2009 following extensive consultation with doctors, the general public, medical schools, postgraduate medical training bodies, government departments, employers and a range of other stakeholders.

Doctors are expected to adhere to the Council's Guide in their professional practice. However, it is important to note that the Medical Council's Guide is <u>not</u> a legal code. In drafting its ethical guidance, the Council seeks to incorporate and reference relevant legislation in order to ensure doctors are aware of the legal framework within which they operate.

This Guide is a principles based document, which must be relevant to each of the approximately 18,000 doctors registered to practise in Ireland regardless of their speciality, interest or discipline. It covers issues as diverse as consent,

confidentiality, end-of-life care, advertising, clinical trials, prescribing practices and referral of patients. It has been designed to support doctors in decision-making regarding conduct and ethics and to complement other sources of clinical guidance developed by professional bodies, expert groups, the HSE and others.

The Council's guidance provides the principles which are the cornerstone of each doctor's practice. It is then the role of expert bodies and employers to devise procedures and protocols for use by doctors at practice level.

In relation to the Protection of Life During Pregnancy (Heads of) Bill 2013.

The Medical Council makes the following general comments in relation to certain matters arising in the Bill that, in the view of the Council, need to be provided for either in primary legislation or regulations.

- The Medical Council is of the opinion that the process underlying the certification of the decision regarding termination of pregnancy should be the same for grounds of risk of loss of life from physical illness and risk of loss of life from self-destruction. Accordingly, the Council is of the opinion that Head 2 and Head 4 should be merged into a single Head.

- In circumstances where the pregnant woman's capacity to consent is or may be impaired, the Council believes it is not clear from the draft Heads how a decision regarding termination of pregnancy will be made and how the woman will be enabled and supported to participate in this decision.

- The opinions of all registered medical practitioners certifying a procedure that will end unborn human life must be recorded in writing.

- The Council expresses concern about the ability of the pregnant woman to access treatment by the required registered medical practitioners as currently outlined under Heads 2 and 4 in all areas of the country.

- Processes for a monitoring system should incorporate appropriate requirements to preserve the confidentiality of the patient and the certifying practitioners.

Processes for an appeal mechanism either by way of High Court Appeal or Judicial Review should be incorporated where the pregnant woman is not satisfied with the decision.

The Council provides the following responses in relation to the Heads. Given time constraints today, I will provide an overview of the main points contained in the Council's submission.

In regard to Head 1 the Medical Council has no specific comment to make on these provisions. Council is of the view that it is in the public interest that doctors have legal clarity when making clinical decisions.

In regard to Head 2, the Medical Council is of the opinion that: Head 2 should be merged with Head 4 into a single head.

The text in subhead 1(a) should be amended to read: "that procedure is carried out by a registered medical practitioner registered <u>in the Specialist Division</u> in the relevant specialty at an appropriate location" to ensure the registered medical practitioner has completed specialist training recognised by the Council.

The text in subhead 1(b) should be amended to read: "two medical practitioners, registered on the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007 under a relevant specialty, have, in accordance with this head, jointly certified in good faith that –

(i) There is a real and substantial risk of loss of the pregnant woman's life ,

and

(ii) In their reasonable opinion this risk can be averted only by that medical procedure

The amended subhead 1(b) thereby renders subhead (2) redundant.

Where the clinical decision is made to proceed with a termination of pregnancy, if neither of these registered medical practitioners is an

obstetrician, at least one of the two registered medical practitioners shall then consult with an obstetrician employed at the appropriate location.

In regard to Head 3, the Medical Council is of the opinion that:

The text in subhead 1 (a) should be amended to read "registered medical practitioner" to ensure it defines a medical practitioner who is registered with the Medical Council.

The text in subhead 1 (b) should be amended to read "immediate real and substantial risk" in line with drafting in other Heads.

The text in subhead 1 should be amended to include a provision that, in forming his/her opinion, the registered medical practitioner should consult with another registered medical practitioner, where practicable.

In regard to Head 4, the Medical Council is of the opinion that:

Head 4 should be merged with Head 2 into a single head.

The text in subhead 1(a) should be amended to specify that the procedure should be undertaken by a registered medical practitioner registered in the Specialist Division in the relevant specialty.

The text in subhead 1(b) should be amended to read: "two psychiatrists, have, in accordance with this head, jointly certified in good faith that –

(i) There is a real and substantial risk of loss of the pregnant woman's life by way of self-destruction, and
(ii) In their reasonable opinion this risk can be averted only by that medical procedure

Where the clinical decision is made to proceed with a termination of pregnancy, at least one of the two certifying psychiatrists shall then consult with an obstetrician employed at the appropriate location.

Not all psychiatrists work in centres registered by the Mental Health Commission, as referenced in subhead 1 (b).

It is not clear why one of the certifying psychiatrists must be attached to a location where such a procedure is carried out. The majority of psychiatrists are not attached to such institutions.

In regard to Head 5, the Medical Council is of the opinion that the formal framework developed to record a medical opinion should be:

- Independent
- Accessible
- Transparent
- Timely, and
- Preserve the confidentiality of the pregnant woman

In regard to Head 6, the Medical Council is of the opinion that:

The text in subhead 1 should be amended to read "registered medical practitioner" rather than "medical practitioner."

Subhead 1 does not make clear which registered medical practitioner is vested with the duty to inform the woman of the formal review option.

Criteria in subhead 1 have not been set out to ensure that information is conveyed to the woman in an effective, accessible and timely manner.

A time frame has not been set out in subhead 7 for notification to the woman who made the application and, if applicable, the person who made the application on her behalf and the Executive regarding the outcome of the committee's review.

The Council is of the view that subheadings 5 – 6 are not necessary as these provisions are adequately covered under Heads 7 & 8.

In regard to Head 7, the Medical Council is of the opinion that:

Reflecting the Council's recommendation that Heads 2 and 4 be merged, the Medical Council is of the opinion that Head 7 and Head 8 should also be merged and the processes from Head 8 adopted in the legislation.

The text in subhead 1 should be amended to read: "in the case of a pregnant woman who believes there may be a real and substantial risk of loss of her life, a committee established by an authorised person shall consist of two medical practitioners registered on the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007 under a relevant speciality.

The text in subhead 1 should be further amended to include an additional sentence: "Where the clinical decision is made to proceed with a termination of pregnancy, if neither of these registered medical practitioners is an obstetrician, at least one of the two registered medical practitioners shall then consult with an obstetrician employed at the appropriate location."

A time frame has not been set out in subhead 4 for notification to the woman who made the application and, if applicable, the person who made the application on her behalf and the Executive of the outcome of the committee's review.

The text in subhead 6 should be amended to read: "The procedures set out in this Head are without prejudice to Head 3, which shall apply where there is an immediate risk of loss of the life of the pregnant woman, and therefore the provision of Head 3 shall apply irrespective of review procedures which are in train".

In regard to Head 8 specifically, the Medical Council is of the opinion that:

The text in subhead (1) should be amended to read: "in the case of a pregnant woman who believes there may be a real and substantial risk of loss of her life, a committee established by an authorised person shall consist of two medical practitioners registered on the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007 under a relevant speciality.

The text in subhead (3) should be amended to include a further sentence: "Where the clinical decision is made to proceed with a termination of pregnancy, if neither of these registered medical practitioners is an obstetrician, at least one of the two registered medical practitioners shall then consult with an obstetrician employed at the appropriate location.

It is not clear in subhead (1) why one of the certifying psychiatrists must be attached to a location where such a procedure is carried out. The majority of psychiatrists are not attached to such institutions.

As referenced in our submission on Head 7, there is no time limit set in subhead (4) for notification to the woman who made the application and if applicable the person who made the application on her behalf and the Executive of the outcome of the committee's review.

In regard to Head 9, the opinion of the Medical Council is that the text in subheads (1) and (2) should be amended to read "registered medical practitioner" rather than "medical practitioner"

A subhead should be inserted to enable the committee to have access to legal expertise on a formal basis.

In regard to Head 10, the Medical Council is of the opinion that the formal framework developed to support the collation of information on the workings of the formal medical review process should be:

- Independent
- Accessible
- Transparent
- Timely, and;
- Preserve the confidentiality of the pregnant woman.

In regard to Head 12, the Medical Council is of the opinion that:

Subheads (1) and (4): are largely consistent with the Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners (2009) which states:

> *10.1 'As a doctor you must not allow your personal moral standards to influence your treatment of patients'.*
>
> *10.2 'If you have a conscientious objection to a course of action, you should explain this to the patient and make the names of other doctors available to them'.*

The Medical Council suggests that Head 12 should be expanded to ensure that the holding of a conscientious objection does not absolve the registered medical practitioner from their responsibility to a patient in emergency circumstances. The view of the Council is that the right to conscientious objection must be balanced against the right of the patient – particularly in the case of a medical emergency. The Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners states:

> *10.3 'Conscientious objection does not absolve you from responsibility to a patient in emergency circumstances.'*

The text in subhead 1 should be amended to specifically include the term conscientious objection.

It is not clear whether subhead (1) applies exclusively to the carrying out of the procedure or whether it also applies to the involvement by certifying registered medical practitioners in the assessment of risk, the certification process and the review process.

Subhead 2 as currently drafted is unclear.

In regard to Head 14, 15 and 16, the Medical Council is of the opinion that the underlying principles to the development of regulations should ensure that procedures developed are:

- Independent
- Accessible
- Transparent
- Timely
- Preserve the confidentiality of the pregnant woman.

In regard to Head 19 the Medical Council is of the opinion that subhead (1) should be modified to read as follows: 'It shall be an offence for a person to do any act with the intent to destroy unborn human life other than in accordance with the provisions of Heads 2, 3, and 4 of this Bill.'

We are grateful for the opportunity to engage with the Committee on this important issue and commend the Committee for seeking a range of expert views as part of this process. If our future input can provide support at later stages, we will engage with the Department of Health to assist in their processes.

Ends.

Medical Council Submission to the Joint Committee on Health and Children on the Protection of Life During Pregnancy (Heads of) Bill 2013.

Part A. Introduction

The Medical Council welcomes the opportunity to provide the Joint Committee on Health and Children with views to assist the Committee in formulating its report to Government on the General Scheme of the Protection of Life during Pregnancy Bill 2013.

The Medical Council is the statutory body responsible for the regulation of doctors in Ireland. Its purpose is to protect the public by promoting and ensuring the highest standards among doctors. From the day a student first enters medical school until the day they retire from practice, the Medical Council works to ensure that medical education and training remains up-to-date and is benchmarked to the highest international standards.

The Medical Council sets standards for all undergraduate education and postgraduate training of doctors and also requires that all doctors fulfil ongoing professional competence requirements to ensure they keep their knowledge and skills up-to-date throughout their professional lives.

In the interests of patient safety and the protection of the public, the Council has been vested by the Oireachtas with responsibility to ensure that only those doctors with the necessary education, training and skills are registered to practise in Ireland. The Council also specifies standards of practice for doctors in the areas of professional conduct and ethics.

Part B. Medical Council Ethical Guidance

In accordance with Section 7 of the Medical Practitioner's Act, the Medical Council provides principles based guidance to doctors on matters relating to conduct and ethics through its Guide to Professional Conduct and Ethics for Registered Medical Practitioners. The seventh edition of the Guide was published in 2009 following extensive consultation with doctors, the general public, medical schools, postgraduate medical training bodies, government departments, employers and a range of other stakeholders.

Doctors are expected to adhere to the Council's Guide in their professional practice. However, it is important to note that the Medical Council's Guide is not a legal code. In drafting its ethical guidance, the Council seeks to incorporate and reference relevant legislation in order to ensure doctors are aware of the legal framework within which they operate.

This Guide is a principles based document, which must be relevant to each of the approximately 18,000 doctors registered to practise in Ireland regardless of their speciality, interest or discipline. It covers issues as diverse as consent, confidentiality, end-of-life care, advertising, clinical trials, prescribing practices and referral of patients. The Council's guidance provides the principles which are the cornerstone of each doctor's practice. It has been designed to support doctors in decision-making regarding conduct and ethics and to complement other external sources of clinical guidance, procedures and protocols devised by expert bodies and employers.

In order to ensure the Guide is as relevant as possible, taking on board the views of all those consulted with, the Council established an Ethics Working Group to oversee the development of the Guide. This multi-stakeholder working group, which included Council members and non-Council members including a number of medical and non-medical experts, was established to ensure that the guidance was both evidence-based and developed in line with best practice and the current legal position.

Part C. General Comments

The Medical Council makes the following general comments in relation to certain matters arising in the Bill that, in the view of the Council, need to be provided for either in primary legislation or regulations.

- The Medical Council is of the opinion that the process underlying the certification of the decision regarding termination of pregnancy should be the same for grounds of risk of loss of life from physical illness and risk of loss of life from self-destruction. Accordingly, the Council is of the opinion that Head 2 and Head 4 should be merged into a single Head.
- In circumstances where the pregnant woman's capacity to consent is or may be impaired, it is not clear from the draft heads how a decision regarding termination of pregnancy will be made and how the woman will be enabled and supported to participate in this decision.
- The draft Heads do not make reference to the legal age of consent for minors. Specifically, it is not clear who will have decision-making authority in circumstances where the pregnant woman is under 16 years. In accordance with national policy, the Council believes that the voice of the young person in decision making should be considered and appropriate provisions should be made.
- The opinions of all registered medical practitioners certifying a procedure that will end unborn human life must be recorded in writing.
- The Council expresses concern about the ability of the pregnant woman to access treatment by the required registered medical practitioners as currently outlined under Heads 2 and 4 in all areas of the country.
- Processes for a monitoring system should incorporate appropriate requirements to preserve the confidentiality of the patient and the certifying practitioners.
- Processes for an appeal mechanism either by way of High Court Appeal or Judicial Review should be incorporated where the pregnant woman is not satisfied with the decision.

Part D. Views of the Medical Council on the "Protection of Life During Pregnancy (Heads of) Bill 2013."

Head 1 Interpretation

(1) In this Act-

"Appropriate location" means any premises which is carried on by the Executive or by a person with whom the Executive has entered into an arrangement for the provision of a health and personal social service under section 38 of the Health Act 2004 and which are, either wholly or partly, used for the care and treatment of

(a) pregnant women in relation to pregnancy, childbirth and post-partum care, and

(b) neonates.

"Executive" means the Health Service Executive;

"implantation" means implantation in the womb of woman;

"medical procedure" includes the provision of any drug or any medical treatment;

"midwife" means a person whose name is registered in the midwives division of the register of nurses and midwives established under section 46 of the Nurses Act 2011;

"Minister" means the Minister for Health;

"neonate" means a baby who is 4 weeks old or younger;

"nurse" means a person whose name is registered in the nurses division of the register of nurses and midwives established under section 46 of the Nurses Act 2011;

"obstetrician/gynaecologist" means a medical practitioner who is registered in the Specialist Division of the register of medical practitioners established under section 43(2) (b) of the Medical Practitioners Act 2007 under obstetrics/gynaecology;

"psychiatrist" means a medical practitioner who is registered in the Specialist Division of the register of medical practitioners established under section 43(2) (b) of the Medical Practitioners Act 2007 under psychiatry;

"reasonable opinion" means an opinion formed in good faith which has regard to the need to preserve unborn human life as far as practicable;

"registered medical practitioner" means a medical practitioner whose name is entered in the register of medical practitioners established under section 43(1) of the Medical Practitioners Act 2007;

"relevant specialty" means a medical specialty listed in the Specialist Division of the register of medical practitioners established under section 43(2) (b) of the Medical Practitioners Act 2007, and relevant to the threat to the life of the pregnant woman;

“review committee” means a committee established under Head 7;

“unborn” as it relates to human life means following implantation until such time as it has completely proceeded in a living state from the body of the woman.

“woman” means a female person of any age.

In regard to Head 1, the Medical Council has no specific comment to make on these provisions. Council is of the view that it is in the public interest that doctors have legal clarity when making clinical decisions.

Head 2 Risk of loss of life from physical illness, not being a risk of self destruction

Provide that

(1) It is not an offence to carry out a medical procedure, in accordance with this Head, in the course of which or as a result of which unborn human life is ended, where –

(a) that procedure is carried out by a registered medical practitioner at an appropriate location, and

(b) two medical practitioners, have, in accordance with this Head, jointly certified in good faith that –

(i) there is a real and substantial risk of loss of the pregnant woman's life other than by way of self-destruction, and

(ii) in their reasonable opinion this risk can be averted only by that medical procedure.

(2) One of the two medical practitioners referred to in paragraph (b) of subhead (1) shall be an obstetrician/gynaecologist, who must be employed at that location, and one shall be a medical practitioner who is registered on the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007 under a relevant specialty.

(3) (a) In forming their opinion, at least one of the two medical practitioners referred to in paragraph (b) of subhead (1) shall consult with the pregnant woman's general practitioner where practicable.

(b) In forming the aforesaid opinion both medical practitioners should examine the woman.

(4) Where two medical practitioners referred to in subhead (2) have jointly certified an opinion referred to in paragraph (b) of subhead (1), the certifying obstetrician/gynaecologist referred to in subhead (2) shall forward the certificate to a location referred to in paragraph (a) of subhead (1) and shall make arrangements for carrying out the procedure at that location.

(5) It will always be a matter for the patient to decide if she wishes to proceed with a termination following a decision that it is permissible under this Act.

In regard to Head 2, the Medical Council is of the opinion that:

Head 2 should be merged with Head 4 into a single Head.

Subhead 1(a): the text in this subhead should be amended to read: "that procedure is carried out by a registered medical practitioner registered in the Specialist Division in the relevant specialty at an appropriate location."

The text in subhead 1(b) should be amended to read: "two medical practitioners, registered on the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the

Medical Practitioners Act 2007 under a relevant specialty, have, in accordance with this Head, jointly certified in good faith that –

(i) There is a real and substantial risk of loss of the pregnant woman's life, and

(ii) In their reasonable opinion this risk can be averted only by that medical procedure

The amended subhead 1(b) thereby renders subhead (2) redundant.

Where the clinical decision is made to proceed with a termination of pregnancy, if neither of these registered medical practitioners is an obstetrician, at least one of the two registered medical practitioners shall then consult with an obstetrician employed at the appropriate location.

Head 3 Risk of loss of life from physical illness in a medical emergency

Provide that

(1) It is not an offence to carry out a medical procedure, in accordance with this Head, in the course of which or as a result of which unborn human life is ended, where –

(a) that procedure is carried out by a medical practitioner,

(b) he or she in good faith believes that there is an immediate risk of loss of the pregnant woman's life other than by way of self- destruction, and

(c) the medical procedure is, in his or her reasonable opinion, immediately necessary to save the life of the woman.

(2) The opinion referred to in subhead (1) shall be certified by the registered medical practitioner referred to in subhead (1) in the form and manner prescribed by the Minister.

In regard to Head 3, the Medical Council is of the opinion that:

Subhead (1) (a): the text in this subhead should be amended to read "registered medical practitioner."

Subhead (1) (b): the text in this subhead should be amended to read "immediate real and substantial risk."

Subhead (1): the text in this subhead should be amended to include a provision that, in forming his/her opinion, the registered medical practitioner should consult with another registered medical practitioner, where practicable.

The Medical Council is of the view that the use of the word "immediate" in subhead 3 appears to extend the understanding of a real and substantial risk as the test used in the Supreme Court judgment.

Head 4 Risk of loss of life from self-destruction

Provide that

(1) It is not an offence to carry out a medical procedure, in accordance with this Head, in the course of which or as a result of which unborn human life is ended, where –

(a) that procedure is carried out by a registered medical practitioner at an appropriate location,

(b) one obstetrician/gynaecologist, who must be employed at that location, and two psychiatrists, both of whom shall be employed at a centre which is registered by the Mental Health Commission, and one of whom shall be attached to an institution where such a procedure is carried out, in accordance with this Head, jointly certified in good faith that –

(i) there is a real and substantial risk of loss of the pregnant woman's life by way of self-destruction, and

(ii) in their reasonable opinion this risk can be averted only by that medical procedure.

(2) (a) At least one of the three medical practitioners referred to in paragraph (b) of subhead (1) shall consult with the pregnant woman's general practitioner where practicable.
(b) In forming the aforesaid opinion, the medical practitioners should examine the woman.

(3) Where three medical practitioners referred to in this Head have jointly certified an opinion referred to in *paragraph (b)* of *subhead (1)*, the certifying obstetrician/gynaecologist referred to in paragraph (b) shall forward the certificate to a location referred to in *paragraph (a)* of *subhead (1)* and shall make arrangements for the carrying out of the procedure at that location.

(4) It will always be a matter for the patient to decide if she wishes to proceed with a termination following a decision that it is permissible under this Act.

In regard to Head 4, the Medical Council is of the opinion that:

Head 4 should be merged with Head 2 into a single Head.

The text in subhead 1(a) should be amended to specify that the procedure should be undertaken by a registered medical practitioner registered in the Specialist Division in the relevant specialty.

The text in subhead 1(b) should be amended to read: "two psychiatrists, have, in accordance with this Head, jointly certified in good faith that –

(i) There is a real and substantial risk of loss of the pregnant woman's life by way of self-destruction, and

(ii) In their reasonable opinion this risk can be averted only by that medical procedure

Where the clinical decision is made to proceed with a termination of pregnancy, at least one of the two certifying psychiatrists shall then consult with an obstetrician employed at the appropriate location.

Subhead (1) (b): Not all psychiatrists work in centres registered by the Mental Health Commission.

Subhead (1) (b): it is not clear why one of the certifying psychiatrists must be attached to a location where such a procedure is carried out. The majority of psychiatrists are not attached to such institutions.

Head 5 Medical opinion to be in the form and manner prescribed by the Minister

Provide that

(1) A medical opinion referred to in Heads *2*, 3*, or 4* shall be given in the form and manner prescribed by the Minister.

In regard to Head 5, the Medical Council is of the opinion that:

Subhead (1): the formal framework developed to record a medical opinion should be:

- Independent
- Accessible
- Transparent
- Timely
- Preserve confidentiality of the pregnant woman

Head 6 Formal Medical Review Procedures

Provide that

(1) Where a medical practitioner qualified to certify in accordance with Head 2 or as the case may be Head 4 has been consulted by a pregnant woman in relation to whether there is a real and substantial risk of loss to her life that can only be averted by a medical procedure in the course of which or as result of which unborn human life may be terminated and the practitioner is not of an opinion referred to in Head 2 or Head 4, he or she shall inform the pregnant woman that she may make an application as set out in subhead (2) of this Head.

(2) A pregnant woman or a person on her behalf with her consent may apply in writing to the HSE in the form and manner prescribed by the Minister to have her case reviewed if she has consulted a medical practitioner qualified to certify in accordance with Head 2, or as the case may be, Head 4, and the medical practitioner is not of the opinion referred to in those heads or has not given an opinion in relation to the matter.

(3) The Executive shall establish and maintain a panel of medical practitioners meeting the requirements in relation to certification under Head 2 and Head 4 and of sufficient size and composition for the purposes of a review referred to in subhead (2*)* on the nomination of

(a) Institute of Obstetricians and Gynaecologists

(b) College of Psychiatrists of Ireland

(c) Royal College of Surgeons in Ireland

(d) Royal College of Physicians of Ireland

(4)The Executive shall appoint and authorise one or more of its employees with appropriate qualifications and experience for the purposes of establishing and convening a committee in accordance with subhead 5.

(5) As soon as possible but no later than 7 days after receiving a completed written application in accordance with subhead (2), an authorised person referred to in subhead (4) shall establish and convene a committee drawn from the panel established and maintained by the Executive under *subhead* (3).

(6) As soon as possible but no later than 7 days after having been convened in accordance with subhead (5), the committee shall review the case and shall form an opinion in good faith as to whether or not there is a real and substantial risk of loss of life of the pregnant woman that can only be averted by a termination of her pregnancy.

(7) Notification in the form and manner prescribed by the Minister of the outcome of the committee's review shall be given to

(a) the woman who made the application and if applicable the person who made the application on her behalf and

(b) the Executive.

(8) A medical practitioner may not be a member of a committee established and convened under subhead (5) to review a case where he or she has previously been consulted by the woman who is the subject of the application in relation to whether there is a real and substantial risk of loss of her life that can only be averted by a medical procedure in the course of which or as a result of which unborn human life is ended.

In regard to Head 6, the Medical Council is of the opinion that:

Subhead (1): the text in this subhead should be amended to read "registered medical practitioner."

Subhead (1): the subhead does not make clear which registered medical practitioner is vested with the duty to inform the woman of the formal review option.

Subhead (1): criteria have not been set out to ensure that information is conveyed to the woman in an effective, accessible and timely manner.

Subhead (7): a time frame has not been set out for notification to the woman who made the application and if applicable the person who made the application on her behalf and the Executive of the outcome of the committee's review.

The Council is of the view that **subheadings (5) – (6)** are not necessary as these provisions are adequately covered under **Heads 7 & 8**.

Head 7 Review where risk arises from physical illness, not being a risk of self destruction

Provide that

(1) In the case of a pregnant woman who believes there may be a real and substantial risk of loss of her life other than by way of self-destruction, a committee established by an authorised person shall consist of an obstetrician/gynaecologist who must be employed at an appropriate location and one medical practitioner who is registered on the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007 under a relevant specialty.

(2) As soon as possible but no later than 7 days after receiving a completed written application in accordance with subhead 7(2), an authorised person referred to in subhead 7 (4) shall establish and convene a committee drawn from the panel established and maintained by the Executive under subhead 7(3).

(3) As soon as possible but no later than 7 days after having been convened in accordance with subhead (5), the committee shall review the case and shall form an opinion in good faith as to whether or not there is a real and substantial risk of loss of life of the pregnant woman that can only be averted by a termination of her pregnancy.

(4) Notification in the form and manner prescribed by the Minister of the outcome of the committee's review shall be given to

> (a) the woman who made the application and if applicable the person who made the application on her behalf, and (b) the Executive.

(5) Where a committee referred to in subhead (1) forms an opinion referred to in Head 2, the committee shall jointly certify this opinion in the form prescribed by the Minister and the certifying obstetrician/gynaecologist shall make arrangements for the procedure to be carried out in an appropriate location.

(6) The procedures set out in this Head are without prejudice to Head 3, which shall apply where there is a material deterioration in the health of a pregnant woman such that there is an immediate risk of loss of her life other than by way of self destruction, and thereupon the provision of Head 3 shall apply irrespective of review procedures which are in train.

In regard to Head 7, the Medical Council is of the opinion that:

Reflecting the Council's recommendation that Heads 2 and 4 be merged, the Medical Council is of the opinion that Head 7 and Head 8 should also be merged and the processes from Head 8 adopted in the legislation.

The text in subhead 1 should be amended to read: "in the case of a pregnant woman who believes there may be a real and substantial risk of loss of her life, a committee established by an authorised person shall consist of two medical practitioners registered on the Specialist Division of the register

of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007 under a relevant speciality.

The text in subhead 1 should be further amended to include an additional sentence: "Where the clinical decision is made to proceed with a termination of pregnancy, if neither of these registered medical practitioners is an obstetrician, at least one of the two registered medical practitioners shall then consult with an obstetrician employed at the appropriate location."

Subhead (4): a time frame has not been set out for notification to the woman who made the application and, if applicable, the person who made the application on her behalf and the Executive of the outcome of the committee's review.

Subhead (6): should be amended to read: "The procedures set out in this Head are without prejudice to Head 3, which shall apply where there is an immediate risk of loss of the life of the pregnant woman, and therefore the provision of Head 3 shall apply irrespective of review procedures which are in train".

Head 8 Review in case of risk of loss of life through self-destruction

Provide that

(1) In the case of a pregnant woman who believes there may be a real and substantial risk of loss of her life arising from self-destruction the committee shall consist of one obstetrician/gynaecologist who must be employed at an appropriate location and two psychiatrists both of whom shall be employed at a centre which is registered by the Mental Health Commission and one of whom shall be employed at an appropriate location.

(2) As soon as possible but no later than 7 days after receiving a completed written application in accordance with subhead 7(2), an authorised person referred to in subhead 7 (4) shall establish and convene a committee drawn from the panel established and maintained by the Executive under subhead 7(3).

(3) As soon as possible but no later than 7 days after having been convened in accordance with subhead (5), the committee shall review the case and shall form an opinion in good faith as to whether or not there is a real and substantial risk of loss of life of the pregnant woman that can only be averted by a termination of her pregnancy.

(4) Notification in the form and manner prescribed by the Minister of the outcome of the committee's review shall be given to (b) the woman who made the application and if applicable the person who made the application on her behalf and (b) the Executive.

(5) Where a committee referred to in subhead (1) forms an opinion referred to in Head 4, the committee shall jointly certify this opinion in the form prescribed by the Minister and the certifying obstetrician/gynaecologist shall make arrangements for the procedure to be carried out in an appropriate location.

In regard to Head 8, the Medical Council is of the opinion that:

Subhead (1): should be amended to read: "in the case of a pregnant woman who believes there may be a real and substantial risk of loss of her life, a committee established by an authorised person shall consist of two medical practitioners registered on the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007 under a relevant speciality.

Subhead (3): should be amended to include a further sentence: "Where the clinical decision is made to proceed with a termination of pregnancy, if neither of these registered medical practitioners is an obstetrician, at least one of the two registered medical practitioners shall then consult with an obstetrician employed at the appropriate location.

Subhead (1): it is not clear why one of the certifying psychiatrists must be attached to a location where such a procedure is carried out. The majority of psychiatrists are not attached to such institutions.

Subhead (4): There is no time limit set for notification to the woman who made the application and if applicable the person who made the application on her behalf and the Executive of the outcome of the committee's review.

Head 9 General provisions for Committee

(1) A committee established under Head 6 to review a case, or an authorised person at its request, may direct in writing any relevant medical practitioner to produce to the committee any document or thing in his or her possession or control that is specified in the direction.

(2)The committee or an authorised person at its request may direct in writing any medical practitioner to attend before it on a date and at a time and place specified in the direction.

(3) At her request, the committee shall enable

(a) a woman who has made an application or on whose behalf an application has been made,

or

(b) a person on her behalf, to be present at a meeting of the Committee to present her case to the committee.

(4) A person who –

(a) having been directed under subhead (2) to attend before the committee without just cause or excuse disobeys the direction,

(b) fails or refuses to send any document or things legally required by the committee under subhead (1) to be sent to it by the person without just cause or excuse, shall be guilty of an offence and shall be liable on summary conviction to a class C fine (not exceeding €2,500).

(5) Summary proceedings for an offence under subhead (3) may be brought and prosecuted by the HSE.

(6) A member of a committee established under Head 6(5) shall be paid by the Executive out of funds at its disposal, remuneration and allowances for expenses, if any determined under subhead (8).

(7) A medical practitioner who attends a review committee under subhead (2) shall be paid by the Executive out of funds at its disposal, remuneration and allowances for expenses, if any determined under subhead (8).

(8) With the consent of the Minister for Public Expenditure and Reform, the Minister may determine the remuneration and allowances for expenses, if any, payable to members of a review committee and medical practitioners attending a review committee under subhead *(2).*

In regard to Head 9, the Medical Council is of the opinion that:

Subheads (1) and (2): the text in these subheads should be amended to read "registered medical practitioner"

A subhead should be inserted to enable the committee to have access to legal expertise on a formal basis.

Head 10 Formal medical review reports to Minister

Provide that

(1) The Executive shall in each year, at such times and in such manner as the Minister may determine, provide the Minister with a general report on applications made during the previous year indicating:

(a) the total number of applications received

(b) the number of reviews carried out

(c) in the case of reviews carried out, the reason why the review was sought

(d) the outcome of the review and

(e) any other information specified by the Minister.

In regard to Head 10, the Medical Council is of the opinion that:

Subhead (1) (a) – (e): the formal framework developed to support the collation of information on the workings of the formal medical review process should be:

- Independent
- Accessible
- Transparent
- Timely
- Preserve confidentiality of the pregnant woman.

Head 11 Notifications

Provide that

(1) The person in charge of an appropriate location or other establishment, at which a medical procedure permitted under this Bill is carried out, shall keep a record in the form and manner prescribed by the Minister.

(2) Where a medical procedure permitted under this Bill has been carried out, the person carrying on the business of the premises at which the procedure is carried out, shall, no later than 28 days after the medical procedure has been carried out, notify the Minister of the such procedure and such notification shall include any information as maybe prescribed for this purpose.

(3) No notification under this Head shall give the name or address of the woman in respect of whom the termination was carried out.

(4)The Freedom of Information Act 1997 shall not apply to any record under this Head.

In regard to Head 11 the Medical Council has no suggested amendments to these provisions.

Head 12 Conscientious Objection

Provides that

(1) Nothing in this Bill shall be construed as obliging any medical practitioner, nurse or midwife to carry out, or to assist in carrying out, a lawful termination of pregnancy.

(2) Nothing in subhead (1) shall affect any duty to participate in treatment under Head 3.

(3) No institution, organisation or third party shall refuse to provide a lawful termination of pregnancy to a woman on grounds of conscientious objection.

(4) In the event of a doctor or other health professional having a difficulty in undertaking a required medical procedure, he or she will have a duty to ensure that another colleague takes over the care of the patient as per current medical ethics.

In regard to Head 12, the Medical Council is of the opinion that:

Subheads (1) and (4): are largely consistent with the Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners (2009) which states:

> *10.1 'As a doctor you must not allow your personal moral standards to influence your treatment of patients'.*
>
> *10.2 'If you have a conscientious objection to a course of action, you should explain this to the patient and make the names of other doctors available to them'.*

The Medical Council suggests that Head 12 should be expanded to ensure that the holding of a conscientious objection does not absolve the registered medical practitioner from their responsibility to a patient in emergency circumstances. The view of the Council is that the right to conscientious objection must be balanced against the right of the patient – particularly in the case of a medical emergency. The Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners states:

> *10.3 'Conscientious objection does not absolve you from responsibility to a patient in emergency circumstances.'*

Subhead (1): should be amended to specifically include the term conscientious objection.

It is not clear whether Subhead (1) applies exclusively to the carrying out of the procedure or whether it also applies to the involvement by certifying registered medical practitioners in the assessment of risk, the certification process and the review process.

Subhead (2): as currently drafted is unclear.

Head 13 Travel and Information

Provide that

(1) This Act does not limit freedom to travel between the State and another state or freedom to obtain or make available in the State, in accordance with conditions for the time being laid down by law, information relating to services lawfully available in another state.

(2) This Act does not operate to restrict any person from travelling to another state on the ground that his or her intended conduct there would, if occurred in the State, constitute an offence under Head 19 of this Act.

In regard to Head 13 the Medical Council has no suggested amendments to these provisions.

Head 14 Regulations

Provide that

(1)The Minister may make regulations that the Minister considers necessary or expedient for purposes under this Act.

(2) Without limiting the generality of subhead (1), the Minister may make regulations –

(a) for any purpose in relation to which regulations are provided for in this Act,

(b) prescribing any matter or thing referred to in the act as prescribed or to be prescribed,

and

(c) generally for the purpose of giving effect to this Act.

(3) A regulation under this Head may contain such consequential supplementary and ancillary provisions as the Minster considers necessary or expedient.

In regard to Head 14, the Medical Council is of the opinion that:

Subheads (1) – (3): the development of regulations should ensure that procedures developed are:

- Independent
- Accessible
- Transparent
- Timely
- Preserve the confidentiality of the pregnant woman.

Head 15 Regulations respecting certification of opinions referred to in this Act

Provide that

(1) Without limiting the generality of Head 14, the Minister shall make regulations

(a) respecting the written form and manner in which an opinion referred to Head 2, 3or 4, and

(b) respecting the notification where the review committee is not of the opinion referred to in Head 2 or 4.

(2) Without limiting the generality of subhead (1), regulations under paragraphs (a) and (b) of that subhead shall specify that certifications shall indicate the clinical reason or reasons for the opinion referred to in Head 2, 3 or 4.

In regard to Head 15, the Medical Council is of the opinion that:

Subheads (1) – (2): the formal framework developed to record certification of opinions and the clinical reason or reasons for the opinion should be:

- Independent
- Accessible
- Transparent
- Timely
- Preserve the confidentiality of the pregnant woman.

Head 16 Regulations respecting notifications to the Minister

Provide that

(1) Without limiting the generality of Head 14, the Minister shall make regulations respecting the form and manner information is notified to the Minister under Head 10.

In regard to Head 16, the Medical Council is of the opinion that:

Subheads (1): the formal framework developed to record information notified to the Minister should be:

- Independent
- Accessible
- Transparent
- Timely
- Preserve the confidentiality of the pregnant woman.

Head 17 Laying of regulations before Houses of the Oireachtas

Provide that

(1) The Minister shall ensure that every regulation made by the Minister under this Act other than an order under Head 11 is laid before each House of the Oireachtas.

(2) Either House of the Oireachtas, by resolution passed within 21 sitting days after the day on which a regulation is laid before it under this Head, may annul the regulation.

(3)The annulment of a regulation under subhead (2) takes effect immediately on the passing of the resolution concerned, but does not affect the validity of anything done under the regulation before the passing of the resolution.

In regard to Head 17 the Medical Council has no suggested amendments to these provisions.

Head 18 Repeal and Consequential Amendments

Provide that

(1) Sections 58 and 59 of the Offences Against the Person Act 1861 are hereby repealed.

In regard to Head 18, the Medical Council is of the opinion that:

Subhead (1): Sections 58 & 59 of the 1861 Act should be repealed.

Head 19 Offence

Provide that

(1) It shall be an offence for a person to do any act with the intent to destroy unborn human life.

(2) A person who is guilty of an offence under this Head is liable on conviction on indictment to a fine or imprisonment for a term not exceeding 14 years or both.

(3) Where an offence under this Act—

(*a*) is committed by a body corporate, by a person purporting to act on behalf of a body corporate or by an individual or an unincorporated body of persons, and

(*b*) is proved to have been committed with the consent or approval of, or to have been attributable to any neglect or connivance on the part of, any person who, when the offence was committed, was—

(i) a director, member of the committee of management or other controlling authority of the body concerned, or

(ii) the manager, secretary or other officer of the body concerned, that person shall also be deemed to have committed the offence and may be proceeded against and punished accordingly.

(4) A prosecution for an offence under this Head may be brought only by or with the consent of the Director of Public Prosecutions.

In regard to Head 19 the Medical Council is of the opinion that:

Subhead (1): the subhead should be modified to read as follows: 'It shall be an offence for a person to do any act with the intent to destroy unborn human life other than in accordance with the provisions of Heads 2, 3, and 4 of this Bill.'

Head 20 Commencement – with short title

Provide that

(1) This Act comes into operation on such day or days as the Minister may appoint by order.

(2) Different days may be appointed under this Head for different purposes or different provisions of this Act.

In regard to Head 20, the Medical Council takes no view on these provisions

Health and Children on
the Protection of Life during Pregnancy Bill 2013

Chairman, Deputy and Senators, on behalf of the Irish Medical Organisation (IMO), which represents over 5,000 doctors of all craft groups in Ireland, I want to thank you for inviting us to address the Committee today. I know that everyone here agrees that the matters before this Committee are of enormous importance and sensitivity for people across the country and deal with issues on which people have very strong , and often very opposing, views and opinions.

We in the Irish Medical Organisation have debated the issue of abortion on a number of occasions and when we have done so we have found that that diversity of opinion that we see in the wider community is mirrored closely amongst our own members.

Our official position on the issue dates back 20 years to 1993 and states that the IMO endorses the principle of respect for all human life, born and unborn, and that it rejects abortion.

More recently at our Annual General Meeting in April, the issue was debated in a number of motions but our policy did not change.

However the IMO accepts that that whatever our own policy position might be, our members operate within a legal framework. Therefore without turning our backs on the formal policy position we have adopted, we have an obligation to engage in the debate about the legal framework that is being established.

We understand that it is the role of the people through referendums and Deputies and Senators through the Oireachtas to frame the laws under which this country operates.

Furthermore we accept that the Government is now moving to introduce a legislative framework.

In that context we have a number of concerns as follows:

- The patient's health and welfare is paramount

- The legislation must provide adequate clarity and protection to healthcare professionals who have to operate under it.

- The legislation must be practical and realistic for application in a hospital environment

- The legislation must be sufficiently resourced

- Where issues of morals are concerned – such as abortion - the laws must provide adequate flexibility to ensure that an individual can abstain from engaging in an activity which he/she may deem, in conscience, to be immoral without jeopardising the right of the relevant patient to all the facilities and treatments which the law provides.

In respect of the Heads of the Bill we are considering today we would make the following points:

Head 1 – Interpretation
The term 'reasonable opinion' should be replaced by the term 'opinion' and the term 'unborn' should be replaced by the medical term 'foetus'.

Head 2 - Risk of loss of life from physical illness, not being a risk of self-destruction
Under Head 2 the opinion of two medical practitioners is required to jointly certify that there is a real and substantial risk to the life of the mother and where the risk can only be averted by the termination of the pregnancy.

Where a pregnant woman presents with a physical condition that poses a real and substantial risk to her life, clear clinical guidelines are required in order to identify, monitor and treat such patients.

While such cases are rare, public obstetric units must be appropriately resourced to ensure that patients are adequately cared for according to clinical guidelines and that no delay to life saving procedures arises due to under-resourcing.

A system should be in place to allow Medical practitioners to declare a conscientious objection to participation in termination procedures.

Protocols must be in place to deal with such situations as they arise.

Medical practitioners that have no conscientious objection must receive appropriate training either during postgraduate training or as part of compulsory CPD programmes organised and resourced by the state.

The health and welfare of the patient is paramount and therefore women must be provided with appropriate follow-on care, both physical and psychological, following any termination.

Head 3 - Risk of loss of life from physical illness in a medical emergency
Head 3 provides that in a medical emergency a termination of pregnancy where there is a risk of loss of life may be carried out in a public healthcare facility other than an obstetric unit and the opinion of just one medical practitioner is required.

Such cases again are likely to be rare and again clear clinical guidelines must be in place, patients must be attended by a practitioner that has no conscientious objection and is appropriately trained to perform such procedures.

Patient consent must be obtained where possible.

Women must be provided with appropriate follow-on care, both physical and psychological, following any termination.

Head 4 - Risk of loss of life from self-destruction
Under Head 4 the opinion of three medical practitioners (one obstetrician/gynaecologist and two psychiatrists) is required to jointly certify that there is a real and substantial risk to the life of the mother and where the risk can only be averted by the termination of the pregnancy.

Imposing a requirement for three doctors may cause unnecessary delay and is in excess of the maximum of two doctors recommended by the expert group.

Obstetricians should not be required to certify risk of loss of the pregnant woman's life by way of self destruction. This should be done by two Psychiatrists in consultation with the woman's GP.

The Bill requires the Psychiatrists to be employed in an institution registered with the Mental Health Commission. This is an unnecessary specification. Specialists are required to be registered with the Medical Council and this should be the only stipulation.

Such cases again are likely to be rare and again clear clinical guidelines must be in place, patients must be attended by specialists that have declared no conscientious objection.

As it stands mental health services throughout the country are under-resourced. Adequate resources must be provided to ensure that patients at imminent risk of suicide must receive appropriate psychiatric care. Additional resources must be provided to ensure that there is no drop off in services as clinicians are tending reviews specified within this Act.

Head 5 - Medical opinion to be in the form and manner prescribed by the Minister

Medical opinion should be given in the form and manner prescribed through clinical guidelines established by the relevant professional colleges and not by the Minister.

Mental Capacity

Given the importance of this piece of legislation, and that decisions may be contentious, it is important that the legislation removes the potential for ambiguity and gives a clear definition of the criteria for determining capacity to make a medical decision. It is quite possible that in many of the cases that will actually occur the woman will lack capacity temporarily either due to a mental health problem or secondary to a severe physical illness.

The legislation should also clearly state what should be done in cases where a woman is found not to have capacity.[1]

Also the legislation should define at what age a woman has the legal capacity to ask for a termination as the Non-Fatal Offences Against the Person Act 1997 defines the age to give consent for medical examination at 16 but the Mental Health Act 2001 defines the age of medical consent in mental health issues to 18.

Head 6 - Formal Medical Review Panels

Under Head 6 the HSE is to establish and maintain a panel of medical practitioners for the purpose of review. Practitioners that declare a conscientious objection must be excluded from such panels.

Head 7 - Review where risk arises from physical illness, not being a risk of self destruction and Head 8 - Review in case of risk of loss of life through self-destruction

Under heads 7 and 8 the establishment and convening of a review committee and the review procedures combined may take up to 14 days.

During this time there is a risk that the patient's health could deteriorate significantly therefore 14 days is unacceptable. Resources must be in place to ensure that patients are adequately cared for and receive appropriate support during the period of review.

The opinion of the review committee should be made in accordance with appropriate clinical guidelines.

Head 10 Formal medical review reports to Minister and Head 11 - Notifications

[1] Unless someone is a ward of court then the authority for making medical decisions rest solely on the medical practitioner and next of kin have no legal authority or responsibility. The ward of court system is based on the 1871 regulation of lunatics act which does not contain a definition of capacity and is only invoked when incapacity is quite prolonged and usually permanent (i.e. learning disability or dementia).

Under Heads 10 and 11 the number of reviews and medical procedures permitted and carried out under this Bill are to be notified to the Minister. This seems unnecessarily prescriptive.

The HIPE currently records the numbers and types of procedures carried in acute hospitals and the Medical Council is the body authorised to investigate complaints relating to the performance of individual medical practitioners.

Patient confidentiality must be guaranteed and patient anonymity is welcomed. There must be no possibility of identification of the women in respect of whom the termination was carried out.

In order to protect both the patients and the medical practitioners involved and to avoid sensationalist media reporting of such procedures, the names of medical practitioners involved should not be publicised.

Head 12 Conscientious Objection

Recent debate at the IMO's AGM shows that there are a number of physicians who object strongly to the termination of pregnancy on moral and ethical grounds and the IMO welcomes the provision for conscientious objection under Head 12 of the Bill.

However patients who present with life threatening illness must be reassured that they will receive adequate care and the necessary termination to protect maternal life. Clear protocols must be in place to ensure appropriate and timely referral of patients to other colleagues in the case of conscientious objection.

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AN OPINION ON THE PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013

SUBMISSION BY THE ROYAL COLLEGE OF PHYSICIANS OF IRELAND

1. Introduction

We thank the Joint Committee on Health and Children for the invitation to make a submission on the recently published "Protection of Life During Pregnancy (Heads of) Bill 2013".

To discuss the bill and to prepare a submission, a meeting was convened of Fellows from the relevant specialties to discuss the issues. The specialties represented were:

- Gastroenterology
- Cardiology
- Oncology
- Infectious Disease
- Neurology
- Respiratory Medicine
- Nephrology
- Obstetrics and Gynaecology

The Chairman of the RCPI Institute of Obstetricians and Gynaecologists, Prof Robert Harrison, presented the Institute's submission to the Joint Committee on Health and Children. The Institute submission represents a consensus from Institute members in relation to the draft Heads of Bill.

A discussion followed on the Heads of the Bill, the Institute submission and the involvement of consultant physicians in the very rare clinical instances where a decision is required to terminate the pregnancy of a woman whose illness during pregnancy poses a real and substantial threat to her life.

Based on that discussion, the Royal College of Physicians of Ireland fully supports the submission of the RCPI Institute of Obstetricians and Gynaecologists, with the addition outlined below.

2. HEAD 2: RISK OF LOSS OF LIFE FROM PHYSICAL ILNESS, NOT BEING A RISK OF SELF DESTRUCTION.

We believe that in addition to the support of a second obstetrical opinion, and where the patient's condition warrants the opinion of another medical practitioner from a different specialist register, that two specialist opinions from that register should be involved.

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We accept that while only one specialist is needed to examine the patient, the supportive opinion of an additional specialist should be sought. In an elective situation, where practical and in conformity with best practice, a Multi Disciplinary Team would consider a decision to terminate pregnancy.

In medicine generally, it is appropriate in complex cases (regardless of whether or not the patient is pregnant) for a specialist to seek a second opinion and again where practical and appropriate to consider the issue within a multidisciplinary team.

Clearly in emergency situations, this may not be practical, and we agree with the content relating to emergency situations under **HEAD 3**.

3. Conclusions

To ensure best treatment for a patient, it is important to recognise that legislation should not seek to define treatment pathways that are more appropriately and safely dealt with through professional judgement in a specific clinical situation. Doctors seek to treat patients in line with best clinical practice which is constantly evolving.

Guidelines for the operation of the legislation will be complex and will require the input of the relevant professional bodies. RCPI is prepared to participate with the Department of Health and the HSE in the development of guidelines on the operation of the legislation.

Yours sincerely

Prof John Crowe

President,

Royal College of Physicians of Ireland

Opening Presentation - Dr. Peter Boylan, MAO, FRCPI, FRCOG.

Clinical Director – National Maternity Hospital.

I have been a practicing Obstetrician/Gynaecologist since 1975. Part of my training was undertaken in London, and after I qualified, I held an academic post in the United States for four years. Over many years, I have been invited to give lectures and perform clinical practice reviews in the United Kingdom, the United States, Europe, Scandinavia, Singapore, Israel, Australia and New Zealand. All this experience has given me wide opportunity to observe the practice of Obstetrics as it relates to the issue under discussion, that is termination of pregnancy.

Ireland is in a unique position in that there is ready access to termination of pregnancy in the United Kingdom for residents of the State despite it being illegal here. It could be interpreted that the State has implicitly agreed to facilitating this access by way of the Constitutional amendments of 1992 which guaranteed the right to access information regarding termination of pregnancy, and guaranteed the right to travel to obtain termination.

The situation in Ireland regarding termination of pregnancy where there is a real and substantial risk to the life of the mother remains unclear. As doctors, we are aware of the Supreme Court judgment in respect of the X Case, but are left, in the absence of legislation and regulation, to attempt to interpret that judgment on an *ad hoc* basis when it comes to termination of pregnancy in order to save the life of the mother. Meanwhile, the 1861 Criminal Offences Against the Person Act remains on the statute books. This is a wholly unsatisfactory and, I believe, unreasonable, situation to expect doctors to operate in. It also places the woman in the highly unsatisfactory position where doctors caring for her are unsure as to whether or not they may be breaking the law in cases where they feel they have to intervene to save her life.

For these reasons, I welcome the intention to enact legislation.

Dr Peter Boylan, Clinical Director, National Maternity Hospital
Protection of Life During Pregnancy Bill - Commentary on Heads of Bill

Head 1 - Interpretation

"Appropriate location"

The three Dublin Maternity Hospitals do not have Intensive Care Units. There is a strong likelihood that where termination of pregnancy is required to save the life of a mother she will require intensive care. For this reason I believe that terminations should be performed in all public general hospitals.

In cases of an emergency, termination should be allowed in a Private Hospital also.

Specialist Registration

The Committee will be aware that Ireland has one of the lowest ratios of specialists per head of population in Europe. For this reason, it is not unusual that consultant cover, at weekends and during holiday periods, is provided by Obstetricians/Gynaecologists who are not on the Specialist Registrar of the Medical Council. I would advise, therefore, that this provision be amended accordingly.

"Reasonable Opinion"

I welcome the confirmation that the Constitutional protection of the right to life of the unborn child be retained at all times where practicable. Some campaigners are attempting to suggest that "late" terminations will be performed in Irish hospitals if this legislation is passed, implying that doctors would deliberately kill an unborn baby who is capable of existence outside the uterus. Indeed, some of the more extreme groups are suggesting that new-born babies might be killed if this legislation is passed. These views are clearly extremist and have no basis in fact. There should be no suggestion that Obstetricans and Neonatologists would ever fail to make to make every effort to maintain the life of a baby once the threshhold of viability is reached.

Head 2 - Risk of loss of life from physical illness, not being a risk of self -destruction

I have made reference above to appropriate location and specialist registration.
Otherwise I have no difficulties with Head 2 and consider that it is workable.

Head 3 - Risk of loss of life from physical illness in a medical emergency

My only comment on this Head is that consideration should be given to the possibility that a termination might need to be carried out in a private institution in the case of an emergency.

Head 4 - Risk of loss of life from self-destruction

My expertise is not in the field of Psychiatry so I am happy to defer to the College of Psychiatrists of Ireland's presentation and opinion.

I understand that the Council of the College of Psychiatrists of Ireland, the elected decision-making body representing over 864 members, has made a single submission on behalf of all members.

Head 5 - Medical Opinion to be in the form and manner prescribed by the Minister

I have no comment.

Head 6 - formal Medical Review Procedures

I would question the need for a woman to have to apply in writing to the H.S.E. to have her case reviewed. In my opinion a verbal request for review should be sufficient. There should also be an obligation on any doctor who might not be of an opinion that termination is necessary to facilitate the initiation of the review process.

I believe that 7 days is too long to initiate the review process. The proposals, as they stand, might mean a delay of 14 days before the clinical situation is reviewed. In my opinion, this is too long and potentially dangerous.

Head 7- Review where risk arises from physical illness, not being a risk of self-destruction

My comments regarding the timing of a review apply here also.

Head 8 - Review in case of risk of loss of life through self-destruction

I defer to the opinion of the College of Psychiatrists of Ireland.

Head 9 - General provisions for Committee

I have no difficulty with any of this.

Head 10 - Formal medical review reports to Minister

I wholeheartedly support this proposal. Audit forms an integral part of Obstetric practice in this country and has done so for many many years.

Head 11 - Notifications

I have no difficulty with this and welcome the proposal that the Freedom of Information Act 1997 should not apply to any individual record under this Head. I think it important, however, that overall statistics are available, as should be the case for all medical procedures in the State.

Head 12 - Conscientious Objection

I have no difficulty with anything in this Head.

Head 13 - Travel and Information

I have no comment.

Head 14 - Regulations

I have no comment

Head 15 - Regulations respecting certification of opinions referred to in this Act

I have no comment.

Head 16- Regulations respecting notifications to the Minister

I have no comment.

Head 17 - Laying of regulations before the Houses of the Oireachtas

I have no comment.

Head 18 - Repeal and Consequential Amendments

I have no comment.

Head 19 - Offence

I have difficulty with the proposal that a pregnant woman who undergoes a termination will potentially face 14 years imprisonment. If a woman is subject to medical opinion and if that opinion, even if erroneously, concludes that termination is necessary to save her life, it is entirely unreasonable, in my opinion, to expect her to "second guess" a doctor's opinion in this respect. It would appear somewhat bizarre and contradictory to propose that a woman be sentenced to 14 years imprisonment on foot of accepting medical advice in this State,

whereas should she travel to the U.K. and have a termination there, she is protected under the Constitutional amendments of 1992.

Head 20 - Commencement – with short title

In my opinion the Act should not be introduced piecemeal.

Dr Peter Boylan.

Report for the Oireachtas Health Committee on the Protection of Life during Pregnancy Bill 2013

My name is Dr. Sam Coulter-Smith, Master of the Rotunda Maternity Hospital in Dublin. My submission to the Committee is based on my own views and the views of my consultant colleagues at the Rotunda, following our consideration of the draft heads of bill.

Mr. Chairman and members of the Oireachtas Health Committee I would like to thank you for giving me the opportunity to present my views on this important piece of draft legislation. If I could first of all make some general comments. I would like to acknowledge the work that was done on this extremely difficult and contentious document and commend those who drafted the text for avoiding the word 'abortion' in the terminology. I think this is a positive move and ensures that those women who have to have a pregnancy terminated in an emergency situation are not stigmatised in any way and this is to be welcomed.

Where can termination of pregnancy occur?

I think there are two factors that need to be considered here. I would welcome the fact that this legislation provides for a termination of pregnancy in an emergency situation in any of the 19 maternity units in the country. However there are occasions when it may be necessary to terminate a pregnancy outside these institutions. For example in Mount Carmel which is a private non HSE hospital, delivering maternity care.

In addition in each of the big Dublin Maternity Hospitals there is no provision for intensive care, therefore the sickest patients from these units, some of whom will have been transferred from other units around the country to Dublin for care, will be looked after in the intensive care units in either the Mater, St. James's or St. Vincent's. There may be occasions when it is necessary to provide the type of emergency care which is provided for within this legislation to patients in these intensive care units which are currently outside the draft legislation.

Clinical Scenarios

The document broadly covers three clinical scenarios: firstly, when a woman's life is acutely at risk in an emergency situation; secondly, when the acuity of the situation is less urgent but

the severity of the situation relates to a co-morbidity, such as cancer, significant heart disease or other significant illness; the third clinical scenario is where there is an imminent risk of death resulting from suicide. In relation to the first two scenarios, I think the bill provides clarity and appropriate protection for those giving care to the pregnant woman. This should provide clarity and reassurance for all professionals both medical and midwifery and nursing, that their actions in giving best care to the mother are covered under the law. It should also provide reassurance for women and their families that the medical profession can act in their best interests during difficult, life-threatening situations, and this is to be welcomed. It is also important to note that no gestational limit has been applied to either of the first two scenarios and, in my view, this is appropriate. I think it is also important to note that it is confirmed and reiterated in several areas within the draft document that doctors must have regard to the protection and preservation of the unborn human life where practicable. This should provide appropriate reassurance for patients and their families in difficult and distressing situations.

In relation to the first scenario where a woman's life is at risk in an acute emergency situation where it is now acceptable for one obstetrician to decide whether a termination of pregnancy is required to save the woman's life, I think it is good practice in any institution for an obstetrician to seek a second opinion from a colleague if it is possible to do so. However in these difficult situations there would often be other consultants involved such as the haematologist in the case of haemorrhage; a microbiologist in the case of infection; it is also likely that a consultant anaesthetist would be available and it would be appropriate for the consultant obstetrician to seek advice and discuss the decision making with these colleagues.

In relation to risk of loss of life from self-destruction, I think there are a number of issues which need to be raised. Firstly, this is an extraordinarily rare situation, with an incidence of suicide in pregnancy of the order of one per half a million pregnancies, as per UK figures. Secondly, there is currently no available evidence to show that termination of pregnancy is a treatment for suicidal ideation or suicidal intent, and as obstetricians we are required to provide and practice evidence treatment. It therefore creates an ethical dilemma for any obstetrician who is requested to perform a termination of pregnancy for the treatment of someone with either suicidal ideation or intent. Thirdly, this legislation is I'm sure, designed to create clarity and reassurance for both health professionals and patients alike. The fact that there is no gestational limit in relation to the third scenario covered by head 4, relating to suicidality is a major ethical issue for obstetricians, and if I may illustrate this with two case

scenarios. Firstly if a patient at twenty-five weeks gestation is deemed sufficiently suicidal to require a termination of pregnancy by one or more psychiatric colleagues, the obstetrician tasked with dealing with this situation is faced with an enormous ethical dilemma. Delivery of this baby at twenty-five weeks gestation could lead to the death of the child from extreme prematurity, could lead to a child with cerebral palsy, or with significant developmental issues for the future. This outcome would be entirely iatrogenic and the responsibility of those clinicians who agreed to be involved in the process. This is a source of serious concern for myself and my colleagues. Another clinical scenario which provides a difficult ethical dilemma is a situation where at a woman's twenty week anatomy scan a significant but non-lethal malformation is discovered. The patient for a variety of reasons may decide that she cannot continue with this pregnancy and it is causing her significant mental health issues with a risk of suicide. The obstetrician is left in the unenviable position of by law having to have the best interests of the baby at heart but also understanding the issues the mother faces. It would therefore seem appropriate in the case where there is a risk of self-destruction that there is a gestational limit applied in this case. These situations create major ethical issues for us.

However, my overriding concern in relation to the whole area of self-destruction and termination of pregnancy to prevent same relates to the lack of evidence to show that termination of pregnancy is of any assistance in this scenario and that we as obstetricians and gynaecologists must be able to stand over the decisions we make as being based on good medical evidence.

Infrastructure and Resources

It is the view of many of my colleagues that the inclusion of suicidality within this legislation may in the long term lead to an increased demand for termination of pregnancy in this country and we currently do not have any real understanding of how big that demand may be. Currently in excess of 5,000 women per year go from Ireland to the UK to have termination procedures performed. We cannot be certain how many of these women will decide to use this current legislation as a means of obtaining a termination in this country and even if they are unsuccessful in obtaining a termination in this country a huge amount of time and resources will be spent on the assessment of these patients.

We currently have three sub-specialists psychiatrists with a special interest in mental health issues in pregnancy and these part-time posts are attached to each of the three big Dublin Maternity Hospitals. Mental health issues in pregnancy are one of the commonest complications that we see effecting 10 to 15% of the pregnant population. The impact of this very high incidence of mental health complications mean that these services are overstretched and find it difficult to cope with the workload currently in existence. Any increase in the workload on these services would put a huge strain on the system and take it beyond breaking point.

Each of the Dublin Maternity Hospitals delivers approximately 9,000 women a year. The midwife to patient ratio is half of what it should be and the consultant to patient ratio is again half of what it should be. We have seen an increase in the delivery rate in Dublin of about 30% over the last six years and this has put an enormous strain on the infrastructure of our hospitals. The increase in the number of mothers delivered is now leading to a huge increase in the demand for gynaecology to the extent that waiting lists for routine gynae out-patient clinics are currently well over a year and growing. The combination of these factors means that it would be extremely difficult for us in the maternity hospitals to take on any additional service which would require the input of staff in an out-patient setting in terms of assessment, and theatre time to cope with the increase in the number of termination procedures.

In conclusion Mr. Chairman and members of the Oireachtas Health Committee I welcome this draft legislation, particularly in the area of real and substantial risk to the life of the mother where this pertains to physical illness, however I think there are significant concerns from all areas of the medical profession in relation to this bill when it comes to suicidality and our overriding concern relates to the lack of evidence to show that termination of pregnancy is the appropriate treatment for a woman who is deemed to be at risk of suicide. As obstetricians we are expected to practice evidence based interventions and first and foremost to do no harm. This legislation should help to provide clarity and reassurance to professionals and patients alike. However, to enact and underpin the idea that termination of pregnancy is a solution or a treatment for a patient at risk of committing suicide when there is no evidence to support that intervention, creates a huge ethical dilemma for our profession. To make matters even more difficult there is no gestational limit mentioned in the draft at which this termination might happen. This opens the possibility for iatrogenic prematurity with all its risks of infant morbidity and mortality. Who will be held responsible for these

outcomes? I would also like to confirm to the Committee that we as a profession have concerns about the potential for an increased demand for termination services in the country and this may be an unintended consequence of this legislation drafted in its current fashion.

The General Scheme of the Protection of life during pregnancy (heads of) Bill 2013
Submission By
Dr Rhona Mahony, Master of the National Maternity Hospital, Dublin

Introduction:

I am the Master (CEO) of the National Maternity Hospital, Dublin. In addition, I am a practising Obstetrician and Gynaecologist and a Specialist in Fetal and Maternal Medicine, practising as a Consultant at NMH since 2008. I am a member of the Executive of the Irish Institute of Obstetricians and Gynaecologists and am a Fellow of the Royal College of Obstetricians and Gynaecologists in the UK.

I welcome the decision of the Government to approve draft Heads of the Bill for the General Scheme of the Protection of Life during Pregnancy Bill 2013. I am pleased to accept the invitation to make this written submission

In making this submission, I would appreciate that consideration be given to my original submission and hearing at the Joint Oireachtas Committee on Health and Children on January 8th 2013 following the publication of the Expert Group Report in relation to matters arising from the European Court Judgment in A,B,C versus Ireland.

I am concerned that the 1861 Offences against the Person act (Section 58 and 59) leaves women and their doctors legally vulnerable because there is a lack of clarity surrounding when termination of pregnancy is legally permissible in Ireland. The Supreme Court Judgment in the X Case provides for termination of pregnancy where there is a substantial risk to a pregnant woman's life. At present in Ireland, there is no legal framework through which a substantial risk to maternal life can be defined.

I believe this proposed legislation addresses my concerns as a practising obstetrician. In addition, I am satisfied that under this legislation, the constitutional protection of the unborn is protected where practicable as we are under obligation to vindicate the life of the fetus where it is practicable according to Article 40.3.3 of the constitution. This means that when a fetus has reached a gestation where survival is possible, if it is necessary to terminate the pregnancy to save the mother's life, every effort is made to optimise survival of her fetus. In practical terms, with current Neonatal Intensive Care, neonatal survival is now possible as early as twenty three weeks gestation and at birth weights as little as 500g. This precludes the concept that "late termination of pregnancy" could involve the destruction of a fetus. Once a fetus is viable (around 23 weeks gestation), if delivery is necessary to save a woman's life medical staff are required to make every effort to optimise survival for her baby. At early

gestations prior to any prospect of fetal viability because of prematurity, if a pregnant woman dies, so will her baby.

I have studied the draft Heads of Bill and wish to make the following observations:

Head 1 Interpretation:

Relating to Obstetrician/Gynaecologist, it should be noted that obstetricians may sometimes be on the General Register.

In my view it is important to include all public general hospitals and not just the 19 Units providing obstetric and gynaecological services. In the case of the three Dublin Maternity Hospitals women who are seriously ill may be managed in a general hospital setting. For example, at the National Maternity Hospital we will sometimes transfer patients to St. Vincent's University Hospital for intensive care support depending on the underlying disease. It should be possible to perform life saving termination of pregnancy in any Government approved hospital which may care for pregnant women.

Head 2: Risk of loss of life from physical illness not being a risk of self-destruction.
I believe that this is a workable provision. It specifies that it will always be a matter for the patient to decide if she wishes to proceed with a termination following a decision that is permissible under this Act. In addition, under the explanatory notes on page 7, it is recognised that the risk to life need not be inevitable or immediate. This provides essential flexibility for doctors to make appropriate decisions in very complex medical circumstance.

Head 3: Risk of loss of life from physical illness in an emergency situation.
This head rightly responds to the need to facilitate an emergency procedure when there is an immediate risk to life. This is a practical issue and provides legal support to women and their Consultants in the tragic circumstance when the risk to life is immediate. Although consultation between two Obstetrician Gynaecologists is desirable in an acute emergency setting, single opinion is sufficient and every effort must be made to save the woman's life. It should also be considered that any registered doctor should have the ability to terminate a pregnancy in a situation where the risk to life is immediate. For example if a woman is admitted to a general hospital with life threatening haemorrhage, the surgical team may be required to manage this situation.

Head 4: Risk of loss of life from self –destruction
I support the inclusion of this Head which deals with the potential for maternal suicide as a consequence of pregnancy. The genesis of this Head is in the X-Case in which a fourteen year old child became pregnant following rape. She expressed suicidal intent as a result of her situation. As suicide entails death by self destruction, a woman who wishes to commit suicide is at risk of dying. Therefore she requires access to expert psychiatric care. It should be pointed out the vast majority of women who are suicidal want treatment for their distress of suicidal feelings and do not want termination of pregnancy.
Notwithstanding , in very rare cases, women and teenage girls will be suicidal as a consequence of their pregnancy and will not wish to continue with their pregnancy. These women and teenage girls should be listened to, believed and supported. In the same way that any woman who is at risk of dying while pregnant, these women should equally have access to a process which enables them to determine whether or not termination of pregnancy is part of a treatment process indicated to save their life. This raises the question as to whether

failure to legislate for this process runs counter to the European Court Judgement in A, B, C vs. Ireland.
In terms of the process I would make the following comment:
It is reasonable that two psychiatrists must come to an agreed decision regarding the need for termination of pregnancy on the grounds of suicide risk. I also agree that an obstetrician should be involved in this process. While an obstetrician cannot assess suicide intent, obstetric considerations apply and should be addressed by an obstetrician.
In this overall context consideration must be given to the lack of resources that prevail in Irish psychiatric services today. These resource issues would need to be addressed in accordance with the direction of the The College of Psychiatrists of Ireland.

Head 5: Medical opinion to be in the form and manner prescribed by the Minister:
No comment

Head 6: Formal Medical Review Procedures
I agree that a formal medical review process should be available. I consider the 7 day time threshold reasonable but it is very important that the review process is accessible and that no unnecessary barriers are presented given the sensitive nature of the issues involved.
Head 7: Review where risk arises from physical illness not being a risk of self destruction.
I agree that a formal medical review process should be available. I consider the 7 day time threshold reasonable but it is very important that the review process is accessible and that no unnecessary barriers are presented given the sensitive nature of the issues involved.

Head 8: Review in case of risk of loss of life from self destruction
I support the right of appeal to a review panel at a patient's request. It is important to separate the different skill sets between obstetricians and psychiatrists. For example, obstetricians are not trained to assess suicide ideation and psychiatrists are not trained to dictate obstetric intervention. The review process should have regard to the sensitive and distressing issues which pertain when a patient is suicidal as a result of her pregnancy.
If the original decision to refuse termination of pregnancy is on psychiatric grounds but not on the grounds of obstetric objection, it should not be necessary to require further obstetric assessment. Further assessment by two independent psychiatrists should be sufficient.
Similarly if the decision to refuse termination is on obstetric grounds but where there is unanimity in the psychiatric assessment, further review should be obstetric in nature.
Head 9: General provisions for committee
No comment
Head 10: Formal medical review reports to Minister
I support a reporting mechanism to facilitate medical audit. Audit is a very important part of obstetric practice with many clinical benefits
Head 11: Notifications
This further supports an audit process which I support. I regard it as most important that the Freedom of Information Act 1997 will not apply to these records.
Head 12: Conscientious Objection
I support any doctor's right to conscientious objection given the sensitivity of the issue. However, in the context of a profound emergency where the risk of death is immediate, there can be no hesitation to save a woman's life and the issue of conscientious objection does not arise.
Head 13: Travel and information
No comment

Head 14: Regulations
No comment
Head 15: Regulations respecting certification of opinions referred to in this act
No comment
Head 16: Regulations respecting notifications to the Minister
No comment
Head 17: Laying of regulations before Houses of the Oireachtas
No comment.
Head 18: Repeal and consequential Amendments
Sections 58 and 59 of the 1861 Offences against the Persons Act must be either repealed or amended to protect women and doctors from a life of penal servitude if a termination of pregnancy is performed under any circumstances.
Head 19: Offence
No comment
Head 20: Commencement-with short title
No comment

Conclusion:
I interpret the draft Heads of Bill as intent to legislate for the X Case. Central to this judgement is the interpretation of article 40.3.3 of the Constitution. Prior to any prospect of fetal survival outside the uterus as a consequence of prematurity, it cannot be a question of a balance of rights between the mother and the fetus. It a question of survival and prevention of maternal death because at these early gestations if a pregnant woman dies, her baby dies too. I believe the proposed legislation is appropriate and with some practical amendments is workable.

Joint Committee on Health and Children Public Hearings on the Protection of Life During Pregnancy (Heads of) Bill 2013

Opening Statement

Dr Gerry Burke
Consultant Obstetrician and Gynaecologist
Mid-Western Regional Maternity Hospital
Limerick

I thank the Chairman, Mr Buttimer, for his kind invitation.

I welcome the publication of the General Scheme of the Protection of Life During Pregnancy Bill 2013, which I have read.

Given the title of the Bill, and its objective, it is appropriate to make a general comment about the background to this piece of legislation in order to place it in the wider context of the care we give to pregnant women and babies.

Legislation about the exact circumstances in which termination of pregnancy is allowable to save the life of a mother is important but, in terms of lives saved, it is far less important that the state of the maternity services, which are under considerable strain and about which there has been almost no debate. I am informed that the number of maternal deaths in Ireland in 2012 was twelve, giving a rate of 16 per 100,000, which represents a doubling of the rate for the three previous years.

Turning to the specifics of the Heads of Bill, my overall impression of it is that the approach taken is very thoughtful and reasonable. There is a good deal of common sense in it.

However, the document contains one major flaw, a potentially fatal one – the lack of any attempt to define what is meant by '*real and substantial risk*', a term which appears frequently in the text.

It will be critical to the succcess of this legislation, in terms of preventing deaths due to, for example, septicaemia following on from rupture of the membranes and ascending infection, that this fundamental matter is dealt with clearly.

Without such a definition, the legislation will be practically useless.

I respectfully suggest that, in the context of the permanent and irreversible outcome that is death, a risk in the order of 1-5% should be considered 'substantial', since that figure represents something in the order of 100 to 600 times the overall risk of a maternal death in Ireland (8 per 100,000 in 2009-2011).

It should be noted, however, that doctors do not usually have very precise data with which to estimate the amount of risk in the complex clinical circumstances that could lead to a maternal death. Such data are very sparse in the medical literature.

Consequently, some sensible latitude about the matter should be built into the legislation. The figure of 1-5% that I mentioned could be offered as a guideline rather than as an absolute threshold below which an intervention would be considered illegal. The assumption should be that the medical 'opinion' will almost always be 'reasonable', as defined above.

There are two more minor issues.

Firstly, it is possible for a pregnancy to be ectopic but within the womb. This happens when a pregnancy implants in the cervix of the womb or, as we are seeing more frequently now, in the scar of a previous Caesarean section in the womb. The latter condition can result in a successful outcome for both mother and baby but the more severe forms carry a risk of maternal death of up to 7% (1). It would be helpful if the Heads of Bill specifically referred to these types of ectopic pregnancy.

Secondly, it should be noted that, in certain circumstances, the treatment might need to be carried out in a general hospital rather than in an obstetric hospital so that the patient could be transferred immediately to facilities such as an intensive care unit.

(1) O'Brien JM, Barton JR, Donaldson ES. The management of placenta percreta: conservative and operative strategies. Am J Obstet Gynecol. 1996 Dec;175(6):1632-8. PubMed PMID: 8987952.

Submission to the Oireachtas Committee on Health and Children on The Heads of Bill Protection of Life during Pregnancy Bill 2013
Submitted by: Dr Mary McCaffrey, Consultant Obstetrician/ Gynaecologist, Kerry General Hospital.

This submission is intended to reflect on the proposed legislation and how it may impact on the practice of obstetrics in Maternity Units that have three Consultant Obstetricians on staff. Such Units make up a large number of the Maternity Units in Ireland and deliver a significant number of babies every year.

Head 2 Risk of loss of life from physical illness, not being a risk of self-destruction
Currently, Consultant Obstetricians manage such cases in accordance with best practice, and in consultation with the specialist caring for the medical condition causing concern.
Under the proposed legislation one Obstetrician is required to make a decision regarding on going management. However, due to the complex nature of such cases which may involve women with serious cardiac disease or cancer, their care will be managed in tertiary care centres and is less unlikely to involve the obstetrician in smaller maternity units.

Head 3 Risk of loss of life from physical illness in a medical emergency
Such emergency situations may include women with severe or impending infection or conditions such as severe pre eclampsia. Currently, such clinical cases are managed in accordance with best practice in smaller maternity units. The legislation would, in fact, now protect the obstetricians in their delivery of care in such situations. It is always best medical practice to have two doctors consulting on such cases and, in reality, this is usually the case. However, there will be situations where only one obstetrician is present in a maternity unit e.g. weekends or at night.

Head 4 Risk of loss of life from self-destruction
Many colleagues would require clarification on the role of an obstetrician as a signatory in such cases. A Consultant Obstetrician in current practice is unlikely to have appropriate experience in the diagnosis of suicide. The question of working outside of scope of practice arises. Clearly, obstetricians would wish to be aware that such a difficult case could come under their care but the appropriateness of an obstetrician being involved in a final diagnosis of suicide is questionable.
Head 12 Conscientious Objection
In current practice all obstetrician / gynaecologists practice in such a way as to protect the life of both mother and baby at all costs. In medical/ obstetric emergencies which are life threatening women will always receive adequate care to protect the mother's life.
There are medical staff, and probably other healthcare staff, who have conscientious objections to being involved in procedures to be performed under the proposed legislation. It is crucial that such a moral and ethical viewpoint is respected at all times. Procedures must be developed to ensure women have access to an alternative medical colleague to take over their care in a timely manner.

(3) No institution, organisation or third party shall refuse to provide a lawful termination of pregnancy to a woman on grounds of conscientious objection.
The question of whether medical practitioners should "declare" their moral or ethical objections prior to taking up employment has been mooted in media etc.
As someone who has worked in jurisdictions where termination of pregnancy is practiced, such a question was not acceptable at interviews or by an employer in advance of a decision to employ a doctor. A person's ethical stance was respected at all times.
A medical practitioner's ethical viewpoint must not be the subject of any interview question or decision on whether they would be employed in a particular post. There must be no discrimination of any doctor.
The above subsection refers to "institution, organisation or third party". Clarification on the parties referred to is required.

Other Issues not highlighted in Heads of Bill

- Resources must be in place in all workplaces to allow medical practice to be carried out safely
- Medical / surgical procedures which may need to be performed may require training for obstetricians who have previously not carried out such procedures. No person should be expected to carry out such procedures without adequate training, especially as it is likely to be a very rare procedure being performed by individual obstetricians.
- Any additional procedures required when the person is under age

Submission in relation to the general scheme of the PROTECTION OF LIFE DURING PREGNANCY BILL 2013.

AUTHOR.

Dr John Monaghan is a consultant obstetrician/gynaecologist in Portiuncula hospital, Ballinasloe, County Galway, a general and maternity hospital delivering 2200 mothers annually.
A graduate of Trinity College Dublin in 1976, he trained in Ireland, the UK and Nigeria. He was assistant master at the National Maternity Hospital from 1983 to 1986 and has been a consultant for 27 years, currently a member of the Irish Medical Council.

Introduction.
This submission relates to 4 principal items related to the heads of bill as published.

These are:
Head 2 The question of "clarity" as it relates to the findings of the European Court of human rights.
Head 4 The question of suicide, or self-destruction as it relates to obstetric practice.
Head 12 The question of conscience, or "refusal of treatment"
Head 19 The offence of destroying unborn human life.

Head 2 THE QUESTION OF "CLARITY".

In the case of A, B and C v Ireland, the case of the woman referred to as "C" was successful in the European Court of Human Rights(ECHR). This was a woman who had been treated for cancer. She was unable to obtain clear advice as to the effect of the pregnancy on her health, or the effect of medical treatment on the fetus. Arising from this judgement the Expert group stated: "Ireland is under a legal obligation to put in place and implement a legislative or regulatory regime providing effective and accessible procedures whereby pregnant woman can establish whether or not they are entitled to a lawful abortion".

As it appears that C was unable to establish the degree of medical risk involved, I would question whether these Heads of Bill offer any further clarity in resolving what is a medical issue, in other words would such a patient have access to appropriate medical advice under the proposed legislation?
There has been a considerable amount of published work on the question of cancer in pregnancy and it is clear that therapeutic opportunities and new treatments have made a substantial change in the treatment of cancer in pregnant women. A series of articles published in "the Lancet" in 2012 are attached to this submission. While three of them are of a technical nature, the leading article gives a fairly clear picture of how this field is changing. The lead author, Dr Frederic Amant, has spoken in Ireland.
It is clear that pregnant women with cancer should have access to a specialised service, led by an Oncologist, but with expertise from a multidisciplinary team including surgeons and radiotherapists. Such a service is available in other countries, most notably, as can be seen from the attached literature, in Belgium.
In the context of The Protection of Human Life During Pregnancy Bill, the development of such a service should be seriously considered by the Committee on Health and Children. It is clear from these papers that many of the circumstances were abortion was practised in the past, it is no longer necessary, with the availability of new regimes of chemotherapy and directed surgery which does not harm the uterus and the unborn child.
If it is the priority of this Bill to protect women's lives, then the committee should be seriously concerned with the development of a specialised National unit to manage cancers in pregnancy, which are becoming more frequent. It appears likely that an existing Centre of Excellence could offer this service without great costs. It is a matter of acquiring expertise rather than any specialised equipment or other resources.
In the context of the ECHR and "Clarity", offering a woman the best treatment for cancer in pregnancy, in a specialised centre, would serve a womans' needs, and those of her child, much more effectively than an abortion law.

Head 4 The Supreme Court and the X case.

The second reason for bringing forward this legislation is the Supreme Court judgement of 1992,(Attorney General vs X). In the X case the stated risk to the woman's life was the threat of suicide.
While the stated risk of suicide is a matter for the expertise of psychiatrists, it is proposed that an obstetrician be involved in the decision-making, and the proposed termination of pregnancy would be undertaken by that obstetrician.
It is a matter of grave concern that no evidence supporting a medical benefit to a suicidal patient appears to have emerged during the first round of hearings held by the Health Committee in January 2013.
In contemporary medical practice any course of treatment must be based on evidence, from the best quality research, which shows benefit from a course of treatment given to the patient.

An obstetrician, though not the expert in mental health, if he or she knows that there is no medical evidence of patient benefit, and possibly harm, will find themselves in an impossibly conflicted situation ethically if required to terminate the life of a normal fetes where no benefit to the mother exists.
It would be of the gravest importance that the Committee on Health and Children satisfy themselves on the evidence on this matter before enacting any legislation that relates to suicidal ideation in pregnancy.
If the evidence presented to the Committee shows that abortion is not beneficial to the mother, or is harmful, then it is impossible for this Head of bill to stand as it is. In particular the sentence "It is not necessary for medical practitioners to be of the opinion that the risk to the womans life is inevitable or immediate " would appear to be open to the widest exploitation and abuse. While a doctor, in the case of, for example, heart disease, may be able to anticipate future deterioration as pregnancy progresses, this could not be said to apply to the question of suicidal ideation.

There is a serious problem with an increasing suicide rate in Ireland, media reporting, for example may affect suicidal ideation in people who exposed to it. To link pregnancy, particularly unintended pregnancy, with suicide would appear to be dangerous.In other words to relate a crisis pregnancy situation to suicide in a legislative act, may of itself increase suicidal ideation in some women who are pregnant and vulnerable .

Head 12 Conscientious Objection.

The question of conscience in medicine has a long history. It is not question of conscientious objection, but that physicians should behave in a conscientious manner. Medicine in the past has many examples of the appalling failure of doctors to behave with conscience. Doctors have been involved in the deliberate infection of patients(with syphilis for example), forced sterilisation or abortion, illegal experimentation, torture and mass murder. These events, well documented, have given insights to doctors which profoundly influence the practice of medicine today.

Arising from the atrocities of World War II a series of declarations came into existence in, the Nuremberg Principles(1947), the Declaration of Geneva(1948) Helsinki(1964) and Tokyo (1975). These were designed to lay down rules to prevent unconscionable behaviour by doctors. A recent conflict between State authority and the medical profession related to the torture of prisoners at Guantanemo Bay in Cuba (see attached article, British Medical Journal). The notion of Conscience has recently come under attack, mainly because increasing numbers of doctors find abortion ethically unacceptable. (see article 4 and 5 attached)

Head 12 (1) in stating that "no medical practitioner, nurse or midwife is obliged to carry out or assist in a termination of pregnancy", acknowledges conscience
The notes which follow Head 12 however appear to undermine this, in stating that this right to conscientious objection does not apply in emergency situations. The question of emergency or not does not affect the rightness or wrongness of any clinical act. That a doctor would refuse to treat a patient whose life was in danger on conscientious grounds, is an irrational assumption, because if the mother dies, the baby invariably dies. To refuse to treat a woman because she is pregnant has been rightly been regarded as professional misconduct.

Head 19 The Offence of Abortion

(1) "it shall be an offence for a person to do any act with the intent to destroy or unborn human life".

This is a most important statement vindicating the right to life of the unborn child under the Irish constitution. It gives legal force to 2 statements given in the explanatory notes of Head 2. "An obstetrician/gynaecologist is obliged to care for the pregnant woman and the fetus and, therefore has a duty of care to both patients" (page 7) and: "in circumstances where the unborn may be potentially viable outside the womb, doctors must make all efforts to sustain its life after delivery". (page 8)
It has become practice in some countries to kill the child with a lethal injection before delivery, so that he, or she cannot be born alive. (example: "Feticide should be performed before medical abortion after 21 weeks and six days of gestation to ensure there is no risk of a live birth ") While termination of pregnancy may be necessary to save the life of the mother, this has to mean that to the offence: "act with the intent to destroy human life" applies in all circumstances, notwithstanding that it may be necessary to deliver the child to save the mothers life. By this the doctor would not do any act to kill the unborn child. I believe that this should be explicit in all parts of the Act, i.e. that a doctor does not kill an unborn child in the womb in any circumstances.

Other Comments in relation to the Heads of Bill.

Head 1: "reasonable opinion" means an opinion formed in good faith, **and based on evidence that the intervention is an appropriate treatment for the medical condition in question** and which has regard to the **obligation** to preserve the life of the child as far as practicable.

Head 4: If the serious problem of any medical evidence to support termination of pregnancy in cases of suicidal ideation is confirmed, this section should be removed.

Head 9: The powers conferred on the Committee under subhead (1) appear extremely broad as in "may direct any relevant medical practitioner to produce to the Committee any document or thing in his possession………" . (This is a legal matter)

Head 10: Last explanatory note: last sentence beginning "Furthemore , if it were……" This may contain misprint.

Head 12: Professionals other than doctors , midwives and nurses have rights to exercise conscience also such as: counsellors,social workers, clerical staff and porters. Everybody should be permitted to exercise their conscience where innocent human life is concerned.

End of written submission

Cancer in pregnancy: a challenging conflict of interest

> Great and sacred are the thoughtful deliberations required to preserve the lives and health of creatures.
>
> *Maimonides, 12th-century physician*

The incidence of pregnancy-associated cancer ranges from 0·02% to 0·1%.[1] Cancer during pregnancy is a challenge for the physician since, in the absence of major patient cohorts and large randomised trials, the relationship between the patient's trust and the physician's conscience is a key factor in the medical decision-making process. Decisions about the best treatment for cancer in a pregnant patient are often difficult because they are indicative of the conflict between the mother's wellbeing and that of the fetus. The physician has to provide accurate information and has the difficult role of defining when and how far to push back usual treatment limits to satisfy the patient's wishes while thinking about oncological risks. Additionally, ethical, legal, or personal concepts, particularly religious or emotional ones, vary from one patient (or couple) to another. The patient's dilemma might be as difficult as that of the physician but the two sets of issues are not necessarily the same. *The Lancet*'s Series on Malignancies in Pregnancy[2–4] aims to present the most important developments in this sphere to help physicians and patients so that cancer during pregnancy will no longer be a *poena magna* as stated by Pentheroudakis and Pavlidis.[1]

Two major deleterious risks arise frequently: first, an initially misdiagnosed tumour that will probably lead to a long delay (and thus progression of disease) before initiation of treatment and, second, undertreatment because of pregnancy. The crux of the dilemma is finding a balance between the need to delay treatment while the fetus develops and the need to induce a premature delivery. This induced prematurity might be unnecessary and lead to unjustified morbidity for the newborn.[5]

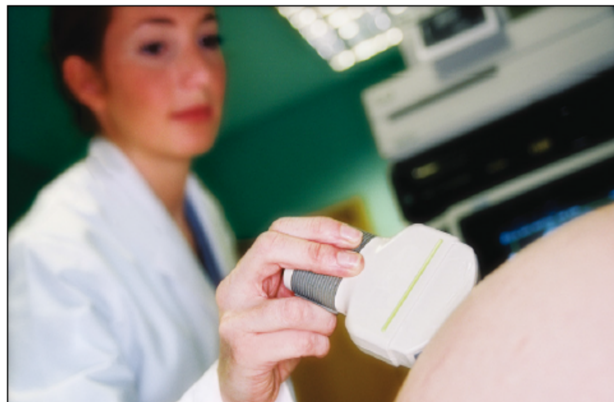
True oncological emergencies in pregnant patients are rare (except for leukaemia), and time is required to deliberate and to draw up a personalised treatment plan[3] that the patient will view as clear and balanced, with an understanding of our gaps in knowledge about cancer during pregnancy. The physician must be prepared to answer legitimate questions that the patient might ask about timing of treatment and fear of progression. For particular cancers treatment can be delayed until after delivery but first physicians must define the initial stage of the disease (eg, with MRI and laparoscopic lymphadenectomy for early-stage cervical cancer[4]) to minimise the potential deleterious effect of postponing therapy. The question of the best timing is always crucial.

See Perspectives page 511

See Series pages 558, 570, and 580

The main goal is to offer pregnant patients the same optimum management (and therefore similar predicted survival) as non-pregnant patients. Overall survival and recurrence-free survival rates are well documented for most cancers, and survival is not worsened by pregnancy for many of them.[6] The physician must clearly define the real oncological risk for a specific patient—ie, they should stop thinking about cancer and pregnancy in general but focus on the particular cancer with its known characteristics (eg, oestrogen receptors, nodal status, disease stage, new biomarkers) for the patient in question (according to her age and wishes).

So how can we achieve progress for patients? First, every obstetric practitioner (eg, physician or midwife) and oncologist should keep in mind that, in the future, pregnancy-associated cancer will occur with increasing frequency (because of the epidemiology of postponed motherhood, and increasing incidence of cancers) and know the incidences of the main cancers that arise during pregnancy. This will help them to diagnose cancer at an early stage, and to define basic but systematic screening during pregnancy (eg, breast examination,



Science Photo Library

Pap smear). Second, we have to achieve the same prognosis as for non-pregnant patients. A physician should not have to face this situation alone. An analysis of the situation, which is essential for elaborating potential strategies and appraising their consequences, should be done by a multidisciplinary care team, including organ system specialists, oncologists, psychologists, obstetricians, perinatologists, and paediatricians to remove the patient and her physician from isolation. But the unique human relationship between patient and attending physician remains essential.

National and international recommendations[7–11] are essential to guide treatment teams and can be improved by collaborative studies. In Europe and the USA, three groups (the French Cancer Associated with Pregnancy Network, the European Society of Gynaecological Oncology's Task Force on Cancer in Pregnancy, and the Cooper University, NJ, USA, Cancer and Pregnancy team) coordinate registries that exist to obtain data prospectively about pregnant patients with cancer, to try to respond to these therapeutic challenges. Where possible, every patient with cancer during pregnancy should be recorded in a database or registry, including information about medical management (eg, on biological samples, pharmacology, and psychology). Oncologists should collaborate with paediatricians for long-term follow-up of children who were exposed to chemotherapy during fetal development. Research into fundamental aspects such as pharmacology is essential, especially dynamic studies of the diffusion of chemotherapy during pregnancy. There are many studies of chemotherapy regimens that are no longer the standard of care; we urgently need studies of drugs such as taxanes that are now the standard treatment for most breast cancers.[2]

For the **French Cancer Associated with Pregnancy Network** see http://www.cancer-et-grossesse.fr

For the **European Society of Gynaecological Oncology's Task Force on Cancer in Pregnancy** see http://www.esgo.org/Networks/Pages/TaskForces.aspx

For **Cooper University Cancer and Pregnancy team** see http://www.cancerandpregnancy.com

Treatment of malignancy in pregnancy is still associated with unacceptable errors: eg, the sometimes unjustified termination of pregnancies or the choice of an inadequate strategy for treatment of a tumour with the risk of compromised survival. The treatment of every pregnant woman, and by extension every woman of childbearing age, should include a wider reflection on how to preserve the pregnancy or subsequent fertility, or both. Preservation of fertility in young women with cancer (an entirely new specialty, oncofertility) is every patient's right.[12,13] Oncofertility networks (involving researchers, physicians, and scholars) are active, for example, in the USA in the form of a national consortium.[14] Such networks should be extended to include cancer during pregnancy as a priority. We never know what the future holds, but we should try to influence it for the better.

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We declare that we have no conflicts of interest.

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ANALYSIS

The interrogation of detainees: how doctors' and psychologists' ethical policies differ

The treatment of detainees in prisons such as Guantanamo Bay is controversial. **Kenneth Pope** and **Thomas Gutheil** ask whether the different stances of doctors and psychologists are justified

AMNESTY INTERNATIONAL

Detainee at Abu Ghraib prison, Baghdad, with a bag on his head and wires attached to his hands

The professions of medicine and psychology share many ethical values, but their ethical policies differ sharply. The contrasting responses of physicians and psychologists in the United States to the interrogation of detainees provide a striking example and show the ethical challenges that confront all healthcare professions. The results of such decisions can affect the public interest, how a profession understands itself, and countless individual lives.

In the years since the 11 September terrorist attacks in the US, numerous articles have considered what forms of involvement, if any, are appropriate for physicians and psychologists in detainee interrogations in settings like Abu Ghraib prison and Guantanamo Bay detainment camp.[1] In this article we take a brief look at the contrasting ethical policies adopted by physicians and psychologists in the United States regarding this controversy and consider some of the reasons for the differences.

Contrasting ethics policies

Physicians limited their involvement in detainee interrogations to such a degree that they prohibited even monitoring an interrogation with intent to intervene. Priscilla Ray, chair of the American Medical Association (AMA) council on ethical and judicial affairs, stated: "Physicians must not conduct, directly participate in, or monitor an interrogation with an intent to intervene, because this undermines the physician's role as healer. Because it is justifiable for physicians to serve in roles that serve the public interest, AMA policy permits physicians to develop general interrogation strategies that are not coercive, but are humane and respect the rights of individuals."[2] At a press conference she elaborated that the statement should not be interpreted to mean that physicians could participate in developing rapport building or other strategies for individual detainees.[3]

In contrast, the American Psychological Association (APA) in 2005 adopted a policy that allowed consultation and monitoring of individual interrogations with the intent of intervening.[4] The APA decided not to add detainees to the enforceable standards section of its code, which protects groups that are vulnerable or at risk and allows complaints to be made to the ethics committee. Groups designated in the code include persons "for whom testing is mandated by law or governmental regulations," "persons with a questionable capacity to consent," research participants, "subordinates," clients, students, supervisees, and employees. There is even an enforceable standard on the humane treatment of laboratory animals.[5]

Reasons for difference

Why did the APA take such a different approach from the AMA? Below we discuss some of the factors that may explain the decision.

Age of the profession

Psychology is a younger profession than medicine. Without the centuries of teachings, traditions, and shared identity as an independent profession, a newer profession might more easily comply with the demands of government.

View of ethics code

Founded in 1892, the APA functioned for 60 of its 117 years without an ethics code. Its decision to adopt a code was controversial.[6]

Attitude to prevailing medical and scientific consensus

Historically the APA has been willing to adopt a stance at odds with the medical and scientific consensus about issues affecting the public interest. For example, in the 1980s the APA bought *Psychology Today* to bring psychological science to the public.[7] Although journals belonging to medical associations refused to carry tobacco advertisements because of the health effects of smoking, the APA board of directors unanimously decided that *Psychology Today* would accept advertisements for cigarettes (and alcohol). Its statement reflected the tobacco industry's position that cigarettes are but one of a number of "products considered by some to be hazardous."[8]

Protecting non-US citizens at risk during conflict

Despite many admirable humanitarian stances, the APA has sometimes been reluctant to take formal steps to protect non-US citizens who are at risk during conflicts. For example, when Jewish psychologists and their families were fleeing to safety from Nazi Germany in the 1930s, an APA "Council proposal in 1933 to inquire into racial discrimination against psychologists in Nazi Germany was tabled permanently [rejected] . . . When some of the victims of this discrimination sought refuge in the U.S., the APA waited until 1938 to acknowledge the problem of displaced foreign psychologists by the appointment of a committee to 'survey' it."[9]

Response to conflicts between ethics and governmental authority

US psychologists' views about the relation between ethics and the government's authority seem to differ sharply from the views of their medical colleagues. After the 11 September attacks, the APA changed its ethics code's enforceable standard about responsibilities that conflict with governmental authority. Before 11 September 2001, the code acknowledged that ethics and the authority of the state might conflict: "If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict."[10] In 2002, however, the APA adopted a new enforceable standard allowing members to set aside any ethical responsibilities that were in irreconcilable conflict with governmental authority: "If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority."[5] An attempt to limit the scope of this permission to apply only to ethical responsibilities not

involving human rights was relegated to the non-enforceable section of the code.

The AMA and other physician organisations have not allowed state authority to serve as a rationale for evading fundamental ethical responsibilities. In 2003 the World Medical Association's president stated: "At Nuremberg in 1947, accused physicians tried to defend themselves with the excuse that they were only following the law and commands from their superiors . . . the court announced that a physician could not deviate from his ethical obligations even if legislation demands otherwise."[11]

Perceptions of professional competence and roles

Not surprisingly, different professions hold different perceptions of their (and others') competence, training, and roles. Physicians do not design interrogation plans for specific detainees or observe interrogations with the intent to intervene because "this undermines the physician's role as healer."

Psychologists' ethical policies, on the other hand, reflect a view that interrogation is a psychological endeavour and that psychologists' competencies allow them to take a special role in detainee interrogations.[12] The APA statement on psychology and interrogations submitted to the US Senate Select Committee on Intelligence maintained: "Conducting an interrogation is inherently a psychological endeavour. . . . Psychology is central to this process because an understanding of an individual's belief systems, desires, motivations, culture and religion likely will be essential in assessing how best to form a connection and facilitate educing accurate, reliable and actionable intelligence . . . Psychologists have valuable contributions to make toward . . . protecting our nation's security through interrogation processes."[13]

Perceived difficulties of doing no harm

Differences in beliefs may also exist about the challenges of doing no harm. "First, do no harm" is a constant reminder to physicians. In 2006 the American Psychiatric Association voted overwhelmingly to discourage its members from participating in devising strategies to get information from detainees. When the Pentagon announced it would try to use only psychologists in this role, Stephen Behnke, director of ethics for the American Psychological Association, said "psychologists knew not to participate in activities that harmed detainees."[14] In 2007, the president wrote: "The association's position is rooted in our belief that having psychologists consult with interrogation teams makes an important contribution toward keeping interrogations safe and ethical."[15]

"Military psychologists were enlisted to help develop more aggressive interrogation methods, including snarling dogs, forced nudity and long periods of standing, against terrorism suspects"

It seems worth examining these assurances in light of increasingly detailed reports about detainee interrogations. Writing in *Vanity Fair,* Eban reported, "Psychologists weren't merely complicit in America's aggressive new interrogation regime. Psychologists, working in secrecy, had actually designed the tactics and trained interrogators in them."[16] A Senate investigation found that "Military psychologists were enlisted to help develop more aggressive interrogation methods, including snarling dogs, forced nudity and long periods of standing, against terrorism suspects."[17] Mayer noted that a general "drafted military psychologists to play direct roles in breaking detainees down. The psychologists were both treating the detainees clinically and advising interrogators on how to manipulate them and exploit their phobias."[18]

The *Boston Globe* summarised a major theme of a series of news articles: "From the moment US military and civilian officials began detaining and interrogating Guantanamo Bay prisoners with methods that the Red Cross has called tantamount to torture, they have had the assistance of psychologists."[19] Previously classified US Justice Department documents released in April 2009 in response to freedom of information requests described the roles played by both "on-site psychologists" and "outside psychologists" in justifying the use of waterboarding and other techniques.[20]

LYNNE SLADKY/AP/PA

A detainee from Afghanistan en route to interrogation at Camp X-Ray, Guantanamo Bay, Cuba

In April 2008 American Civil Liberties Union released government documents that it said confirmed "psychologists supported illegal interrogations in Iraq and Afghanistan."[21] The APA ethics director responded that the documents actually showed how psychologists were fighting abuse and thus validated APA's ethical policy. The union disagreed with the APA's conclusion and added, "We are deeply concerned by the fact that, viewed in context, these documents warrant the opposite conclusion."[22]

Many psychologists are reported to be unhappy about their colleagues' role in interrogating detainees.[19] In 2008, the APA took a vote of its membership on a resolution stating that psychologists may not work in settings where "persons are held outside of, or in violation of, either International Law (eg, the UN Convention Against Torture and the Geneva Conventions) or the US Constitution (where appropriate), unless they are working directly for the persons being detained or for an independent third party working to protect human rights." It was approved by 8792 members, with 6157 voting against (from a membership of over 148 000).[23] However, this new policy is not enforceable or part of the ethics code. Responses to a series of questions about the resolution posted on the APA's website state: "The petition would not become part of the APA Ethics Code nor be enforceable as are prohibitions set forth in the Ethics Code."[24] The APA has released several admirable public statements against torture over the years, but has included none in the enforceable section of its ethics code.

We can see no reason why the APA offers protection to many vulnerable groups but refuses detainees even the "humane treatment" accorded experimental laboratory animals

Policy considerations

The interrogation of prisoners at places like Abu Ghraib and Guantanamo Bay poses complex ethical questions lacking easy answers. Similar questions arise in any custodial setting and in any setting in which governmental authority may stand in sharp contrast to a professional's basic ethical responsibilities. The controversy around physicians' participation in capital punishment exemplifies the difficulties that can occur in adopting and enforcing a clear ethical standard. The continuing misunderstandings and disagreements among AMA members despite a clear prohibition for over three decades led Abraham Halpern, professor emeritus of psychiatry at New York Medical College, to comment: "The vast majority of physicians do not know what the AMA policy is on this, and they think they are helping the authorities and making the death of these prisoners more comfortable or peaceful, [a goal that] supports the code of medical ethics. All the while they are in violation of the code of ethics."[25]

We submit the following recommendations for consideration. Firstly, the Nuremberg ethic—that individuals cannot avoid personal accountability by just following orders, laws, or other forms of state authority—should be central to all professions despite their differences. There is great diversity of professional roles, values, and activities not only between professional organisations but also within them. The 54 divisions of the APA, for example, represent such divergent fields as consumer psychology, population and environmental psychology, industrial and organisational psychology, experimental psychology, the psychology of aesthetics, creativity, and the arts, and military psychology. Ethics codes may differ to reflect major differences of roles, but no one should be able to escape personal ethical accountability merely through following orders, laws, and other forms of state authority. History has shown what can result when professionals follow this kind of fallacious ethical reasoning.

Secondly, when special ethical considerations are relevant to professionals' work with a particular at risk group, those considerations should be explicitly included in an enforceable ethics code. We can see no reason why the APA offers protection to many vulnerable groups but refuses detainees even the "humane treatment" accorded experimental laboratory animals.

Thirdly, professional organisations should make greater efforts to ensure that all members know the nature of their ethical responsibilities. Ideally, all AMA members would understand its policy on participation in executing prisoners and all APA members—rather than the relatively small percentage of the membership that voted on the 2008 initiative—would believe that the ethics of participation in the government's detainee interrogation programme was an issue of sufficient importance to take part in a ballot to determine that policy.

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Conscientious Objection Gone Awry — Restoring Selfless Professionalism in Medicine

Julie D. Cantor, M.D., J.D.

A new rule from the Department of Health and Human Services (DHHS) has emerged as the latest battleground in the health care conscience wars. Promulgated during the waning months of the Bush administration, the rule became effective in January. Heralded as a "provider conscience regulation" by its supporters and derided as a "midnight regulation" by its detractors, the rule could alter the landscape of federal conscience law.

The regulation, as explained in its text (see the Supplementary Appendix, available with the full text of this article at NEJM.org), aims to raise awareness of and ensure compliance with federal health care conscience protection statutes. Existing laws, which are tied to the receipt of federal funds, address moral or religious objections to sterilization and abortion. They protect physicians, other health care personnel, hospitals, and insurance plans from discrimination for failing to provide, offer training for, fund, participate in, or refer patients for abortions. Among other things, the laws ensure that these persons cannot be required to participate in sterilizations or abortions and that entities cannot be required to make facilities or personnel available for them. And they note that decisions on admissions and accreditation must be divorced from beliefs and behaviors related to abortion. On their face, these laws are quite broad.

But the Bush administration's rule is broader still. It restates existing laws and exploits ambiguities in them. For example, one statute says, "No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded" by DHHS if it "would be contrary to his religious beliefs or moral convictions."[1] Here the rule sidesteps courts, which interpret statutory ambiguities and discern congressional intent, and offers sweeping definitions. It defines "individual" as physicians, other health care providers, hospitals, laboratories, and insurance companies, as well as "employees, volunteers, trainees, contractors, and other persons" who work for an entity that receives DHHS funds. It defines "assist in the performance" as "any activity with a reasonable connection" to a procedure or health service, including counseling and making "other arrangements" for the activity. Although the rule states that patients' ability to obtain health care services is unchanged, its expansive definitions suggest otherwise. Now everyone connected to health care may opt out of a wide range of activities, from discussions about birth control to referrals for vaccinations. As the rule explains, "an employee whose task it is to clean the instruments used in a particular procedure would also be considered to assist in the performance of the particular procedure" and would therefore be protected. Taken to its logical extreme, the rule could cause health care to grind to a halt.

It also raises other concerns. In terms of employment law, Title VII of the Civil Rights Act, which applies to organizations with 15 or more employees, requires balancing reasonable accommodations for employees who have religious, ethical, or moral objections to certain aspects of their jobs with undue hardship for employers. But the new rule suggests that if an employee objects, for example, to being a scrub nurse during operative treatment for an ectopic pregnancy, subsequently reassigning that employee to a different department may constitute unlawful discrimination — a characterization that may be at odds with Title VII jurisprudence.[2] As officials of the Equal Employment Opportunity Commission remarked when it was proposed, the rule could "throw this entire body of law into question."[3]

Furthermore, although the rule purports to address intolerance toward "individual objections to abortion or other individual religious beliefs or moral convictions," it cites no evidence of such intolerance — nor would it directly address such intolerance if it existed. Constitutional concerns about the rule, including violations of state autonomy and rights to contraception, also lurk. And the stated goals of the rule — to foster a "more inclusive, tolerant environment" and promote DHHS's "mission of expanding patient access to necessary health services" — conflict with the reality of extensive objection rights. Protection for the silence of providers who object to care is at odds with the rule's call for "open communication" between patients and physicians. Moreover, there is no emergency exception for patient care. In states that require health care workers to provide rape victims with information about emergency contraception, the rule may allow them to refuse to do so.

Recently, the DHHS, now answering to President Barack Obama, took steps to rescind the rule (see the Supplementary Ap-

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pendix). March 10 marked the beginning of a 30-day period for public comment on the need for the rule and its potential effects. Analysis of the comments (www.regulations.gov) and subsequent action could take some months. If remnants of the rule remain, litigation will follow. Lawsuits have already been filed in federal court, and Connecticut Attorney General Richard Blumenthal, who led one of the cases, has vowed to continue the fight until the regulation is "finally and safely stopped."[4]

This state of flux presents an opportunity to reconsider the scope of conscience in health care. When broadly defined, conscience is a poor touchstone; it can result in a rule that knows no bounds. Indeed, it seems that our problem is not insufficient tolerance, but too much. We have created a state of "conscience creep" in which all behavior becomes acceptable — like that of judges who, despite having promised to uphold all laws, recuse themselves from cases in which minors seek a judicial bypass for an abortion in states requiring parental consent.[5]

The debate is not really about moral or religious freedom writ large. If it were, then the medical profession would allow a broad range of beliefs to hinder patient care. Would we tolerate a surgeon who holds moral objections to transfusions and refuses to order them? An internist who refuses to discuss treatment for diabetes in overweight patients because of moral opposition to gluttony? If the overriding consideration were individual conscience, then these objections should be valid. They are not (although they might well be permitted under the new rule). We allow the current conscience-based exceptions because abortion remains controversial in the United States. As is often the case with laws touching on reproductive freedom, the debate is polarized and shrill. But there comes a point at which tolerance breaches the standard of care.

Medicine needs to embrace a brand of professionalism that demands less self-interest, not more. Conscientious objection makes sense with conscription, but it is worrisome when professionals who freely chose their field parse care and withhold information that patients need. As the gatekeepers to medicine, physicians and other health care providers have an obligation to choose specialties that are not moral minefields for them. Qualms about abortion, sterilization, and birth control? Do not practice women's health. Believe that the human body should be buried intact? Do not become a transplant surgeon. Morally opposed to pain medication because your religious beliefs demand suffering at the end of life? Do not train to be an intensivist. Conscience is a burden that belongs to the individual professional; patients should not have to shoulder it.

Patients need information, referrals, and treatment. They need all legal choices presented to them in a way that is true to the evidence, not the randomness of individual morality. They need predictability. Conscientious objections may vary from person to person, place to place, and procedure to procedure. Patients need assurance that the standard of care is unwavering. They need to know that the decision to consent to care is theirs and that they will not be presented with half-truths and shades of gray when life and health are in the balance.

Patients rely on health care professionals for their expertise; they should be able expect those professionals to be neutral arbiters of medical care. Although some scholars advocate discussing conflicting values before problems arise, realistically, the power dynamics between patients and providers are so skewed, and the time pressure often so great, that there is little opportunity to negotiate. And there is little recourse when care is obstructed — patients have no notice, no process, and no advocate to whom they can turn.

Health care providers already enjoy broad rights — perhaps too broad — to follow their guiding moral or religious tenets when it comes to sterilization and abortion. An expansion of those rights is unwarranted. Instead, patients deserve a law that limits objections and puts their interests first. Physicians should support an ethic that allows for all legal options, even those they would not choose. Federal laws may make room for the rights of conscience, but health care providers — and all those whose jobs affect patient care — should cast off the cloak of conscience when patients' needs demand it. Because the Bush administration's rule moves us in the opposite direction, it should be rescinded.

Dr. Cantor reports representing an affiliate of Planned Parenthood in a legal matter unrelated to conscientious objection. No other potential conflict of interest relevant to this article was reported.

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Malignancies in Pregnancy 1

Gynaecological cancers in pregnancy

Philippe Morice, Catherine Uzan, Sebastien Gouy, Claire Verschraegen, Christine Haie-Meder

Lancet 2012; 379: 558–69

See Comment page 495

This is the first in a Series of three papers about malignancies in pregnancy

Department of Gynecologic Surgery (Prof P Morice MD, C Uzan MD, S Gouy MD), Unit INSERM U 10-30 (Prof P Morice, C Uzan), and Department of Radiation Oncology (C Haie-Meder MD) Institut Gustave Roussy, Villejuif, France; Universite Paris-Sud, Le Kremlin Bicetre, France (Prof P Morice); and University of Vermont, Burlington, VT, USA (Prof C Verschraegen MD)

Cervical and ovarian cancers are the most common gynaecological cancers diagnosed during pregnancy. In early-stage cervical cancer during the first and at the beginning of the second trimester, the two main considerations for management of the patient are the tumour size (and stage) and nodal staging. MRI and laparoscopic lymphadenectomy are useful for clinicians planning a potentially conservative approach. The management of patients with locally advanced cervical disease is controversial and should be discussed on a case-by-case basis according to the tumour size, radiological findings, the term of pregnancy, and the patient's wishes. Different histological types of malignant ovarian diseases arise during pregnancy and their management depends on the diagnosis (histological subtypes, tumour differentiation, and nodal status), the tumour stage, and the trimester of the pregnancy. In patients with peritoneal spread or high-risk early-stage disease, neoadjuvant chemotherapy with pregnancy preservation could be appropriate.

Introduction

Of the cancers diagnosed during pregnancy, gynaecological malignancies are common.[1-4] When managing these tumours, physicians need to consider both fetal preservation (if possible) and the potential loss of the patient's reproductive capacity as a result of cancer therapy.

The most common gynaecological cancers diagnosed during pregnancy are of cervical and ovarian origin.[5] Because the management of these diseases is complex, a multidisciplinary discussion between a gynaecological surgeon, medical oncologist, radiation oncologist (in cervical cancer), radiologist, pathologist, obstetrician, neonatologist, and the patient herself is imperative. Endometrial and vulvar cancers are less common. Endometrial cancers are usually incidental findings at the time of a uterine curettage undertaken after a miscarriage or delivery.[4,5] The management of vulvar cancers in pregnant patients is much the same as that in non-pregnant women (except for rare cases in which patients need neoadjuvant chemotherapy and radiotherapy for large vulvar tumours). Consequently, the management of these tumours has little or no effect on the pregnancy. Thus, our report focuses on the two most common and complex cancers, cervical and ovarian lesions, including the ethical conflict between the optimum management of the cancer and preservation of the pregnancy.

Key messages

- The incidence of pregnancy-associated cancer ranges from 0·02 to 0·1%. The most common malignancies diagnosed during pregnancy are gynaecological (mainly uterine or cervical and less frequently ovarian), breast, haematological (leukaemia and lymphoma), and skin (melanoma) cancers.
- Pregnancy does not have a deleterious effect on the prognosis of cervical or ovarian cancers. Pregnant patients have a similar outcome to non-pregnant women. European recommendations state that pregnancy should be preserved whenever feasible.
- Treatment strategies should be decided by a multidisciplinary care team including organ system specialists, oncologists, psychologists, obstetricians, perinatologists, and paediatricians.
- Management of cervical cancer mainly depends on four criteria: extent of local spread (ie, tumour stage and tumour size), nodal status, term of pregnancy, and histological subtype.
- In early-stage cervical cancer during the first and at the beginning of the second trimester, MRI and laparoscopic lymphadenectomy are useful for planning of a potentially conservative approach. In patients with a small tumour and without nodal spread, an intentional delay (with a careful clinical and radiological follow-up) to postpone treatment of the tumour until fetal maturity and delivery could be discussed. In such cases, radical trachelectomy and neoadjuvant chemotherapy might be appropriate.
- The management of patients with locally advanced cervical disease is controversial (neoadjuvant chemotherapy with preservation of the pregnancy or chemotherapy and radiotherapy) and should be discussed on a case-by-case basis according to the tumour size, radiological findings, the term of pregnancy, and the patient's wishes.
- Different histological types of malignant ovarian diseases arise during pregnancy and their management depends on the diagnosis (histological subtypes, tumour differentiation, and nodal status), the tumour stage, and the term of the pregnancy. In patients with peritoneal spread or high-risk early-stage disease, neoadjuvant chemotherapy with pregnancy preservation might be possible.

Search strategy and selection criteria

Data for this review were identified from searches of Medline, Current Contents, and PubMed from 1965 to May, 2011, and references from relevant articles with the following search terms: "pregnant patients", "pregnancy", "cancer", "gyn(a)ecological cancer", "cervical cancer", "ovarian cancer", "neoadjuvant chemotherapy", "radical trachelectomy", "delay and pregnancy", and "laparoscopic lymphadenectomy". Abstracts and reports from meetings were not included. Only articles published in English were included. We focused on case reports of particular issues in this context (neoadjuvant chemotherapy, delayed treatment awaiting fetal maturity, radical trachelectomy, or laparoscopic lymphadenectomy during pregnancy). Papers on more general topics were selected on the basis of their relevance or interest in the discussion.

Cervical neoplasms

Epidemiology and general considerations

The incidence of cervical disease in pregnancy is uncertain because reported series are retrospective. Some series include both preinvasive and invasive lesions, whereas others include cases of cancer diagnosed during the pregnancy or during the post-partum period. The incidence of abnormal cervical cytological findings is estimated at 1–5% of all pregnancies and the reported rate of cervical cancers ranges between 1 and 12 per 10 000 pregnancies.[1,6–9] Pregnancy does not have a negative effect on the prognosis of cervical cancer; outcomes are much the same for pregnant and non-pregnant women.[2,10–13]

Management of preinvasive cervical disease

Screening for cervical cancer is an essential component of prenatal care, especially for patients who are not used to having regular gynaecological follow-up. Many consensus guidelines[14,15] recommend that all pregnant women undergo a Pap test at the time of their initial prenatal examination. The Pap test can be difficult to analyse during pregnancy (because of large ectropion, frequent inflammation, presence of confusing decidual cells that can be mistaken for atypia, also called an Arias-Stella reaction), but has the same accuracy as in non-pregnant women.[16]

Diagnostic procedures after abnormal cervical screening should be the same as in non-pregnant women. Colposcopy with a biopsy has a sensitivity of 73–95% and the results accord well with those of the cytological examination.[15,17] Endocervical curettage is contraindicated.[17,18] Low-grade lesions regress in 48–62% of cases, and remain unchanged in 29–38% of cases.[19–21] Progression to more severe lesions is rare (0–6% in reported studies).[19,21] For high-grade lesions (cervical intraepithelial neoplasia grade 3), the regression rate is low (27·4–34·2%) and progression occurs in 2·7–9·7% of cases.[15] If there is no sign of invasive carcinoma, no treatment is needed during pregnancy and management can be delayed to the post-partum period. Colposcopic follow-up is recommended for women without invasive lesions every trimester with repeated biopsies in cases of suspected progression. 40–63% of patients have a persistent lesion after delivery.[20,22]

The indications for conisation decrease with the duration of pregnancy because the risk and morbidity of this procedure—bleeding in 4–15% of cases, pregnancy loss, premature delivery, or premature rupture of the membranes—increase with gestational stage.[23,24] If micro-invasive or invasive disease is suspected, conisation or a large-loop excision procedure should be done early in the pregnancy; the choice between these procedures depends on the size of the cervix, the clinical team's preference, and the degree of suspicion.

Management of cervical cancers

The management of cervical cancer mainly depends on four criteria: extent of local spread (shown by the tumour stage and tumour size), nodal status, term of pregnancy, and histological subtype. Conventional subtypes such as squamous-cell, adenocarcinoma, and adenosquamous lesions have much the same prognosis and therefore similar management as opposed to rare subtypes such as small-cell carcinoma, which has a poor prognosis. In such subtypes, pregnancy termination is mandatory and patients should be treated immediately to deliver optimum therapy.

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Until the 1980s, clinicians managed cervical cancer during the first two trimesters by ending the pregnancy and radically treating the cervical neoplasm. Currently, the trend is to preserve the pregnancy, particularly in patients with early-stage disease and no nodal involvement. Staging procedures and the determination of regional lymph-node spread must be done appropriately. MRI is the best imaging procedure for the assessment of locoregional spread (figure).[25] It can be done without a paramagnetic agent in cervical cancer. Zanetta and colleagues[26] describe the use of MRI in six pregnant patients with cervical cancer. In our institute's series of 12 pregnant patients with cervical cancer in which MRI was reviewed, it was essential for planning of the management and treatment of these patients (Corinne Balleyguier and colleagues, Institut Gustave Roussy, Villejuif, France, personal communication).

Fluorine-18-labelled fluorodeoxyglucose (^{18}FDG) PET-CT is used to stage locally advanced cervical cancers. Zanotti-Fregonara and colleagues[27,28] estimated the specific doses absorbed by the embryo after exposure to ^{18}FDG. Fetal uptake during early pregnancy is higher than approved dosimetric standards. In pregnant monkeys, Bartlett and colleagues[29] recorded higher radionuclide uptake with a longer retention time in the fetal liver than in the maternal liver. Consequently, because dosimetric standards during pregnancy are not defined, PET-CT is not recommended during pregnancy.

The gold standard to accurately calculate nodal status is still the histopathological assessment of lymph nodes.

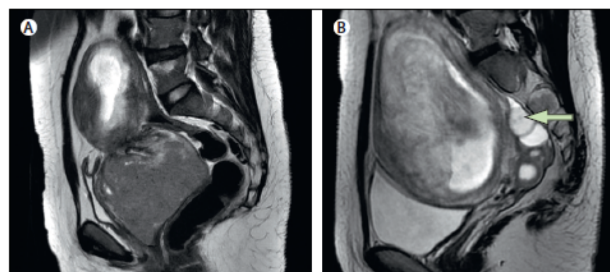

Figure: Pelvic MRI in pregnant patients
(A) Sagittal T2-weighted sequence for a patient at 12 weeks' gestation with a stage IB2 cervical carcinoma. MRI revealed a 7 cm cervical tumour. (B) Sagittal T2-weighted sequence for a patient at 15 weeks' gestation with a right adnexal tumour. Papillary projections are seen inside a cyst located closed to the right tubal wall (arrow). Laparoscopy was done during the pregnancy revealing a papillary borderline tumour in the right adnexa. A conservative treatment (removal of the cyst) was undertaken. Images courtesy of Corinne Balleyguier, Institut Gustave Roussy, Villejuif, France.

The presence of positive nodes modifies the therapeutic approach and alters the outcome of the pregnancy. A laparoscopic lymphadenectomy is feasible up to 20 weeks' gestation. The Society of American Gastrointestinal and Endoscopic Surgeons have produced general technical guidelines for laparoscopy in pregnant women.[30] In the particular case of lymphadenectomy, researchers have reported 31 cases[31,32] with no conversion to laparotomy or any surgery-associated fetomaternal morbidity when done by skilled surgeons. Clinicians undertook lymphadenectomy via the transperitoneal route in 26 patients and via the preperitoneal space in five patients. Most procedures were done before 23 weeks' gestation, with one at 25 weeks' and one at 32 weeks' gestation.[31–35] 25 patients had early-stage cervical cancer (<IB1) and six had advanced-stage disease (>IB2). In the patients with early-stage disease, lymph node metastases were diagnosed in 12% (three of 25), whereas the rate was 50% (three of six) in advanced-stage disease. Thus, pelvic lymphadenectomy seems to be a valid diagnostic procedure during the first or second trimester for patients with early-stage cervical cancer. The rate of positive pelvic metastases is similar to that recorded in non-pregnant patients with disease of the same stage.[31,33] The histological analysis of nodes in pregnant patients needs a skilled pathologist because some physiological decidual changes in pelvic nodes might mimic nodal metastasis, particularly in squamous-cell carcinoma.[36] Immunochemistry (with cytokeratins) could contribute to the differentiation of disease from pregnancy-related changes.

Sentinel node detection with a radiocolloid is not recommended during pregnancy. However, researchers have reported one case of a woman with cervical cancer who underwent sentinel node detection by technetium-labelled radiocolloid lymphoscintigraphy.[37] Two unilateral positive sentinel nodes were detected during radical surgery, which included complete pelvic lymphadenectomy and radical hysterectomy with the fetus in situ (14 weeks' gestation).[37] The investigators concluded that lymphatic mapping and sentinel node detection are technically feasible during pregnancy.[37]

70% of cervical cancers during pregnancy are diagnosed at stage I[8,10,12] (according to the 1995 International Federation of Gynecology and Obstetrics [FIGO] classification[38]). In the absence of nodal spread, two treatment approaches are feasible at this stage. The most common approach is to carefully follow up patients clinically and radiologically (to rule out tumour progression) and to postpone treatment of the cervical tumour until fetal maturity. Therapy is administered after delivery. The second option is conservative surgical treatment of the cervical tumour with a radical trachelectomy to preserve the uterus and the pregnancy.

Delayed treatment until fetal maturation for patients with stage IA disease has an excellent prognosis and is now the standard of care. The webappendix shows reports of delays in treatment exceeding 6 weeks in patients with cervical cancer at stage IB1 or higher.[10–13,26,31,34,39–51] The average treatment delay was 16 weeks. Of the 76 patients for whom the outcome is known, only four (5%) died of the disease.[31,41,42,49] However, since the first use of laparoscopic lymphadenectomy in pregnant patients in 2005, no patients with cervical cancer at stage IB1 and negative lymph nodes have relapsed, despite delayed therapy. Laparoscopic staging of lymph nodes is the best possible approach in patients with stage IB1 cancer; if the nodes are negative, the patient can await fetal maturation before receiving appropriate therapy after delivery.

See Online for webappendix

A radical trachelectomy (via a vaginal, laparotomic, laparoscopic, or robotic approach) is used in non-pregnant women with early-stage disease and cervical lesions measuring less than 2 cm without nodal involvement and who want to preserve their fertility. This technique consists of a laparoscopic pelvic lymphadenectomy followed by the removal of the cervix together with the surrounding parametria with preservation of the uterine corpus and the ovaries. We know of 15 women (14 stage IB1 or less, one IB2) who underwent trachelectomy during pregnancy (14 reported cases and one personal communication from Prof Patrice Mathevet, Lyon, France)[31,52–56] All patients underwent pelvic lymphadenectomy. Seven trachelectomies were done via the vaginal route and eight via the abdominal route. The patient with stage IB2 disease had a miscarriage a few hours after surgery, and no follow-up was recorded.[56] We would not recommend a trachelectomy for stages exceeding IB1. The other 14 patients (two IA2 and 12 IB1), were operated on between 4 weeks' and 19 weeks' gestation. Only one patient had nodal spread at the time of the radical trachelectomy and she underwent a caesarean section at 30 weeks' gestation with hysterectomy followed by radiotherapy.[31] The rate of fetal loss after this procedure is high (five fetal losses occurred 0–16 days after surgery)[31,52,56] and it should be undertaken at centres with much experience of the procedure to reduce this risk. All patients with negative nodes were free of disease with follow-up of 9–54 months (there were no follow-up data in one case).

For management of locally advanced disease, the main treatment choice is either neoadjuvant chemotherapy or chemotherapy and radiotherapy. In most countries, the therapeutic recommendation for tumours larger than 4 cm (stage IB2 or greater) or for disease with nodal involvement is concomitant chemotherapy and radiotherapy in non-pregnant patients.[57,58] In pregnant patients, this approach means that the pregnancy must be ended before the initiation of therapy,[31,59] but in exceptional cases in which surgery to end the pregnancy is not technically feasible (ie, a bulky cervical tumour), radiation therapy can be delivered with the fetus in utero, resulting in a spontaneous abortion in about 3 weeks.[59]

An alternative to combined treatment is neoadjuvant chemotherapy with preservation of the pregnancy.

Completion surgery (or chemotherapy with radiotherapy) is done after delivery. Researchers have reported 25 women given chemotherapy in pregnancy (webappendix),[33,60–74] most of whom were treated with cisplatin and paclitaxel. Cisplatin can be given as a weekly dose of 20–50 mg/m^2, or 50–100 mg/m^2 every 3 weeks. All cases reported underwent the 3-weekly administration and this schedule should be the standard in pregnant patients. Few cases have been reported with carboplatin but this drug could be an option to reduce renal toxic effects, particularly in pregnant women with pre-eclampsia. Both regimens yield equivalent efficacy.[75]

Nine of these 25 patients (webappendix) were diagnosed with stage IB1 disease, which is not a conventional indication for neoadjuvant chemotherapy in non-pregnant patients. One patient had a high-risk histological subtype (small-cell carcinoma).[71] Most patients achieved a partial response with residual disease in the cervix and six had persistent nodal involvement on surgical specimens removed at the time of completion surgery. Three patients had a poor response or progression and were switched to concomitant chemotherapy and radiotherapy (during the pregnancy or post-partum period).[33,61,68] None of the babies had abnormalities with follow-up ranging from birth to 80 months. Six patients died of the cancer including one who refused further treatment and two who had recurrent disease when their cases were reported (webappendix). One patient was still undergoing treatment when her case was reported.[72] Importantly, of the 16 patients with no evidence of disease, nine had a short follow-up of less than 12 months.

National and international recommendations for management of invasive disease

The aims of national and international recommendations or guidelines are to harmonise the management of patients with cancer diagnosed during pregnancy and to offer these women the opportunity to preserve the pregnancy if preservation is medically safe. Ultimately, the woman herself needs to understand the recommendations and make the final decision about treatment.

A few national or international recommendations or guidelines have been issued for the management of cervical cancer in pregnant women.[76–78] The main difficulty is the absence of high quality (ie, level A according to the Oxford Centre for Evidence-based Medicine) evidence-based medicine to guide a consensus approach. Recommendations could therefore be arbitrary and could depend on the personal opinion of a panel of experts. In 2009, several French societies and a European consensus meeting produced separate guidelines with specific management recommendations by stage of gynaecological cancer (table 1).[76,77] The guidelines differ in two main ways. The first difference is in the management of tumours measuring less than 2 cm. Both guidelines recommend an initial lymphadenectomy to exclude patients with nodal involvement (15% of patients) from a conservative approach. The French guidelines propose careful follow-up and postponement of treatment until after delivery to avoid the risk of pregnancy loss. The European Consensus Meeting guidelines propose trachelectomy (with risk of bleeding or fetal loss) or neoadjuvant chemotherapy (with risk of fetal exposure to chemotherapy and not conventionally indicated in non-pregnant patients with stage IB1 disease) to avoid the risk of tumour progression.

The second difference is in the treatment of locally advanced disease (stage IB2-II). The French guidelines propose termination of the pregnancy if the diagnosis is made before 18 weeks' gestation, followed by chemotherapy and radiotherapy. The European consensus meeting guidelines propose neoadjuvant chemotherapy as the first option because it allows preservation of the pregnancy (but with a potential risk of tumour progression during the treatment). These differences indicate a different philosophy of standard of care for the management of cervical cancer in non-pregnant patients between different countries. To our knowledge, there are no specific guidelines from American societies for the treatment of cervical cancer during pregnancy.

Ovarian neoplasms

Incidence of ovarian tumours and presurgical staging in pregnant patients

Most pelvic masses diagnosed at the time of prenatal imaging are of ovarian or uterine origin and are benign. They are usually discovered during routine ultrasonography done for the follow-up of a pregnancy. Sometimes, they present as an acute abdominal event such as ovarian torsion or rupture, or intraperitoneal haemorrhage.

Diagnosis and management of an adnexal mass depend on the radiological appearance. The most common diagnostic instrument is ultrasonography. Simple ovarian cysts will resolve spontaneously and no intervention is needed,[79] whereas most complex masses need diagnostic surgery. Various scales or scoring systems are used for ultrasonographic diagnosis, but the usefulness of these criteria in pregnant patients has not been confirmed. In practice, a suspected malignancy in the case of an adnexal lesion is based on these ultrasonographic criteria: tumour size (with a cutoff at 5 cm or 6 cm to define a subgroup of lesions for which surgical exploration is needed), tumour morphological characteristics, and the presence of extra-ovarian disease.[79] Clinicians could use colour doppler imaging to obtain a vascular map of the ovarian mass and to improve the accuracy of plain ultrasonography.[80]

Pelvic CT is contraindicated because of the high level of ionising radiation and the risks of exposure to the fetus.[81] MRI is preferred to CT because it is safer. In non-pregnant patients, MRI is useful in the differential diagnosis between benign and malignant tumours and therefore helps select patients for surgical procedures.[82,83]

Clinicians often use blood markers to monitor ovarian tumours but these markers can be physiologically raised

	French recommendations[76]		European Consensus Meeting guidelines[77] second trimester of pregnancy
	Less than 18–22 weeks' gestation*	More than 18–22 weeks' gestation*	
Stage IB1 <2 cm	Laparoscopic pelvic lymphadenectomy: if nodes are positive, end pregnancy and give chemotherapy and radiotherapy. Chemotherapy and radiotherapy fields depend on para-aortic node status as determined with PET imaging or para-aortic laparoscopic lymphadenectomy. If nodes are negative, await fetal maturity with careful clinical and radiological follow-up (MRI) without invasive cervical procedures. If the disease does not progress, treatment of the tumour can be postponed until after delivery.	Careful clinical and radiological follow-up, with treatment of the tumour delayed until after delivery provided the disease does not progress and in absence of suspicious nodes on MRI.	Laparotomic or laparoscopic lymphadenectomy: if nodes are positive give standard treatment (radical hysterectomy or chemotherapy and radiotherapy depending on local policy). If nodes are negative, give neoadjuvant chemotherapy followed by trachelectomy or large cone after delivery, or a trachelectomy during pregnancy.
Stage IB1 between 2 and 4 cm	Case by case discussion. Ending the pregnancy should be considered as the first option, especially if diagnosis is made during the first stage of pregnancy. If the patient wants to continue the pregnancy, similar management to tumours <2 cm could be appropriate.	Case by case discussion. If the tumour is diagnosed very close to the term of fetal maturity, same management as for tumour <2 cm could be appropriate. Neoadjuvant chemotherapy is another option.	Either lymphadenectomy followed by neoadjuvant chemotherapy or abdominal trachelectomy (if nodes are negative), or neoadjuvant chemotherapy followed by lymphadenectomy. If nodes are negative, give trachelectomy or cone during pregnancy, or manage the tumour after the delivery. For both options, if nodes are positive, give standard treatment (radical hysterectomy or chemoradiation therapy depending on local policy).
Stage IB2–II	First option is chemotherapy and radiotherapy after ending the pregnancy. Para-aortic staging with PET imaging or laparoscopic para-aortic lymphadenectomy determine radiotherapy fields.	Chemotherapy and radiotherapy after caesarean section when fetal maturity is acquired provided the delay between diagnosis and beginning of treatment does not exceed 6–8 weeks. Para-aortic staging surgery at the time of caesarean section is recommended. Neoadjuvant chemotherapy is another option.	Neoadjuvant chemotherapy followed by trachelectomy or standard treatment (including lymphadenectomy) after delivery. Radical hysterectomy or chemotherapy and radiotherapy in non-responders to neoadjuvant chemotherapy.
Stage >II	Similar to IB2–II	Similar to IB2–II	No recommendations
Route of delivery if pregnancy is preserved	Caesarean section	Caesarean section	Vaginal delivery if cervix cleared of tumour and caesarean section if not

*18–22 weeks' gestation is the last term in which laparoscopic lymphadenectomy (by skilled surgeons) is feasible.

Table 1: **Comparison of recommendations or guidelines for the management of cervical cancer during pregnancy in patients wishing initially to preserve pregnancy (management for common histological subtypes: adenocarcinoma, squamous-cell, or adenosquamous carcinoma)**

during pregnancy. In one small study,[84] concentrations of ovarian cancer antigen 125 (CA-125) were higher than 35 IU/mL in 11 of 46 (24%) pregnant women. Concentrations greater than 65 IU/mL are recorded in 16% of patients during the first trimester, with wide variations between weeks 5 and 8.[85,86] CA-125 normalises during the second and third trimesters but rises immediately after delivery, also with wide fluctuations.[86] A return to baseline is recorded after 2–10 weeks post partum.[86] Thus, CA-125 concentrations are not helpful during the first trimester, but can be used during the second and third trimesters.

Surgical diagnosis

The incidence of ovarian masses for which a surgical procedure is needed during pregnancy ranges from one in 600 to one in 1500 pregnancies and the rate of malignant disease in patients treated surgically is 1–3%.[83,87–89] The histological subtypes recorded in pregnancy by order of frequency are non-epithelial tumours (germ-cell and sex-cord tumours), ovarian tumours of low malignant potential, and epithelial ovarian cancers.[83,88,89] The incidence of these subtypes varies between reports.

Treatment approach depends on tumour size, morphological appearance (radiographic and during surgical exploration), histological subtype, extent of disease (presence of extraovarian disease), term of pregnancy, and the patient's wishes. The use of the laparoscopic approach in this context might reduce perioperative morbidity.[90] However, this procedure should be done with all the standard precautions to avoid spread of malignant cells during the laparoscopy (particularly resulting from tumour rupture during handling of the specimen). In patients with suspicious lesions on preoperative imaging or during surgical exploration, the ideal procedure is peritoneal cytology and unilateral salpingo-oophorectomy of the affected side with frozen-section analysis.

Intraoperative management depends on the result of the frozen-section analysis.

Ovarian tumours of low malignant potential

Ovarian tumours of low malignant potential have an excellent prognosis and in most patients are treated surgically without chemotherapy. 95% of these tumours are diagnosed at stage I[88] (according to the 1987 FIGO classification[91]). Mooney and colleagues[92] reported a brief series of ten serous ovarian tumours of low malignant potential in pregnant patients. The disease had microscopic and clinical features suggestive of aggressive behaviour but the lesions regressed after delivery with no effect on survival. Hormonal causes could account for these findings.

The management of this disease is not complex and is much the same as that for non-pregnant patients.[80] When a serous ovarian tumour of low malignant potential is diagnosed during a surgical procedure, resection of the affected cyst and all macroscopic disease is necessary but the macroscopically normal ovary can be left in place. In the absence of macroscopic peritoneal extension, routine peritoneal staging without lymphadenectomy (cytology, random peritoneal biopsies, omentectomy or omental biopsy, and an appendicectomy in mucinous tumours) should be done.[93] Any extraovarian lesions should be removed to help with staging and classification of the histological subtype. If an ovarian tumour of low malignant potential is not diagnosed on the frozen section (or if frozen-section analysis is not done), peritoneal staging is incomplete. Restaging surgery should be offered to patients with serous ovarian tumours of low malignant potential and micropapillary patterns.[93] This histological subtype has a high rate of occult extraovarian disease with invasive implants. Use of restaging procedures should be balanced against morbidity of surgery and trimester of pregnancy. Restaging surgery could be postponed until after delivery if the tumour is diagnosed after 20–24 weeks' gestation. When restaging surgery is indicated in patients before 20 weeks' gestation, a laparoscopic approach could be a good option.

Ovarian cancers

Malignant ovarian tumours differ from borderline ovarian tumours because most patients have an indication for chemotherapy. Preservation of the pregnancy and use of chemotherapy (adjuvant or neoadjuvant) should be discussed. This decision depends on histological criteria (subtypes, tumour differentiation, and eventually nodal status), tumour stage (peritoneal disease), and trimester of pregnancy.

Non-epithelial cancers

Most patients with non-epithelial tumours (germ-cell and sex-cord stromal tumours) have bulky masses, sometimes measuring 30 cm.[94,95] These patients are more likely to have symptoms (pain, abdominal distension, acute abdominal symptoms such as torsion or bleeding) than those with epithelial histological subtypes.[95] The incidence of stage I disease is greater than 90%. In one series, 24 of 27 patients with dysgerminomas were diagnosed at stage IA. In another series, all sex-cord tumours were stage I, but 13 ruptured during surgery.[94,95] Fertility-preserving surgical management is needed. Full peritoneal staging should be done, but a routine lymphadenectomy is not indicated. However, suspicious lymph nodes should be resected.

The present guideline for chemotherapy (if it has to be delivered) recommends the combination of bleomycin, etoposide, and cisplatin in non-pregnant patients.[96] In pregnant patients, the indications for adjuvant chemotherapy are similar to those prevalent in non-pregnant patients.[80] These patients do not need additional surgery and their fertility should be preserved whenever feasible.

Epithelial ovarian cancer

The incidence of epithelial ovarian cancer is low and it is the rarest ovarian cancer in pregnant women, but it is the most difficult to treat. The overall prognosis of epithelial ovarian cancer is worse than that of non-epithelial cancers. Peritoneal and nodal spread occur in two-thirds of patients and most patients need adjuvant chemotherapy (in early-stage or optimally debulked advanced-stage disease) or neoadjuvant chemotherapy (in advanced stage, unresectable peritoneal disease). Surgical treatments are complex because they involve resection of the ovaries, peritoneal metastases, and lymph nodes.

In non-pregnant patients without macroscopic peritoneal spread, standard surgery consists of removal of the ovaries and uterus (except for some very early-stage lesions in young patients that can be treated conservatively), omentectomy, and peritoneal and nodal staging procedures. Surgery is followed by courses of carboplatin and paclitaxel, for all stages except for stage IA and IB and grade 1 or 2 lesions, which are managed exclusively by surgery. During pregnancy, preservation of the uterus with peritoneal staging should be offered as the primary surgical treatment. Nodal staging during initial surgery should be balanced against potential morbidity. Only suspicious lymph nodes should be removed.

In non-pregnant patients with peritoneal spread, standard surgical management is debulking surgery with a complete resection of macroscopic disease (if technically feasible), which frequently necessitates bowel resection, a diaphragmatic procedure, a splenectomy, and total lymphadenectomy followed by adjuvant chemotherapy (similar to that used for early-stage disease). In patients with unresectable disease (because of peritoneal spread) three courses of neoadjuvant chemotherapy followed by interval debulking, and three more courses of chemotherapy should be discussed.[97]

During pregnancy, true debulking surgery ends the pregnancy because a hysterectomy is needed. This

treatment should be the standard procedure for bulky stage III epithelial ovarian cancer diagnosed during the first or second trimester.[98] In most reported cases,[87,99–117] patients with this cancer and peritoneal spread had termination of pregnancy. In some patients with peritoneal spread, preservation of the pregnancy with neoadjuvant chemotherapy could be proposed. The webappendix details cases of chemotherapy during pregnancy with preservation of the fetus. Half the patients had stage I disease with an incomplete surgical procedure. The number of courses of chemotherapy administered during the pregnancy ranged between two and seven. Five patients had recurrence and four died of the disease, two who were initially diagnosed at stage I and three at stage III.[99,112] All their babies developed normally except for one who died of congenital abnormalities diagnosed prenatally by ultrasonography before the start of chemotherapy.[116] These and other reports of patients with various adenocarcinomas during pregnancy confirm that the administration of chemotherapy in high-risk cancer is not deleterious to the fetus during the second and third trimesters of pregnancy. However, follow-up of patients was very short in several cases (webappendix) and, as in the case of neoadjuvant chemotherapy in cervical cancers, reports of oncological outcomes are probably biased by the tendency not to report patients with unfavourable outcomes.

Chemotherapy and targeted therapy during pregnancy

For malignant ovarian tumours chemotherapy is usually necessary to achieve a cure. The risk of a congenital malformation or abortion as a consequence of chemotherapy is very high during the first trimester (particularly between 2 and 8 weeks' gestation), and consideration of a therapeutic abortion versus delayed treatment should be discussed with the patient.[118] Treatment of cancer during the second and third trimesters should follow the usual standard chemotherapy guidelines for germ-cell tumours and epithelial ovarian cancer, because in most cases there are no irreversible consequences for the fetus. Induced premature delivery is not usually needed if the cancer is controlled by chemotherapy, but delivery should be timed during a non-neutropenic period. Table 2 describes chemotherapy and supportive drugs given in gynaecological cancers during pregnancy.[65,67,71,107,111–113,115–117,119–141]

Most case reports describing chemotherapy for gynaecological cancers during pregnancy show a good outcome for the neonate. Cisplatin-DNA or platinum-DNA adducts have been detected in neonates exposed to platinum derivatives during the third trimester of pregnancy, but in general they do not seem to have a long-term effect.[102,123] In a review of 36 pregnant patients who received cisplatin-based chemotherapy between 1977 and 2008 (for various cancers), two fetal malformations were reported; one case of ventriculomegaly with cerebral atrophy in a patient given one course of bleomycin, etoposide, and cisplatin at 25 weeks' gestation for a non-epithelial ovarian cancer (the malformation was diagnosed during prenatal ultrasonography a week after the administration of chemotherapy) and one case of microphthalmia in a patient undergoing multiagent chemotherapy for metastatic melanoma.[129,142] The causative link between cisplatin and these malformations was not clear. No malformation has been reported in patients exposed to taxane regimens for gynaecological disease, except for a case[116] of polymalformations that were diagnosed by prenatal ultrasonography before exposure to docetaxel. One case of pyloric stenosis is known in a patient treated for breast cancer.[135,143]

Cooper University Hospital, NJ, USA, has created a cancer and pregnancy registry, with details of cancer treatment, pregnancy outcome, and annual neonatal follow-up. Up to now, information is available on 231 women for a 13 year period. 13 women chose termination. Of 157 neonates exposed to chemotherapy in utero, the mean gestational age at delivery was 35·8 weeks (SD 2·8), and the mean birthweight was 2647 g (SD 713). Six babies (4%) were born with a congenital anomaly. One fetus died in utero and one neonate died. The gestational age at birth was less than the tenth percentile in 8% of neonates and 6% were born spontaneously premature. Of the 67 women with cancer who did not receive chemotherapy during pregnancy, the mean gestational age at delivery (70 neonates) was 36·5 weeks (SD 3·3) and the mean birthweight was 2873 g (SD 788).[143] Much the same results were reported by Van Calsteren and colleagues[3] for 62 chemotherapy-exposed pregnancies, though their rates of preterm labour and of small-for-gestational age (weighing less than the tenth percentile) babies were higher (24% in neonates exposed to cytotoxic agents in utero *vs* 9% in those who were not exposed).

Few studies have looked at the long-term development of chemotherapy-exposed babies. The absence of such data is a crucial issue. In studies in baboons,[144] substantial concentrations of carboplatin, paclitaxel, and docetaxel were measured in the fetal compartment after administration of the drug to the baboon. Despite a low rate of malformations in offspring of women given carboplatin and taxanes during pregnancy, long-term follow-up of exposed children is needed to assess the effect of chemotherapy during pregnancy.

Targeted therapies are contraindicated during pregnancy. Preclinical studies suggest that some of these therapies could have adverse effects on fetal development or production of amniotic fluid.[145–147] Bevacizumab is the most used targeted therapy in ovarian cancers. As far as we are aware, intravenous use of this drug has not been reported for pregnant patients. However, in several cases in whom low doses of this agent were delivered intravitreally for choroidal neovascularisation in pregnant patients, no adverse effects on the fetus were recorded.[148]

	Mechanism of action	Indications	Number of cases* (single agent *vs* combination)	Fetal complications†
First-line drugs				
Bleomycin[119–122]	A mixture of bleomycin sulphate with two bleomycin glycopeptides Inserts in the minor DNA groove causing DNA damage	Germ-cell tumours	>10	None recorded
Carboplatin[123,124]	Heavy metal derived from platinum Forms DNA adduct leading to DNA damage	Ovarian cancer	3 *vs* 3	None recorded Platinum-DNA adducts noted in cord blood lymphocytes
Cisplatin[102,125]	Heavy metal derived from platinum Forms DNA adduct leading to DNA damage	Cervical cancer, epithelial and non-epithelial ovarian cancers	>10	Neutropenia, hair loss, and some hearing impairment when given within 3 weeks of delivery DNA adducts are found in amniotic cells and in placental tissue, but not in infant blood at 3 or 12 months
Docetaxel[116]	Microtubule poison causing polymerisation	Ovarian cancer	1 *vs* 5	None recorded
Doxorubicin[126]	DNA damaging agent	Ovarian cancer	3	Unfavourable outcome <5% in patients with solid tumours, >20% in patients with leukemia
Etoposide[126–129]	Podophyllotoxin derivative inhibiting topoisomerase II	Germ-cell tumours	>10	Transient pancytopenia when administered in the third trimester One case of ventriculomegaly in patient treated with BEP regimen
Fluorouracil [128,130]	Pyrimidine analogue interfering with the synthesis of DNA and RNA	Cervical cancer	>10	Teratogenic and abortifacient during first trimester Possible intrauterine growth retardation
Gemcitabine[131,132]	Antimetabolite of nucleotide synthesis	Ovarian cancer	0 *vs* 2	Possible intrauterine growth retardation
Irinotecan[133]	Alkaloids inhibiting topoisomerase I	Ovarian and cervical cancers (Japan)	0 *vs* 1	None recorded
Navelbine[134]	Microtubule poison inducing depolymerisation	Ovarian and cervical cancers	1 *vs* 5	None recorded
Paclitaxel[66,71,107,111–113,115,117,135]	Microtubule poison causing polymerisation	Ovarian and cervical cancers	3 *vs* >10	None recorded
Topotecan[136]	Alkaloids inhibiting topoisomerase I	Ovarian and cervical cancers	0	No reports known
Vinblastine	Microtubule poison inducing depolymerisation	Germ-cell tumours	>10	None recorded
Vincristine[65]	Microtubule poison inducing depolymerisation	Cervical cancer	>10	None recorded
Supportive drugs				
Dexamethasone[137]	Corticosteroids	Prevention of nausea	>10	Cerebral palsy reported after repeated administration Category C‡
Ondansetron[138,139]	Selective serotonin receptor antagonist	Prevention of nausea (hyperemesis gravidarum)	>10	Category B‡
Promethazine	Phenothiazines	Prevention of nausea (hyperemesis gravidarum)	>10	Category B/C‡
Aprepitant[138]	Substance P/neurokinin I receptor antagonist	Prevention of nausea	0	No reports known Category B‡
Filgrastim[140]	Cytokines	Prevention of neutropenia	>10	No side-effects recorded Category C‡
Oprelvekin	Recombinant interleukin-11	Prevention of thrombocytopenia	0	No reports known Category C‡
Recombinant erythropoietins[141]	Cytokine	For prevention of anaemia	Most reports not in cancer patients	Category C‡

BEP=bleomycin, etoposide, platinum. *Number of cases including gynaecological and non-gynaecological cancers treated during pregnancy. †Fetal complications after exposure in the second or third trimester of the pregnancy. ‡US Food and Drug Administration pharmaceutical pregnancy categories. Category B drugs do not show negative effects on the fetus in animal studies, or, if negative effects have been reported in animals, these effects have not been recorded in human studies. Category C drugs show negative effects on the fetus in animal studies, no human studies are known, but benefits might outweigh risks.

Table 2: **Drugs used for the treatment of ovarian and cervical cancer during pregnancy**

Conclusions

The current trend is to preserve pregnancy in patients diagnosed with cervical or ovarian cancer, whenever feasible. Clinical studies are needed, particularly for key issues in clinical management such as an intentional delay in early-stage cervical cancer or radical trachelectomy and neoadjuvant chemotherapy, to establish the balance between the best chance of cure for the patient and preservation of a healthy fetus.

The use of chemotherapy during pregnancy helps increase the chances of fetal preservation. Children exposed to chemotherapy in utero after the first trimester do not seem to have more congenital anomalies, preterm deliveries, or growth restriction than do unexposed children. However, such pregnancies are high risk and intense medical assessment is needed during pregnancy and at delivery. Prospective clinical assessments (using national registries) and translational research are underway to elucidate the pharmacokinetics and pharmacodynamics of chemotherapy during pregnancy and to assess the real effect of these drugs on the long-term development of the fetus.[144] These efforts will help to guide the optimum management of gynaecological cancers during pregnancy.

Contributors

All the authors contributed to the design of this review, the collection and interpretation of data, and the writing of the review. The manuscript was approved by all authors.

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Conflicts of interest

We declare that we have no conflicts of interest.

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Malignancies in Pregnancy 2

Breast cancer in pregnancy

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This is the second in a **Series** of three papers about malignancies in pregnancy

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Breast cancer staging and treatment are possible during pregnancy, and should be defined in a multidisciplinary setting. Tumour biology, tumour stage, and gestational stage at diagnosis determine the appropriate approach. Surgery for breast cancer is possible during all trimesters of pregnancy. Radiotherapy is possible during pregnancy but, dependent on the fetal dose received, can result in poor fetal outcomes. The decision to give radiotherapy should be made on an individual basis. Evidence increasingly supports administration of chemotherapy from 14 weeks' gestation onwards. New breast cancer treatments might be applicable to pregnant patients, but tamoxifen and trastuzumab are contraindicated during pregnancy. Cancer treatment during pregnancy will decrease the need for early delivery and thus prematurity, which is a major concern in management of breast cancer in pregnancy.

Introduction

Although breast cancer was known in ancient times, it was uncommon until the 19th century, when improvements in sanitation and control of deadly infectious diseases resulted in substantial increases in lifespan.[1] One of the first reports of breast cancer during pregnancy dates from 1869.[2] Pregnancy-related breast cancer is defined as breast cancer diagnosed during pregnancy or within a year after delivery. In this Seminar, we discuss the coincidence of invasive primary breast cancer and pregnancy.

Cancer is the second most common cause of death in women during the reproductive years,[3] and breast cancer is the second most commonly diagnosed cancer in women younger than 35 years in the UK.[4] Breast cancer is one of the most frequently diagnosed cancers during pregnancy but regional differences, the inclusion of post-partum breast cancers in some studies, and the scarcity of information in cancer registries about whether women were pregnant means reliable data are lacking.[5–7] As women in developed societies defer childbearing, and because the incidence of most malignancies rises with increasing age, the situation in which cancer complicates pregnancy is expected to become more common. We discuss the diagnosis, treatment methods and their effect on the fetus, obstetrical issues, and prognosis of breast cancer during pregnancy. Since randomised trials are almost impossible, only long-term follow-up registry studies can elucidate important uncertainties.

Key messages

- Termination of pregnancy does not improve maternal prognosis.
- A diagnostic strategy should be established in a multidisciplinary setting to reduce fetal radiation exposure.
- Cancer treatment should adhere as much as possible to the newest treatments for breast cancer in non-pregnant women and should also be discussed in a multidisciplinary setting.
- Surgery, chemotherapy, and radiotherapy for breast cancer are possible during pregnancy but treatment should be tailored to the individual.
- Iatrogenic preterm birth is a concern but can be prevented by cancer treatment during pregnancy.

History and physical examination

No specific risk factors for breast cancer in pregnancy are known. Genetic or environmental risk factors are similar to those for age-adjusted breast cancer in the general population. Individuals with *BRCA1* or *BRCA2* mutations might be at increased risk, but they do not have an increased incidence of breast cancer in pregnancy.[8] In view of the necessarily young age at diagnosis, women with breast cancer during pregnancy should be referred for genetic counselling.

Breast cancer in pregnancy typically presents as a painless lump palpated by the woman.[9] Physiological breast changes associated with pregnancy, including engorgement, hypertrophy, and nipple discharge obscure detection for patient and physician. Therefore, delay in diagnosis is common, leading to more advanced stages at diagnosis than in the general population. As a consequence, breast cancer in pregnancy is associated with more metastases, and subsequently poorer

Search strategy and selection criteria

We searched PubMed for meta-analyses, previous systematic reviews, retrospective case series, and case reports published in English or German between 1980 and July 1, 2011, with the keywords "breast cancer", "pregnancy", "PABC", "staging", "sentinel", "ionising', "MRI", "neonatal", "chemotherapy", "cytotoxic", "biology", "oestrogen receptor", "progesterone receptor", "HER-2", "tumour biology", "radiotherapy", "surgery", "long term", and "prognosis". Reference lists were scanned to find any publication not already identified by our electronic search strategy.

outcomes, than breast cancer in non-pregnant women.[10] A clinically suspicious or persisting breast mass during pregnancy should be investigated by biopsy. Although about 80% of breast lesions during pregnancy are benign,[11] clinicians can safely use ultrasound, mammography, and biopsy to rule out breast cancer. A percutaneous biopsy of any lesion that does not meet all the criteria for a simple cyst is strongly recommended.[12]

Diagnosis

Any suspicious breast lump or inflamed breast (figure 1) needs further investigation. Diagnostic examinations of the breast during pregnancy need to be done by a skilled clinician, because gestational changes alter the tissue structure. Breast ultrasonography is the first diagnostic instrument used by clinicians when a breast mass and the axillary area need to be assessed in a pregnant woman, since it is non-ionising and has high sensitivity and specificity.[13] Subsequently, when breast cancer in pregnancy is diagnosed, bilateral and multicentric disease can be ruled out with mammography.[14,15] MRI with contrast agents is possible during pregnancy, but should only be used when it will alter clinical decision making, and when ultrasonography is inadequate.[16] No well designed studies of the efficacy and safety of MRI of the breast during pregnancy have been reported, and results of some studies have shown that gadolinium-based MRI contrast agents pass through the placental barrier and enter fetal circulation. The potentially toxic gadolinium ion could dislocate from its chelate molecule and the effect of free gadolinium ions in the amniotic fluid is unclear.[17] If MRI is needed, approved contrast agents include gadobenate dimeglumine (approved by the European Medicines Agency and US Food and Drug Administration) and gadoterate meglumine (approved by the European Medicines Agency).[18]

The standard examination to obtain a histological diagnosis is a core biopsy under local anaesthesia, which can be done safely during pregnancy with a sensitivity of around 90%.[19] Milk fistulas after such a diagnostic procedure are rare. Gestational and puerperal hormones induce physiological hyperproliferative changes of the breast, which could lead to a false positive or false negative result with fine-needle aspiration cytology. Therefore, this procedure is not recommended during pregnancy.[18] Diagnostic over-interpretation is avoided when the pathologist is aware that the patient is pregnant.

Radiation in staging and treatment

Ionising radiation greatly interferes with cell proliferation.[20] Fetal exposure and damage can occur during staging examinations and radiotherapy. Deterministic effects of radiation—such as fetal death, malformations, or impaired fetal development—can arise when fetal exposure exceeds the threshold dose of 0·1–0·2 Gy.[21] By contrast, no threshold dose exists for stochastic effects of radiation, such as an increased risk of childhood cancer and leukaemia. An individual's 20% lifetime risk of developing fatal cancer without radiation exposure contrasts with an added 0·06% risk at 0·01 Gy fetal exposure.[22] Therefore, stochastic effects are thought to be small, though we believe they should not be neglected, as has been suggested by other groups.[23]

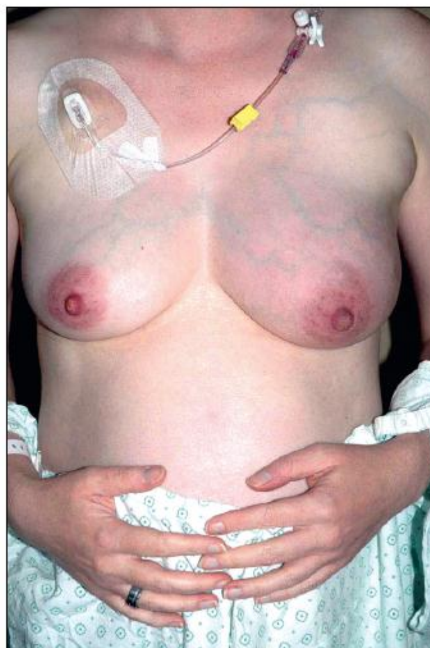

Figure 1: Inflammatory breast cancer during pregnancy with enlarged axillary lymph nodes above the left breast

Radiographic examinations are possible, but should be done only when the results will change clinical management. When the estimated risk of metastatic disease is low, postponement of staging until after delivery can be considered. Radiologists and nuclear medicine physicians should be part of diagnostic strategy planning to estimate cumulative fetal toxicity and reduce radiation exposure.[18,24] Metastatic investigations for breast cancer during pregnancy include chest radiograph, liver ultrasonography, and a non-contrast skeletal MRI. A radionuclear bone scan, with adequate hydration and an indwelling catheter to prevent retention of radioactive agents in the bladder, can be used when MRI is not available or when additional information is needed.[18] PET is not a standard staging instrument in breast cancer in non-pregnant, nor therefore pregnant, patients.

With regard to variations in fetal size, researchers have measured fetal radiation doses from therapeutic breast irradiation using anthropomorphic phantoms.[25–27] In

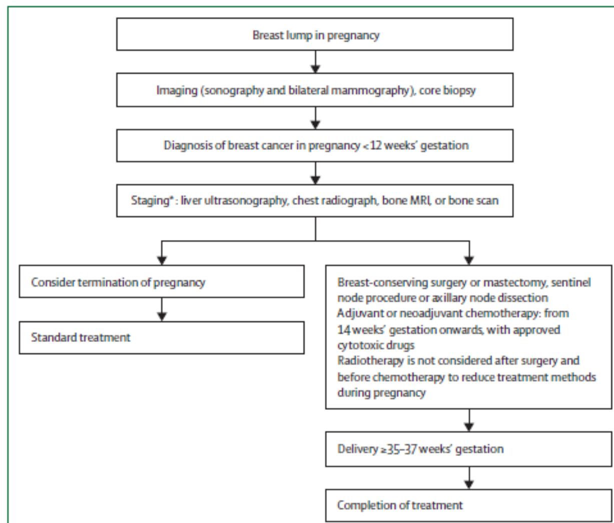

***Figure 2:* Algorithm for treatment of breast cancer diagnosed during the first trimester of pregnancy**
*If results change clinical management, especially important during first trimester. Staging examinations and tumour biology assessment will affect the decision to continue pregnancy.

addition to adequate shielding (50–75% dose reduction from leaked radiation and scatter[21,28]), fetal exposure can be reduced by increasing the distance from the field of irradiation. The absence of deterministic effects is confirmed by the birth of healthy babies after radiotherapy during pregnancy.[29–32] Luis and colleagues[30] recorded that 13 of 109 neonates had adverse outcomes, including perinatal deaths and neurological disorders. Radiotherapy was initiated for different tumours, at different locations, and in all three trimesters. Adverse events occurred at all phases of gestation.[30] However, these effects cannot be directly attributed to radiotherapy because fetal doses were estimated in only four of these neonates, and they had exposure of less than 0·1 Gy. Results of follow-up studies of atomic bomb survivors and their children (65 year follow-up),[33] survivors of the Chernobyl nuclear disaster (25 year follow-up),[34] and data obtained in low-linear energy transfer ionising radiation from medical exposure,[33] suggest a very low long-term health risk after low-dose exposure.

Investigators have described techniques to estimate and reduce fetal dose,[35] but individual risk assessment by a medical physicist is necessary since variations in radiation energy used, stage of gestation, and individual treatment characteristics such as field size, blocks, wedges, and shielding make any comparison impossible.[26] Results of such an assessment should be discussed with the patient and the family to allow her the opportunity to make an informed decision on the fate of her pregnancy.[31]

Pathological changes

The histopathological and immunohistochemical findings of breast cancer in pregnancy are similar to those in non-pregnant women who are younger than 35 years.[7,14,36–44] Most pregnant patients are diagnosed with infiltrating ductal adenocarcinomas (71–100%), which are often associated with aggressive behaviour—eg, high incidence of grade 3 tumours (40–95%), lymphovascular invasion, and a high rate of oestrogen receptor negativity.[15] Gestational breast cancer is associated with larger tumours and a higher incidence of nodal involvement (53–71%) than in non-pregnant patients.[37,39,40] Results of *HER2* expression studies are inconclusive, although data on more than 300 patients from our group showed *HER2* positivity in 42%, which is much the same (39%) as recorded in non-pregnant patients with breast cancer who are younger than 35 years.[36,45] Pathological features of breast cancer do not seem to be changed by the pregnancy, but are determined by age. The significance in preclinical models of pregnancy of a strong but transient increase in mammary stem cells that are highly responsive to steroid signalling despite the absence of hormone receptors is unknown.[46]

Treatment

Therapeutic strategies are determined by tumour biology, tumour stage, gestational stage, and the patient's and her family's wishes. Counselling is crucial because of the complexity of the issue. A multidisciplinary team with all involved specialties should assess the medical (obstetric, oncological, paediatric, and genetic), ethical, psychological, and religious issues. The proposed treatment should adhere to the standard for non-pregnant patients. Figures 2–4 show algorithms for the treatment of breast cancer for the three trimesters of pregnancy. These algorithms refer to general principles and do not necessarily include all clinical situations. They allow some adaptations to standard treatment when fetal health is a concern—eg, some weeks delay to gain fetal maturity. No survival benefit is apparent for women who receive their treatment after delivery.[36] Therefore, preterm delivery or unnecessary delay in diagnosis or treatment to the post-partum period should be avoided. Preterm birth is a concern but can be prevented by cancer treatment during pregnancy.

Pregnancy termination

Whether the patient already has children, her desire to continue the present pregnancy, and to maintain her fertility determine her choices and reactions when breast cancer is diagnosed during pregnancy.[47] The patient and her partner should be informed about the different treatment options and the physician should explain that termination of pregnancy does not seem to improve maternal outcome,[7] but the decision to continue or end the pregnancy is a personal one. In studies that showed lower survival in patients who chose termination than in women who continued their pregnancies, the women were not matched for stage of disease.[48,49] Women with a

poor prognosis at diagnosis were probably more likely to be encouraged to terminate their pregnancies than were women with a good prognosis.

Surgery

In general, surgery can be done safely during any stage of pregnancy and most anaesthetic agents seem to be safe for the fetus.[50–52] A multidisciplinary discussion among breast surgeons, anaesthesiologists, and obstetricians should focus on the prevention of hypoxia, hypotension, hypoglycaemia, fever, pain, infections, or thrombosis since these events can have serious adverse effects on fetal development. Maternal care during the perioperative period is the best insurance for fetal wellbeing. Clinicians use fetal heart-rate monitoring during surgery to detect fetal distress (figure 5) but its application should follow local guidelines. Preterm onset of labour can be provoked by pain, thus sufficient analgesia is needed. Postoperative tocometry will identify any uterine activity that is masked by analgesia.[18] Moreover, since pregnancy is an additional risk factor for thrombosis—apart from the malignant disease—thromboprophylaxis with low-molecular-weight heparin is indicated.

The choice of breast cancer surgery during pregnancy should follow the same guidelines as for non-pregnant women. Radiotherapy after conservative breast surgery is rarely a concern since most women receive chemotherapy with delay of radiotherapy until after delivery. Therefore, mastectomy is not mandatory. In a series of 67 breast operations for cancer in pregnant women,[53] investigators recorded few postoperative complications. If breast reconstruction is considered, a prosthetic implant is possible but in view of physiological changes, autologous reconstructions should be delayed until after delivery.[54]

Clinicians can safely use sentinel lymph-node staging during pregnancy.[21,55–57] The estimated absorbed doses at the epigastrium, umbilicus, and hypogastrium in non-pregnant patients after injection of 92·5 MBq of technetium 99m-labelled sulphur colloid into the breast are below the 0·1–0·2 Gy fetal threshold absorbed dose, under the most adverse conditions.[56,57] Researchers have estimated the dose to the abdomen to be about 0·00045 Gy.[58] By contrast, blue dye is associated with a risk of an anaphylactic maternal reaction, which would probably distress the fetus. Therefore, the use of blue dye should be avoided during pregnancy.[59] Although sensitivity and specificity of sentinel lymph-node biopsies during pregnancy have not been established, researchers have successfully used technetium-based identification in pregnant women.[55] A 1 day protocol needs low radioactive doses and is preferred to the 2 day protocol.

Cytotoxic treatment

The effect of the administration of cytotoxic treatment on a pregnancy varies and depends on the gestational stage during exposure. The fertilisation and implantation period (first 10 days after conception) is characterised by

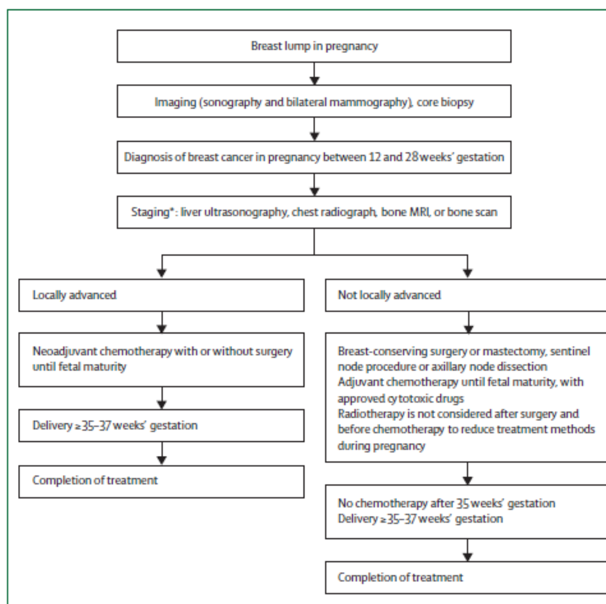

Figure 3: Algorithm for treatment of breast cancer diagnosed between 12 and 28 weeks of pregnancy
*If results will change clinical management.

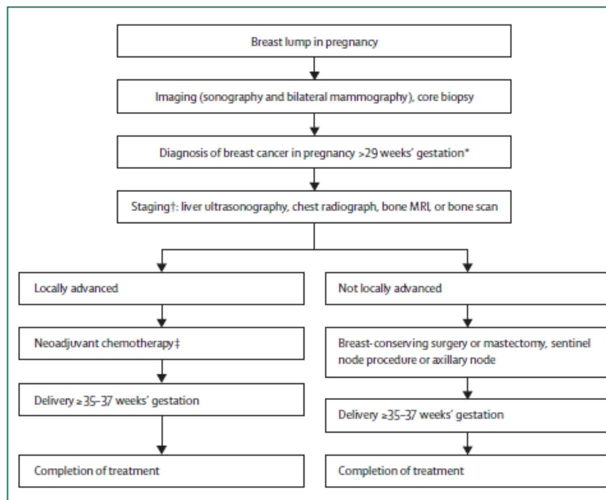

Figure 4: Algorithm for treatment of breast cancer diagnosed from 29 weeks of pregnancy onwards
*If diagnosed ≥35 weeks, consider delivery and post-partum staging and treatment. †If results will change clinical management. ‡If only one chemotherapy cycle is needed to reach fetal maturity, consider delivery at ≥35 weeks' gestation and all chemotherapy after delivery.

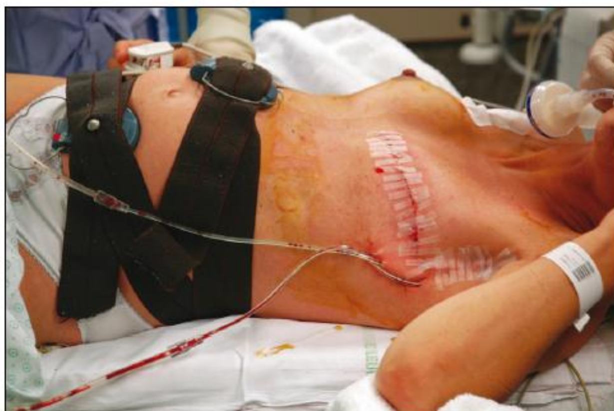

Figure 5: **Left lateral tilt position, monitoring of uterine contractions and fetal heart rate monitoring during breast cancer surgery**

an all-or-nothing event—the number of surviving omnipotent stem cells will determine whether a normal embryo will develop or a miscarriage will occur. Fetal damage in the period of organogenesis (10 days to 8 weeks after conception) is likely to result in congenital malformations. The second and third trimesters of pregnancy are mainly characterised by fetal growth and maturation. Cytotoxic treatment in this period is not associated with fetal anomalies, although researchers have reported growth restriction, intrauterine and neonatal death, prematurity, and haemopoietic suppression.[60] Data for long-term outcomes after prenatal exposure to cytotoxic treatment are needed. On the basis of theoretical assumptions, neurodevelopmental problems, carcinogenesis, sterility, and genetic defects are possible.[21,60]

Chemotherapy as part of primary breast cancer treatment is indicated in most young breast cancer patients. For breast cancer in pregnancy, the decision to administer chemotherapy should follow the same guidelines as in non-pregnant patients, taking into account the gestational age and the overall treatment plan (eg, timing of surgery, need for radiotherapy). Chemotherapy can be adjuvant or neoadjuvant and should be administered after the first trimester. Clinicians can use standard regimens such as fluorouracil and epirubicin or doxorubicin plus cyclophosphamide, or epirubicin or doxorubicin plus cyclophosphamide and taxanes (paclitaxel weekly to every 3 weeks or docetaxel every 3 weeks). Although some researchers recommend weekly epirubicin treatment on the basis of fetal safety data,[61] others argue that it should not be used because it is not a standard treatment for breast cancer.[62] We believe that clinicians should not put maternal prognosis at risk to limit or reduce unproven fetal damage. The main advantage of weekly regimens during pregnancy is shorter nadir periods that might reduce the risk of complications when unexpected delivery occurs. Since there are other options and in view of the third-space effect of methotrexate, the combination of this drug with cyclophosphamide and fluorouracil should not be used.[18] Dose-dense (dose-intensified) regimens result in improved disease-free and overall survival, particularly in women with hormone-receptor negative disease, which is common in patients with breast cancer during pregnancy.[63] However, data on dose-dense chemotherapeutic regimens during pregnancy are scarce.

Researchers have recorded changes in pharmacokinetics for different drugs, including chemotherapeutic agents, during pregnancy.[64–66] Gestational changes include an increased haemodynamic system, an increase in plasma volume and glomerular filtration rate, and hormonal changes in hepatic function. For doxorubicin, epirubicin, paclitaxel, and carboplatin, these changes result in a decrease in plasma drug exposure (area under the curve) and peak plasma concentration and an increase in distribution volume and drug clearance.[65,66] These findings raise doubt about the effectiveness of chemotherapy during pregnancy. In a small study of 11 patients with inflammatory pregnancy-associated breast cancer chemosensitivity was similar to that in non-pregnant patients with breast cancer.[67] However, no direct relation exists between toxic tissue effects and prognosis. Although available outcome data for breast cancer during pregnancy are based on small numbers, they do not show a worse outcome when compared with non-pregnant women.[5] Since no evidence suggests that standard treatment in pregnant women is less efficient than in non-pregnant women, the same drug regimens (based on body surface area or creatinine clearance) should be prescribed for pregnant and non-pregnant patients.[15] The dose should be calculated on the basis of actual weight and be adapted to weight changes during pregnancy.[18]

Since chemotherapy can have teratogenic effects, at least a proportion of these drugs must pass the

	Percent (SD)	Number of samples
Doxorubicin	7·5% (3·2)	6 (in 9 other fetal samples <LLQ)
Epirubicin	4·0% (1·6)	8 (in 3 other fetal samples <LLQ)
Carboplatin	57·5% (14·2)	7
Paclitaxel	1·4% (0·8)	7 (in 4 other fetal samples <LLQ)
Docetaxel	ND	9
4-OH-cyclophosphamide	25·1% (6·3)	3 (<LLQ in 1 fetal and maternal sample)
Vinblastine	18·5% (15·5)	9 (in 1 other fetal sample <LLQ)

LLQ=lower limit of quantification. ND=not detectable.

Table: **Transplacental transfer of chemotherapeutic agents in pregnant baboons, from simultaneously collected maternal and fetal plasma samples**[70,71]

placenta.[60] Only a few case reports on transplacental transfer of chemotherapeutic agents in women are available.[68,69] However, the results from fetal blood samples taken after abortion or delivery within a few days of chemotherapy administration are not consistent, and therefore not conclusive. In a preclinical study of transplacental transfer of chemotheraputic agents in a pregnant baboon, passage rates varied between different agents (table).[70,71] When fetal and maternal plasma samples were collected simultaneously, for all tested chemotherapeutic drugs, fetal concentrations were much lower than maternal concentrations. Concentrations of doxorubicin, epirubicin, paclitaxel, and docetaxel were below the level of quantification in nine, three, four, and nine fetal samples, respectively. When measurable, fetal concentrations of doxorubicin, epirubicin, and paclitaxel were about 7·5%, 4·0%, and 1·4%, respectively, of the simultaneous maternal concentrations.[70,71] These data confirm an important barrier function for the placenta but the difference between anthracyclines and taxanes is too small to define the best chemotherapy regimen in pregnant patients with breast cancer. The placental filter function adds to fetal safety, especially when chemotherapy is administered after the first trimester. Anthracyclines and taxanes have a high molecular weight, a high protein binding capacity, are substrates of ATP-binding cassette transporters such as P-glycoprotein, and result in a low fetal exposure.[64,72] Syncytiotrophoblast contains a variety of ABC transporters, such as P-glycoprotein and BCRP-1,[73] for which several antineoplastic agents (vinca alkaloids, anthracycline derivatives, taxanes, and topotecan) are substrates. These drug transporters are able to keep fetal drug concentrations very low. However, drugs that inhibit P-glycoprotein or which compete with cytotoxic drugs for the transporter might counteract this protection.[74–76]

For fetal protection, chemotherapy is contraindicated until 10 weeks' gestation. With a safety period of 4 weeks, chemotherapy can start from 14 weeks' gestation.[77] In that scenario, the short-term outcome, including the incidence of congenital malformations, is well documented and reassuring for children who were prenatally exposed to chemotherapy for breast cancer.[6,7,36,38,42,61,78–83] Results of several studies showed an increase in growth-restricted fetuses when chemotherapy was given during pregnancy.[60] However, in studies specifically investigating breast cancer treatment in pregnancy, researchers did not record this increase.[33,78] Although tumour types other than breast cancer and associated drug regimens seem to be at risk for growth restriction, numbers are too low for subanalysis.[6]

Data on long-term outcomes after prenatal exposure to chemotherapy are scarce. A study of 84 children who were born to mothers who received chemotherapy during pregnancy for haematological malignancies with an average follow-up of 19 years did not show any congenital, neurological, immunological, or psychological abnormalities including learning and educational behaviour.[84] However, the methods of this study were poorly described. In a survey completed by 57 parents or guardians, normal development was noted in most children at ages ranging from 2 to 157 months. Only two children needed special attention in school: one had attention deficit disorder, and the other had Down's syndrome.[38] In a small study of ten children aged between 2 months and 66 months,[80] we did a full neurological and cardiological examination and recorded no developmental problems apart from a cortical malformation in a twin whose fraternal twin was normal. Whether this malformation was related to cytotoxic drugs is unclear.[80] Results of the few studies that investigated the cardiac effect of chemotherapy in the fetus showed that anthracyclines are associated with acute myocardial dysfunction.[60,69] However, follow-up with cardiac ultrasonography in 81 children who received anthracycline treatment in utero (age 9–29 years, mean 17 years) detected no abnormalities.[85] Results of a study documenting the long-term outcomes of 70 children exposed to chemotherapy in utero showed that general health and growth, CNS, cardiac, and auditory functions did not differ from the healthy population. However, prematurity was frequently encountered, and was associated with impairment in cognitive development. Therefore, iatrogenic preterm delivery should be avoided as much as possible.[86]

Bisphosphonates and hormonal agents

Bisphosphonates are highly effective in premenopausal patients in combination with endocrine therapy,[87] but so far they have not been approved for the treatment of primary breast cancer. Results of studies of bisphosphonates in pregnant animals have shown maternal toxicity, fetal underdevelopment, embryolethality, hypocalcaemia, and skeletal retardation. Bisphosphonates are therefore contraindicated in pregnancy and they are rated a category C pregnancy risk by the US Food and Drug Administration. Their use in premenopausal women before conception or during pregnancy could pose a teratogenic risk, because bisphosphonates remain in mineralised bone for several years. Reports of women treated with bisphosphonates before or during pregnancy, however, showed no increase in incidence of malformations or changes in fetal bone modelling.[88] If indicated in a pregnant patient with metastatic breast cancer, hypocalcaemia affecting the contractility of the uterus must be avoided.

During pregnancy, hormonal agents such as selective oestrogen receptor modulators can disturb the hormonal environment, and so such treatments should be delayed until after birth. Tamoxifen has the potential to induce fetal harm during pregnancy and is associated with birth defects including craniofacial malformations and ambiguous genitalia, and fetal death.[89] Oral aromatase inhibitors are not indicated in premenopausal women.

Panel: Checklist for care of pregnant patients with breast cancer

At diagnosis

- Confirm progressing pregnancy and define duration of pregnancy
- Exclude pre-existing fetal anomalies by ultrasonography before examinations or interventions

Obstetric follow-up during oncological treatment

- Consider intraoperative fetal monitoring from 24 to 26 weeks' gestation onwards, according to local policy
- Chemotherapy is possible during second or third trimester
  - Check for fetal wellbeing and general development
  - Check for preterm contractions
  - Check for intrauterine growth restriction
  - No chemotherapy after 35 weeks' gestation
- Radiotherapy is possible during first or second trimester
  - Check for fetal wellbeing and general development
  - Check for preterm contractions
  - Check for intrauterine growth restriction

Delivery

- Mode of delivery is determined by obstetric indications
- Timing of delivery
  - Preferably after 35–37 weeks' gestation
  - At least 3 weeks after last cycle of chemotherapy (delivered at 21 day intervals)
  - If preterm delivery is inevitable, fetal lung maturity is essential

Post-partum

- Examine placenta for metastatic disease
- Oncological treatment can be continued immediately after vaginal delivery, and a week after uncomplicated caesarean section
- Breastfeeding
  - If physiologically possible—eg, after radiotherapy
  - Contraindicated during and after chemotherapy

Targeted therapy for breast cancer

Treatment with trastuzumab in HER2-positive tumours in pregnant women cannot be recommended. HER2 is strongly expressed in the fetal renal epithelium.[90] In 15 fetuses exposed to trastuzumab,[91] three had renal failure, and four died. In eight cases, the volume of amniotic fluid was reduced. The severity, ie, oligohydramnios or anhydramnios, was linked to the duration of exposure.[91] Although long-term treatment should be avoided,[18] trastuzumab for short periods seems less toxic. In surviving children, renal function spontaneously recovered in utero after withdrawal of the drug. In 11 of 15 fetuses that were unintentionally exposed to trastuzumab in the first trimester,[91] no congenital malformations were reported. This finding might be related to differences in transplacental transport of IgG molecules, which gradually increases with the duration of gestation.[92] New breast cancer drugs, such as bevacizumab and tyrosine kinase inhibitors, should not be used in pregnant patients because they have not been tested in this group.

Supportive treatment in breast cancer

Clinicians report the bedside experience that chemotherapy induced side-effects are less pronounced in pregnant women than in non-pregnant women, although formal studies have not been done. The general principle that during pregnancy, drugs should not be used unless strictly indicated, should also be applied to supportive treatment. Clinicians have used growth factors for white and red blood cells during pregnancy without noting adverse events, but the clinical evidence of their safety during pregnancy is scarce. However, present guidelines give no arguments to withhold these agents if indicated.[77,93] In the particular case of steroids, methylprednisolone and hydrocortisone are extensively metabolised in the placenta and are therefore the preferred steroids to use during pregnancy.[77] Dexamethasone and betamethasone cross the placenta and the repeated administration of these steroids during the first trimester is associated with increased incidences of attention difficulties, high rates of cerebral palsy, and an increased incidence of cleft palate.[94,95]

Prognosis

Pregnant women are less likely to be diagnosed with stage 1 but two and a half times more likely to be diagnosed with advanced disease than non-pregnant women.[96,97] Although several groups have investigated maternal prognosis, they always refer to pregnancy-associated breast cancer, thus including breast cancer diagnosis within a year after delivery. Breast cancers diagnosed during pregnancy are not analysed separately or are too few to allow control for all prognostic factors. Only in a collaborative setting with knowledge of prognostic factors and follow-up data can the maternal prognosis be investigated.

Prenatal care

Apart from the serious maternal illness, the examinations and oncological treatment for breast cancer might interfere with normal fetal development. Therefore, patients should be cared for in a unit for high-risk obstetrics. In general, pregnant patients should be followed up and treated in the same way as other high-risk obstetric patients—eg, with regard to lung maturation and mode of delivery.[15,18] Although no guidelines have been issued for obstetricians to monitor pregnant patients treated for breast cancer, we present some considerations in the panel. Before staging examinations or oncological treatment are started, fetal structural development and growth should be assessed to exclude pre-existing anomalies.[15] Since in a series of 215 patients, the risk of preterm labour and growth restriction were increased,[6] perinatologists should pay special attention to preterm labour and fetal growth restriction.[6] When anthracyclines are used, special consideration should be given when maternal conditions involving the cardiovascular system are apparent (eg, pre-eclampsia).

The aim of a term delivery (>37 weeks' gestation) is important since prematurity affects the cognitive and

emotional development of children.[86,98,99] When breast cancer in pregnancy is diagnosed in the third trimester and when only one cycle of chemotherapy is needed before fetal maturity, delivery at 35 weeks and postnatal start of chemotherapy can be considered. This decision is a balance between the risks of late prematurity and the poorly documented long-term outcome after chemotherapy exposure late in pregnancy. A 3 week interval should be left between the last cycle of chemotherapy and the delivery to avoid problems associated with haemopoietic suppression (bleeding, infection, anaemia) in the mother and baby, and to avoid drug accumulation in the fetus.[15,18,100] We advise examination of the placenta of all pregnant patients with cancer for metastases. For breast cancer, Pavlidis and Pentheroudakis have described 14 cases of placental metastases, but none of fetal metastases.[101] Post-partum oncological treatment, including chemotherapy and radiotherapy, can be restarted immediately after a vaginal delivery. After an uncomplicated caesarean section, an interval of a week is recommended before oncological treatment is continued. After chemotherapy during pregnancy, primary inhibition of milk production is advised to prevent accumulation of lipophilic agents such as taxanes in the milk. Breastfeeding in the first weeks after chemotherapy is, in the absence of safety data, not recommended.

Conclusions

Breast cancer treatment during pregnancy is possible, and termination of pregnancy is not likely to improve the prognosis. Breast cancer during pregnancy is not an emergency and the time needed to consult an expert team does not worsen the prognosis. The first multidisciplinary discussion should consider a diagnostic strategy aiming to reduce the burden of fetal radiation exposure. Non-ionising examinations are preferred to those needing ionising agents, and staging examinations that are likely to alter breast cancer treatment during pregnancy are done. The second multidisciplinary discussion determines the therapeutic strategy, which should adhere as closely as possible to standard protocols for non-pregnant patients, but also consider fetal safety. Future studies need to investigate the effect of reduced serum concentrations of chemotherapeutic agents due to physiological pregnancy-associated changes. Maternal prognosis needs to be defined. Although data suggest clinicians can use chemotherapy and radiotherapy during pregnancy, improved documentation of the long-term outcome of children exposed to these treatments in utero is needed. Prematurity will add to negative long-term outcomes and should be avoided. The European Society of Gynaecological Oncology (ESGO) has a cancer in pregnancy task force, which welcomes active members. Randomised trials are impossible and only international registries, such as one endorsed by ESGO and another run by the German Breast Group, can accrue numbers that allow more robust conclusions.

Contributors

FA designed the concept. All authors were involved in literature search, writing, and final approval of the manuscript.

Conflicts of interest

FA is Senior Clinical Investigator for the Research Fund-Flanders. All other authors declare that they have no conflicts of interest.

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For the **German Breast Group** see http://www.germanbreastgroup.de/pregnancy

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Malignancies in Pregnancy 3

Haematological cancers in pregnancy

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This is the third in a Series of three papers about malignancies in pregnancy

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Haematological cancer in pregnancy, although rare, poses a substantial risk to both mother and fetus. Hodgkin's lymphoma is the most common, followed by non-Hodgkin lymphoma and acute leukaemia. Diagnosis of haematological cancers is challenged by an overlap of the disease and gestation-related symptoms and limitations of imaging studies in pregnancy. Data for safety and effectiveness of therapy are scarce and mostly retrospective. This report provides updated guidance for management, focusing on chemotherapy and biological agents. The primary goal of treatment is to preserve the mother's health; hence, pregnancy termination is often advisable at early stages, allowing delivery of adequate therapy. However, at later gestational stages treatment is often feasible. Pregnancy-related hypercoagulability, augmented by cancer, often necessitates thromboprophylaxis. The consequences and complex management of haematological cancer during pregnancy emphasise the need for collaborative research, focusing on basic mechanisms of disease and prospective epidemiological studies.

Introduction

Diagnosis of cancer during pregnancy is traumatic and poses a substantial challenge to the patient, her family, and the medical team. The need to treat a potentially lethal disease and concerns about adverse fetal outcomes raise therapeutic, ethical, and social dilemmas.

Cancer is diagnosed in about 0·1% of pregnancies and is the second most common cause of maternal death after gestation-related vascular complications. The prevalence of cancer during pregnancy is expected to rise in developed countries because of the increase in average age at pregnancy. Most cases are attributed to solid tumours; haematological cancers are less common.[1,2] The low incidence of haematological cancers during pregnancy has precluded large prospective controlled trials; hence, data are restricted to retrospective series and case reports, which poses difficulties for the establishment of strict guidelines for management.[2]

Evidence obtained so far does not show a causative association between pregnancy and haematological cancers. Epidemiological studies have not established an association between non-Hodgkin lymphoma and exposure to hormonal therapy (oestrogen, progesterone, or both).[3–5] However, some non-Hodgkin lymphoma subtypes express hormone-related receptors, which could contribute to tumour growth and disease progression.[3]

Furthermore, the immunosuppressive milieu characterising pregnancy, mainly induced by the expansion of regulatory T cells, could also enhance tumour progression. However, no reliable animal models or solid clinical data support the involvement of these mechanisms in gestation-associated haematological cancers.

Epidemiology, clinical presentation, and diagnosis

Lymphoma is the fourth most common cancer in pregnancy, with an estimated prevalence of one in 6000 pregnancies.[4,5] The presenting signs and symptoms are similar to those observed in non-pregnant patients, but can be confused with symptoms that accompany normal pregnancy, such as shortness of breath and hypermetabolism.[2]

Diagnosis of both Hodgkin's lymphoma and non-Hodgkin lymphoma (table 1) is usually made by examination of lymph-node biopsy sample, which does not cause additional fetal or maternal risk when done with local or general anaesthesia.[6] Interpretation of blood

Key messages

- Haematological cancer in pregnancy poses a substantial risk to mother and fetus.
- Diagnosis is made difficult by limitations of imaging.
- Management should focus on the mother's survival, while minimising treatment-related fetal toxic effects.
- The hypercoagulable milieu induced by pregnancy and cancer can result in maternal and placental vascular complications and might require thromboprophylaxis.

Search strategy and selection criteria

Data for this Review were identified by searches of Medline, PubMed, and Embase for papers published between January, 1966, and January, 2011. Search terms used were "pregnancy" and "gestation" together with "hematological malignancy", "lymphoma", "Hodgkin", "Burkitt", "multiple myeloma", "chronic leukemia", "acute leukemia", "essential thrombocythemia", "myeloproliferative", "hormones", "progesterone", "estrogen", "foetus", "antibiotics", "anti-emetics", "thrombosis", "bleeding", "ATRA", "rituximab", "tyrosine kinase inhibitors", "chemotherapy", "radiation", "CT", "MRI", and "anesthesia". The search included reports published in English, including English abstracts of articles published in other languages. Articles were selected on the basis of their relevance and clinical trials were included on the basis of their importance as judged by the authors.

tests should take into account physiological changes accompanying pregnancy. Imaging studies are needed to stage patients with lymphoma, usually CT, or PET combined with CT. These tests produce radiation; hence, fetal exposure should be avoided.[7,8] Chest radiography can be done in pregnant women with abdominal shielding.[2] Ultrasonography, particularly useful for abdominal assessment, can be safely used.

MRI can be used in pregnancy.[9] However, the effect of MRI exposure in the prenatal period has not been fully assessed; therefore it should be used cautiously, especially during the first trimester. Furthermore, gadolinium-based contrast agents cross the placental barrier, resulting in growth retardation and skeletal malformations in animals; therefore, they should be avoided, especially in early gestation.[9-11] Reassessment with CT or PET and CT can be done after delivery. However, because fluorine-18-labelled fluorodeoxyglucose is highly concentrated in breast tissue, patients should avoid breastfeeding for 72 h after the scan.

Hodgkin's lymphoma is more frequent than non-Hodgkin lymphoma in pregnant women,[12,13] perhaps because Hodgkin's lymphoma is generally most frequent in young adulthood. The majority of cases seem to be classic nodular-sclerosis Hodgkin's lymphoma, which is a common subtype in women younger than age 40 years. Despite misleading symptoms such as exhaustion and dyspnoea, Hodgkin's lymphoma in pregnancy is generally first diagnosed at about the same disease stage as in patients who are not pregnant, reflecting the slow-growing nature of the tumour in most patients.[14,15] Furthermore, the outcome in women diagnosed with Hodgkin's lymphoma while pregnant does not seem to be worse than that in age-matched non-pregnant patients.[14,15] However, cautious interpretation of these findings is needed because of the few cases reported and analysed.

Non-Hodgkin lymphoma is uncommon during pregnancy; about 100 cases have been reported. However, this number is expected to rise because of the increasing age of women at conception, the observed increase in non-Hodgkin lymphoma incidence over the past two decades, and the growing incidence of HIV-associated lymphoma in developing countries.[5] Although diffuse large B-cell lymphoma accounts for most cases, almost all other histological non-Hodgkin lymphoma subtypes can occur during pregnancy.[16] As for Hodgkin's lymphoma, diagnosis of pregnancy-associated non-Hodgkin lymphoma can be delayed because of overlapping symptoms and the wish to avoid imaging studies during gestation.[2] Such delays could result in advanced disease at presentation, especially in women with an aggressive histopathological subtype in whom even a short delay in diagnosis could lead to clinically significant disease progression.

The reproductive organs (breast, ovaries, cervix, and uterus) are more commonly involved in pregnancy-associated non-Hodgkin lymphoma than in age-matched patients diagnosed with a similar subtype.[17-23] The pathophysiological mechanisms of this tendency could be related to either hormone-dependent growth or a putative pre-existing hyperproliferative state in these tissues caused by pregnancy. Little is known about the effect of excessive extranodal presentations on the risk of CNS involvement and long-term survival, or about the advantage of post-partum administration of local radiotherapy to these organs. Placental and fetal involvement is rare.[24-27] Pregnant women presenting with highly aggressive lymphoma (mainly Burkitt's and Burkitt-like) are likely to have a fulminant course—associated with a poor outcome—caused by either a delay in diagnosis, a worse natural history, or insufficient therapy. Multiple myeloma mainly affects older people, and is therefore rarely reported in pregnant women. Diagnosis can be challenging because anaemia and back pain, presenting features of myeloma, are also common during pregnancy.

The prevalence of leukaemia during pregnancy is low—roughly one in 75 000–100 000 pregnancies.[28,29] Most cases are acute, involving myeloid (acute myeloid leukaemia, accounting for two-thirds of cases), or lymphoid (acute lymphoid leukaemia) lineages. Chronic leukaemias and myelodysplastic syndrome, generally considered diseases of old age, are rarely reported during pregnancy.[29,30] Acute leukaemia is usually reported during the second and third trimesters of pregnancy,[30,31] which could be a result of a selection bias of non-reported cases that occurred earlier and resulted in termination of pregnancy. Acute leukaemia can cause leucostasis, thrombosis, and disseminated intravascular coagulation, which might be aggravated by the gestational thrombogenic milieu,[32] thereby adversely affecting maternal and fetal outcomes.

Acute leukaemia needs immediate full treatment irrespective of gestational stage because delay or modification of therapy results in inferior maternal prognosis.[31] Patients diagnosed with acute leukaemia

	Recommendation
Bone-marrow biopsy	Done with local anaesthesia
Lymph-node biopsy	Done with local or general anaesthesia
Chest radiography	Done with pelvic shielding
CT	Contraindicated, especially in the first two trimesters Recommended after delivery
PET or FDG	Contraindicated, especially in the first two trimesters Recommended after delivery (caution with breastfeeding)
Ultrasonography	Abdominal assessment safe
MRI	Safe*

FDG=fluorine-18-labelled fluorodeoxyglucose. *Gadolinium-based contrast agents should be avoided, especially during the first trimester.

Table 1: **Recommendations for diagnostic procedures**

during the first trimester are recommended to terminate pregnancy, in view of the high risk of toxic effects on fetus and mother, along with the expected need for further intensive treatment, including stem-cell transplantation, which is absolutely contraindicated during gestation.

Leukapheresis in the presence of a very high white-cell count and leucostasis-related symptoms (potentially occurring in acute and chronic leukaemias) seem to be well tolerated by both fetus and mother.[33–36]

Chronic myeloid leukaemia—a relatively slow-growing tumour—can present with severe leucostasis[33–36] and vascular complications, adversely affecting maternal and fetal outcomes.[37,38]

The incidence of pregnancy-associated myeloproliferative neoplasms is increasing, mainly because of the use of improved diagnostic techniques.[39] The combination of pregnancy and myeloproliferative neoplasms increases the risk of both maternal and placental thrombotic events.[40,41] Platelet counts decrease during pregnancy and rebound post-partum, increasing the risk of maternal thromboembolism.[42,43] Thrombosis can also affect the placenta, impairing fetal growth and viability, and resulting in fetal death in about a third of pregnancies.[42,44] The presence of a JAK2 Val617Phe mutation might increase risk of loss of pregnancy.[45]

Treatment

Chemotherapy

The many physiological changes that occur during pregnancy (increased plasma volume, third space created by amniotic fluid, hepatic oxidation, and renal clearance) affect drug distribution, metabolism, and excretion.[46,47] Pharmacokinetic data from studies of pregnant women are scarce. Plasma and tumour concentrations of various chemotherapeutic agents can be reduced during pregnancy;[48] however, clinical data suggest a similar prognosis for pregnant and non-pregnant women.[14,49] Chemotherapy can inhibit the migration and proliferation of trophoblasts in first-trimester human placental explants, which might partly explain the low birthweights of babies whose mothers received chemotherapy.[50]

Most cytotoxic drugs are 250–400 kDa and can therefore cross the placenta.[51] Few animal studies have assessed drug concentrations in the amniotic fluid, cord blood, placenta, or fetal tissues.[52] However, doses used in human beings are usually lower than those reported to be fetotoxic in animals.[52,53] Data regarding patients are mainly for combination therapies, by contrast with single agents studied in animal models, thereby hampering reliable estimation of the effect of each drug. The fetus is most vulnerable to drug-related teratogenicity during organogenesis (the first 2–8 weeks of gestation).[54] However, some organs, including the eyes, genitalia, and haemopoietic and nervous systems, are still vulnerable after the first trimester.[46,54] Notably, non-ionised, low-molecular-weight drugs, characterised by their high lipid solubility and low protein binding, have an increased ability to transfer from the mother to the fetus.[47] Because less than a quarter of fetuses are adversely affected when mothers are treated during the first trimester,[48] teratogenic susceptibility could be affected by genetic predisposition.

Chemotherapeutic agents, especially when administered in combination, should be avoided during the first trimester. If the mother's condition necessitates immediate therapy, termination of pregnancy is strongly recommended. Exposure to chemotherapy in the second and third trimesters is less likely to result in teratogenic effects, although it increases the risk of intrauterine growth restriction.[55]

A detailed review of the potential teratogenicity of classic cytotoxic drugs[56,57] is beyond the scope of this report; however, antimetabolites are highly teratogenic and should be avoided in pregnancy.[58] High-dose methotrexate is associated with the aminopterin syndrome (cranial dysotosis, delayed ossification, hypertelorism, wide nasal bridge, micrognathia, and ear anomalies). Anthracycline-induced fetal cardiotoxicity, especially for idarubicin, seems to vary, ranging from transient to sustained myocardial dysfunction.[59–61] Liposomal doxorubicin, having a higher placental penetration than other anthracyclines, is in theory more likely to result in fetal toxic effects, including cardiac toxic effects. Anthracyclines and cyclophosphamide, commonly used during the second and third trimesters of pregnancy, seem to be safe.[62,63] No data are available for pulmonary toxic effects associated with bleomycin, or neurotoxicity related to vinca alkaloids. Delivery should be planned at least 2–3 weeks after cessation of chemotherapy to allow bone-marrow recovery and fetal drug excretion via the placenta,[64] because several cases of neonatal cytopenia and sepsis have been reported.

Late side-effects in offspring of mothers undergoing chemotherapy while pregnant is a concern, especially in terms of neurodevelopmental, sexual, and fertility functions.[47] Aviles and Neri[65] followed up 84 children exposed to chemotherapy in utero for up to 19 years and reported normal neurological development, school performance, sexual maturation, and reproduction. Likewise, Nulman and co-workers[66] showed favourable neurodevelopment in children exposed in utero to treatment for maternal malignancy.

Targeted therapies

Current treatment of haematological cancers is changing substantially with the development of targeted therapies. We focus on three classes of biological therapies that have a major effect on the treatment of patients with haematological cancers.

Tretinoin is indicated for the treatment of acute promyelocytic leukaemia. The combination of this drug with anthracyclines significantly improves the prognosis of patients with acute promyelocytic leukaemia, resulting in an excellent long-term outcome. However, retinoids

are associated with substantial toxic effects when used in the first trimester, including CNS and cardiovascular malformations (retinoid embryopathy);[67] hence, women diagnosed early in gestation should terminate pregnancy.[68] Administration of tretinoin during the second or third trimester of pregnancy seems to have no adverse

	Suggested approach	Therapies	Maternal outcome*	Fetal outcome
Indolent non-Hodgkin lymphoma (eg, follicular lymphoma)				
All pregnancy stages	Watch and wait	..	Generally unaffected	Generally unaffected
Late pregnancy stage†	Treat if symptomatic or evidence of disease progression	Rituximab with or without CVP or CHOP, consider head or neck radiotherapy for local stage	Generally unaffected	Generally unaffected
Aggressive (eg, diffuse large-cell B-cell lymphoma) and highly aggressive (eg, Burkitt's) non-Hodgkin lymphoma				
Early pregnancy stage‡	Pregnancy termination, then same therapy as for non-pregnant women	Rituximab with CHOP for aggressive non-Hodgkin lymphoma, with intensified regimens for highly aggressive disease§	Probably unaffected	Pregnancy termination
Late pregnancy stage†	Treat as non-pregnant women	Rituximab with CHOP for aggressive non-Hodgkin lymphoma, with intensified regimens for highly aggressive disease§	Probably unaffected	Probably unaffected
Asymptomatic myeloma				
All pregnancy stages	Monitor carefully	..	..	..
Symptomatic myeloma				
Early pregnancy stage‡	Pregnancy termination, then same therapy as for non-pregnant women	..	..	..
Late pregnancy stage†	Treat as non-pregnant women but avoid lenalidomide and thalidomide. Aggressive cases require early delivery	Chemotherapy; consider bortezomib¶	..	..
Hodgkin's lymphoma				
Early pregnancy stage‡	Defer treatment to second trimester if slow growing disease	Standard therapy with ABVD	Unaffected	Pregnancy termination if treatment is needed
Late pregnancy stage†	In progressing cases terminate pregnancy, treat as non-pregnant women	Consider escalated BEACOPP for high-risk cases, adjuvant radiotherapy if required	Unaffected	Unaffected
Acute myeloid leukaemia				
Early pregnancy stage‡	Pregnancy termination, then conventional therapy	Daunorubicin or cytarabine, high-dose cytarabine, consider allogenic stem-cell transplantation	Unaffected	Pregnancy termination
Late pregnancy stage†	Treat as non-pregnant women, consider early delivery if allogeneic stem-cell transplantation is recommended	Daunorubicin or cytarabine, high-dose cytarabine, consider allogenic stem-cell transplantation	Probably unaffected	Probably unaffected
Acute promyelocytic leukaemia				
Early pregnancy stage‡	Pregnancy termination, then conventional therapy	Daunorubicin with tretinoin	Might be affected	Pregnancy termination
Late pregnancy stage†	Treat as non-pregnant women including tretinoin	Daunorubicin with tretinoin	Probably unaffected	Probably unaffected
Acute lymphoblastic leukaemia				
<20 weeks' gestation	Pregnancy termination, then conventional therapy	Multidrug chemotherapy§	Unaffected	Pregnancy termination
>20 weeks' gestation	Treat as non-pregnant women, consider early delivery if allogeneic stem-cell transplantation is recommended	Multidrug chemotherapy§	Probably unaffected	Probably unaffected
Myeloproliferative neoplasias				
All pregnancy stages	Assess thrombotic risk and treat accordingly	Aspirin, consider interferon alfa and LMWH	High incidence of thrombotic events, especially post-partum	High incidence of growth restriction and loss of fetus
Chronic myeloid leukaemia				
Early pregnancy stage‡	Treat but avoid tyrosine kinase inhibitors	Interferon alfa	Unlikely to be affected	Unaffected
Late pregnancy stage†	Treat as non-pregnant women	Tyrosine kinase inhibitors	Usually unaffected	Affected if exposed during first trimester

ABVD=doxorubicin, bleomycin, vinblastine, dacarbazine. BEACOPP=bleomycin, vincristine, procarbazine, prednisone, etoposide, doxorubicin, cyclophosphamide. CHOP=cyclophosphamide, vincristine, prednisone. CVP=cyclophosphamide, doxorubicin, vincristine, prednisone. LMWH=low-molecular-weight heparin. *Compared with age-matched women without cancer. †Second and third trimester. ‡First trimester. §Omit methotrexate until third trimester. ¶The fetal toxic effects of bortezomib are not established; thalidomide and lenalidomide are contraindicated.

Table 2: **Treatment and prognosis of haematological cancers**

effect on outcomes, although preterm deliveries and reversible cardiac symptoms have been reported.[69]

Imatinib is the standard treatment for non-pregnant patients with chronic myeloid leukaemia. In one study, 50% (63 of 125) of women treated with imatinib gave birth to healthy babies.[70] However, 12 infants exposed to imatinib during the first trimester had congenital abnormalities, especially of the kidneys, skeleton, heart, brain, and gut (eg, exomphalos).[70] Thus, if treatment is indicated during this period, interferon alfa should be considered.[33,71] Additionally, patients who become pregnant after a prolonged molecular remission might be considered for imatinib discontinuation or substitution with interferon,[72] and women with an inferior response should postpone pregnancy until they have a better response, or at least be treated with interferon alfa at early gestational stages with an option to readminister tyrosine kinase inhibitors in the second or third trimester, although data for this situation are scarce.

The effect of imatinib cessation on disease course is still being debated. Although most studies report disease relapse after imatinib discontinuation, only a small fraction of patients achieve complete remission after readministration of imatinib,[73–77] emphasising the need for interferon use during pregnancy.[72] Second-generation tyrosine kinase inhibitors, which are increasingly used, especially in patients in whom imatinib has failed, also seem to be teratogenic.[72,73,78–80] Furthermore, women should avoid breastfeeding while taking tyrosine kinase inhibitors.

Management of lymphoma and myeloma

The management of pregnant women with both Hodgkin's and non-Hodgkin lymphoma, although usually the same as that in non-pregnant women, needs to be modified according to gestational stage (table 2). Patients diagnosed during the first trimester with asymptomatic slow-progression Hodgkin's lymphoma might be carefully watched for several weeks, allowing deferral of therapy until the second trimester, instead of termination of pregnancy.[62]

Patients with asymptomatic indolent lymphoma (eg, of the follicular and mucosa-associated lymphoid tissue) are usually closely observed, whereas women with symptomatic disease and those presenting with aggressive non-Hodgkin subtypes—eg, diffuse large-cell B-cell lymphoma, Burkitt's lymphoma, and peripheral T-cell lymphoma—are given chemotherapy, with or without immunotherapy, similar to that administered to non-pregnant patients, with the aim of curing the mother. Notably, patients with symptomatic indolent disease might be first treated with rituximab only, deferring chemotherapy until after delivery. Radiotherapy, usually considered in patients with localised indolent lymphoma, or as part of a combined modality therapy in patients with early diffuse large-cell B-cell lymphoma or Hodgkin's lymphoma, should be postponed until after delivery, although it could be considered at late gestational stages for local fields involving the axilla, head, and neck.[63,81]

The management of multiple myeloma in gestation depends on the presence of myeloma-related organ damage. Patients with asymptomatic myeloma with no evidence of skeletal or kidney impairment should be monitored cautiously.[82] However, patients presenting with progressive disease, resulting in kidney or bone impairment, should be treated irrespective of gestational stage. Steroids are the safest treatment for multiple myeloma during pregnancy;[83] however, patients with rapidly progressing disease might need a more intensive approach. Symptomatic, non-pregnant patients are currently managed with biological agents such as thalidomide, its immunomodulatory analogue lenalidomide, or the proteasome inhibitor bortezomib in combination with steroids, with or without low-dose alkylating agents. However, thalidomide and lenalidomide are highly teratogenic, and therefore strictly contraindicated during gestation;[84] thus, if a myeloma patient conceives while receiving immunomodulatory drugs, pregnancy needs to be terminated. Information about the safety of bortezomib is scarce; nevertheless, unpublished data suggest that bortezomib can pose a risk to the fetus but can be considered for aggressive disease.

Non-pregnant patients with lytic lesions or fractures also receive bisphosphonates, which significantly reduce the risk of myeloma-related bone complications. A retrospective study that assessed the outcome of 51 neonates exposed to bisphosphonates during various gestational stages showed encouraging results, with no evidence of skeletal abnormalities or malformations.[85]

Rituximab, an anti-CD20 monoclonal antibody, is extensively used for the treatment of non-Hodgkin lymphoma and autoimmune diseases. The global drug safety database records 231 pregnancies that had maternal exposure to rituximab.[86] Notably, most cases were confounded by the concomitant use of potentially teratogenic medications. 153 cases were assessable, 90 live babies were born, and there were 61 miscarraiges in the first trimester—33 spontaneous and 28 elective. 22 infants (24%) were born prematurely, two with congenital abnormalities and one neonatal death. 11 neonates had haematological abnormalities (five had B-cell depletion, three had thrombocytopenia, and three had leucopenia); however, none had corresponding infections. Although based on scant information, administration of rituximab during the second and third trimesters, alone or in combination with chemotherapy, seems to be safe.[87]

All chemotherapeutic drugs and especially the new, targeted therapies, should be administered only after a detailed discussion with the patient and her family, and with close fetal monitoring.

Supportive therapy during pregnancy

Chemoimmunotherapy often results in adverse events, including nausea, allergic reactions, and substantial

neutropenia, which might increase the risk of infection. Antiemetics, including the serotonin receptor antagonist ondansetron[88] and the D2 receptor antagonist metoclopramide,[89] are deemed safe.[90] Likewise, previous studies support the safety of antihistamines and phenothiazines.[90,91]

A full review of the use of antibiotics in pregnancy[57,92,93] is beyond the scope of this report. However, macrolides (eg, clarithromycin), cephalosporins, metronidazole, and penicillin are generally safe, whereas aminoglycosides, quinolones, trimethoprim, and tetracyclines should be avoided.[57]

Data on growth factors commonly used in patients receiving chemotherapy, mainly limited to pregnant women who received granulocyte colony-stimulating factor for severe chronic neutropenia,[94] suggest that this therapy is harmless.

Pregnancies in patients with essential thrombocythaemia, polycythaemia vera, and primary myelofibrosis, although not commonly reported, are also associated with an increased risk of spontaneous abortion and preterm delivery.[39,40] Anagrelide and hydroxycarbamide should preferably be avoided, especially during the first trimester of gestation.[39] Interferon alfa is the drug of choice in this setting and should be administered with an adequate antiplatelet agent, usually aspirin.[95] The role of additional low-molecular-weight heparin is unclear.

Thromboprophylaxis

Pregnancy is a hypercoagulable state, associated with an increase in the risk of venous thromboembolism of five times during gestation and up to 50 times immediately post-partum. The hypercoagulable milieu induced by pregnancy and cancer can result in placental thrombosis, fetal growth restriction or loss, and an increased maternal risk of deep-vein thrombosis or pulmonary embolism. This risk is even higher in multiple pregnancy, which is more likely to be complicated by placental hypoperfusion and intrauterine growth restriction.

The mechanisms of gestational thrombogenicity could involve cancer-related factors, including the expression of haemostatic proteins on tumour cells, production of inflammatory cytokines, and adhesion of tumour cells to endothelium, as well as pregnancy-induced procoagulant activity. Microparticles bearing tissue factor could play an essential part in both cancer and pregnancy-associated thrombogenesis.[96] The origin of these microparticles varies and includes tumour cells, monocytes, platelets, endothelial cells, and placental trophoblasts. Finally, heparanase—highly expressed by the placenta and cancer cells—might also contribute to the procoagulant, proangiogenic state in pregnant women with cancer.[97,98]

Chemotherapy and biological agents might also augment thrombotic risk. Asparaginase and methotrexate, essential therapeutic agents for acute lymphoblastic leukaemia, are associated with an increased incidence of vascular events. Low-molecular-weight heparins, which do not cross the placenta, are the drug of choice in pregnancy because of their effectiveness and safety in women at risk.[99] The effect of aspirin for prevention of venous thromboembolism is limited, hence the drug is not recommended in women with haematological cancers. However, antiplatelet agents are useful for prevention of arterial thrombosis and are recommended in women with myeloproliferative neoplasms. The complex thrombohaemorrhagic manifestations in acute promyelocytic leukaemia can be partly ameliorated by transfusion of platelet and blood products.[100]

Notably, the risk of intrauterine growth restriction associated with multiple pregnancy increases substantially in the presence of cancer because of increased maternal thrombogenicity and placental hypoperfusion. Moreover, management of haematological cancers often includes chemotherapeutic agents that might affect placental trophoblasts, resulting in fetal growth restriction.

Reproduction counselling

In the absence of a durable remission of at least 2–3 years, avoidance of pregnancy is advisable in patients with acute leukaemia or lymphoma because the disease is most likely to recur during that period. Whether there is any association between pregnancy and risk of relapse remains unclear. Sufficient antithrombotic prophylaxis is needed to control pregestational blood counts in myeloproliferative neoplasms, because of their chronic nature. Generally, combined hormonal contraceptives increase the risk of thrombosis so they are not recommended in patients with active disease but they can be considered for those in long-term remission. However, progesterone-only preparations, either taken orally or as an intrauterine device, are thought to be safe.

Conclusion

Haematological cancer in pregnancy, although rare, poses diagnostic and therapeutic challenges. Management should focus on survival of the mother, while minimising treatment-related fetal toxic effects. The scarcity of data emphasises the need for extensive collaborative efforts to expand basic and clinical research in this important setting.

Contributors

BB analysed relevant published work and wrote the first and subsequent drafts. IA retrieved and analysed relevant published work, and wrote the first and subsequent drafts. ML analysed relevant published work and contributed to the first and subsequent drafts.

Conflicts of interest

The authors declare no conflicts of interest.

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Day 2 Psychiatry and Other Medical Specialities

Protection of Life during Pregnancy (Heads of) Bill 2013 Hearings 20th May 2013

Opening Statement - Dr Anthony McCarthy

I am Dr Anthony McCarthy, President of the College of Psychiatrists of Ireland and a Specialist in Perinatal Psychiatry at the National Maternity Hospital, Holles Street. I am also the Psychiatric Assessor for the Confidential Enquiry into Maternal Deaths in Ireland.

Our written submission has detailed comments on the Heads of Bill and we recommend that close attention is paid to these points.

This submission was agreed by the Council of the College, the sole organisation recognised by the Medical Council of Ireland as being responsible for the lifelong training of all psychiatrists in Ireland. This Council is the elected decision making body of the College. We know that amongst our 864 members there will be a wide range of opinions with regards to the sensitive issue of abortion, reflecting the deep divisions in society in general about this issue. Many of these views will be heard today.

This bill is about saving women's lives. We recognise that the bill is restricted only to circumstances where the life of the mother is at risk, rather than her mental health. We do recommend that any woman who does have suicidal ideation in pregnancy must be enabled to readily avail of expert psychiatric assessment. And that assessment must be individual, comprehensive, compassionate and not prejudged. Every maternity unit in this country should have such services, and there are significant lacks in such provision currently, as outlined in our written submission.

As so much will be said and heard today about the risk of suicide in pregnancy, I wish to make some brief overall points as someone who has been working as a specialist Perinatal Psychiatrist for over 16 years now, in a service seeing over 500 women every year.

1. Suicide in Pregnancy is real, a real risk, it does happen. This is always a tragedy, at least two lives are lost, and many others are hugely affected. We must do everything we can to prevent such deaths.

2. Much has been made and will be made about the so called lack of evidence with regards to abortion and whether it will ever prevent a suicide. I believe that there will never be statistical evidence to prove this point one way or other. Because trying to prove anything statistically for such a rare event is extremely difficult if not impossible. Only a study involving thousands of women who were expressing suicidal ideas in pregnancy and wanted an abortion, and where half of them had that abortion and the other half did not, could answer this question about statistical evidence and this study will almost certainly never be done, I hope.

3. As doctors, we must always be aware of research but also be very aware of the limitations of research and of the questions which research cannot answer. In our clinical work, we search always for clinical evidence, not statistical evidence. As doctors, we do assess suicidal risk as part of our everyday work and we rely on clinical evidence and on our clinical skills and our experience and training in assessing each woman or child individually. Yes there are extra challenges in assessing

anyone in such emotionally intense situations, and where there are potentially serious outcomes whatever the assessment concludes, but again I stress, we do these sorts of assessments regularly even if most psychiatrists do not do so in this specific circumstance.

4. And part of suicidal risk assessment always includes assessing for the presence or absence of a mental disorder or mental illness, and an assessment of the capacity of the individual to make an informed decision. And that will be essential here too. But we also always assess for, what are called, psychosocial stresses, or life stresses. However, some in this debate have tried to present the case that these are somehow mutually exclusive, as if a woman who is at risk of suicide is either mentally ill, and hence needing psychiatric treatment, or just has a psychosocial stress, an unwanted pregnancy and then she is either not really suicidal or her case has nothing to do with psychiatry.

   Clinical reality, life reality, is that so frequently there is of course a complex interaction between major life stresses, mental distress and mental disorder. While yes, it is sometimes black and white, so often it is not. Attempts to present it as such not only does a great disservice to any women who may find themselves in this particular situation but also to any person at any time in their life who is suffering from major stress or depression or other mental disorder. They too require a comprehensive mental health assessment and treatment, one that does not focus exclusively on the presence or absence of a mental illness but on a holistic assessment and treatment which recognises the individuality of that person.

5. I want to specifically discuss a phrase that is being quoted frequently at the moment that "abortion is never a treatment for suicide". This is true, absolutely true. Abortion is never a treatment for suicide, but nor is counselling or psychotherapy or antidepressants or anything else. There is no treatment for suicide. What society needs to address in general, and what we as psychiatrists have to do specifically, is to try to prevent suicide and this requires looking at what are the causes of suicide and what can be done to address those causes. And so the question here is not does abortion treat suicide but is there ever a case where a woman will kill herself because of an unwanted pregnancy, and if so, what can we do to save her life and would that ever be a termination of pregnancy? And this Bill is about legislating for that very small but real possibility.

6. There are concerns amongst many psychiatrists that somehow this legislation will result in them being placed in very difficult clinical circumstances. For some this is because of their religious, philosophical or ethical beliefs. And these must be respected. For others it is a fear of increased workload for their already overstretched services, and with no extra resources. For others it is a fear of being faced with very difficult clinical situations and dilemmas where, for example, a woman may be genuinely highly distressed, such as after rape, and wants a termination, but is assessed as not being actively suicidal; she does not want to die, she just wants an end to the pregnancy, but she will have to be refused an abortion under this legislation. And that will be difficult for her and for the psychiatrist. These are all real concerns and difficulties, but they still must be addressed. They cannot simply be ignored or denied by our profession and will not be by the College.

7. And many in the profession see this issue as being predominantly a social and political issue, which psychiatrists are now being asked to solve or arbitrate upon, an issue which society as a whole and the legislature need to address. As psychiatrists, we want be there to care for and treat women appropriately and compassionately and not be placed in a position of social policing. But again, at the end of the day, this is about saving women's lives and we as psychiatrists must be prepared to use our professional skills and expertise to assess and treat pregnant women who have suicidal ideation in pregnancy. And if as a result of this legislation, better psychiatric services are put in place so that expert psychiatric assessments and treatments are provided for all pregnant women in Ireland who wish to avail of such services, women and children's lives will be saved.

Protection of Life during Pregnancy (Heads of) Bill 2013 Hearings 20th May 2013

Opening Statement - Dr Joanne Fenton

I am Dr Joanne Fenton, Consultant Adult Psychiatrist and a Specialist Perinatal Psychiatrist in the Coombe Women and Infants University Hospital.

In my role as a Perinatal Psychiatrist I have treated women attending the Coombe Hospital over the past 10 years. These women have had a wide variety of problems and difficulties including illnesses ranging from those with a severe and enduring mental illness like Schizophrenia to those with less severe illness like anxiety or depression but which may cause equal levels of distress.

Suicide is a real risk in individuals who have mental illness and has a devastating impact on all those involved with the woman. As psychiatrists, and in particular in my role as a perinatal psychiatrist, we are trained to carefully assess women who express suicidal ideation or intent. It is my role to provide non judgemental, compassionate care and treatment to these women. The women who present with suicidal intent are in a great deal of distress and it is our aim to treat these women respectively.

In my years in the Coombe Hospital I have seen many women who have had a termination of pregnancy. Each woman has had a different experience and the effect has been different for each. I have never seen a woman where termination of her pregnancy was the treatment for her mental illness nor do I believe that a termination of pregnancy is a treatment for mental illness. However, that said, I cannot say that there will never be a situation where a woman is in such a state of distress and turmoil that for her termination of pregnancy is a life saving option.

The current legislation is very restrictive and many women will continue to travel abroad to seek terminations. There are a number of points which my colleagues and I will address further and are outlined in our written College submission. These include the under 18 age group and those who lack capacity.

I believe that two psychiatrists, as outlined in the Heads of Bill, should assess a woman who is suicidal and pregnant and be in agreement about their assessments but should not have to see the patient at the same time. I believe that the obstetrician should assess the woman from an obstetric point of view and not be expected to assess suicidality, which is beyond their area of expertise. I believe that the timing between initial referral and assessment and the timing for appeal should be shortened as women in this situation are frequently very distressed and may be at risk of a further and serious deterioration in their mental health.

There are many psychiatrists who do not wish to partake in the assessments of these women for many reasons and their concerns must be respected. In my role as a Perinatal Psychiatrist I believe it is my responsibility to continue to assess pregnant women in distress and aim to provide the best and most compassionate care to them.

College of Psychiatrists of Ireland

Wisdom • Learning • Compassion

Protection of Life during Pregnancy (Heads of) Bill 2013 Hearings 20th May 2013

Opening Statement - Dr Anne Jeffers

I am Dr Anne Jeffers, Director of External Affairs and Policy at the College of Psychiatrists. I am a General Adult Psychiatrist, working with adults between the age of 18 and 65 years, in a community based service in East Galway.

In an adequately resourced mental health service, General Adult Psychiatrists work with a multidisciplinary team of nurses, social workers, occupational therapists and psychologists. We receive referrals from General Practitioners (GPs), or emergency departments of hospitals. I will describe the issues related to this legislation, as they are likely to be seen by a general adult psychiatrist:

1. When a woman finds she has a crisis pregnancy and feels suicidal, she follows a number of options. She may decide to have a termination and may travel outside the state to do this. She may visit her General Practitioner who will complete a full assessment, including an assessment of her mental state and the risk of suicide. They will offer non directive counselling, and may advise that the woman seeks the advice of a crisis pregnancy counselling service. If they have concerns that she is at risk of suicide, and requires a specialist psychiatric assessment, they will refer her to a General Adult Psychiatrist.

2. The woman may alternatively present directly to an emergency department, especially if she has attempted suicide or self harmed. In this case she will be assessed by a Liaison Psychiatrist, where they exist, or on to the General Adult Psychiatrist for the area. Only in Dublin will there be an option of referral to a psychiatrist attached to one of the Maternity Hospitals.

3. A psychiatric assessment involves a private, one to one, consultation where the woman has an opportunity to describe her distress. The psychiatrist identifies the issues contributing to the suicidal risk. These include any symptoms of mental illness, and what psychosocial stresses she is experiencing. Each woman's presentation and circumstance is unique and the psychiatrist will provide a comprehensive and non judgemental assessment.

4. A psychiatric assessment in itself is a therapeutic intervention, when a woman is given an opportunity to discuss her concerns and distress in a confidential setting, and in a safe and supportive environment. For many women the outcome of this assessment will reduce her fears and she may decide to continue with the pregnancy. Where the woman and the assessing psychiatrist believe that termination of the pregnancy is the only way to avert self destruction, a second opinion would be requested. Ideally, a psychiatric social worker, or other key team member, would also be involved in this assessment and in the provision of ongoing support. Not all teams have access to a social worker.

5. It is anticipated that in all except very rare cases, the psychiatrist will be recommending interventions other than termination of the pregnancy. This legislation is extremely restrictive, and for the vast majority of women it will not apply. In these cases, the psychiatrist will ensure the woman has access to non directive counselling around options, including adoption, parenting or travel outside the state for termination.

Protection of Life during Pregnancy (Heads of) Bill 2013 Hearings 20th May 2013
Opening Statement - Dr Maeve Doyle

I am Dr Maeve Doyle, Consultant Child and Adolescent Psychiatrist and Chair of the Child and Adolescent Faculty of the College of Psychiatrists of Ireland.

I welcome the invitation from the Joint Committee on Health and Children to make a submission on specific issues with regard to children, particularly because the X case involved a 14 year old girl, a child, who had been raped and sought a termination because she said that she was suicidal.

The written submission, which was sent by the College, includes a number of key and detailed points about the care of children in circumstances where they may be pregnant and request an abortion and how the proposed Heads of Bill which must be amended to address these. My opening statement summarises some of these key issues.

Definition of a Child: The Heads of Bill does not define the word "child". This is very important as in cases involving children there are very specific and complex issues with regards to their care which must be addressed.

Consent: Under the Children Act 2001, and other legislation, a child is someone under the age of 18 years unless married. A person over the age of 16 years can give consent to surgical, medical or dental treatment and it is not necessary to obtain consent from parents and guardians. But for psychiatric assessment the law has been interpreted as meaning that, until the age of 18 children are still not in a position to legally consent to a psychiatric assessment, and as such require consent from their guardians. For children in the care of the HSE the issue of consent is even more complex. I make these points to highlight the need for these issues to be considered by those drafting the final bill.

Confidentiality: The issue of confidentiality is also quite complex. Generally, when a young person is first seen by a Child & Adolescent Psychiatrist they are informed that what they say will remain confidential unless the information disclosed constitutes a risk to themselves or to others.

This may well result in the young person censoring what they say. This is particularly true in the area of sexual activity. The age of consent to sexual intercourse remains at 17 years old. In many cases, however, parents of 17 year olds expect to be informed if their 17 year old child is sexually active so issues with regards to a possible abortion will require expert and experienced and sensitive handling, and clarity for the child, the family and professionals involved.

Pregnancy in the context of a Child & Adolescent Mental Health Setting: While there are no figures available, the occurrence of pregnancy within a population attending a Child & Adolescent Mental Health Service is rare. For a pregnant young person to attend such a service, the consent must come from their parents. In addition, if the young person is under the age of 17, the professional will have to report to the HSE/Guards. The likelihood of parents of pregnant girls seeking advice from a Child & Adolescent Psychiatrist, as to whether or not to proceed with a termination of pregnancy, is therefore unlikely.

What may, however, happen is that in the case of a young girl who is in the care of the HSE, who becomes pregnant, and who indicates a wish to have a termination of pregnancy on grounds of suicidality, the HSE, acting *in loco parentis*, may well seek the advice of a Child & Adolescent Psychiatrist in making that decision, and this is probably the main group of pregnant teenage girls for whom the proposed legislation will, in effect, apply.

Conclusion: I hope that the foregoing will draw attention to some of the difficulties which would need to be overcome in any legislation involving young women, children in the eyes of the law, who present with suicidality in the context of pregnancy.

College of Psychiatrist of Ireland

Comment on

General Scheme of

Protection of Life during Pregnancy Bill 2013

May 2013

Executive Summary

The College of Psychiatrists of Ireland welcomes the invitation from the Joint Committee on Health and Children to make a submission on the Heads of Bill.

The submission has detailed comments on the Heads of Bill. There are many very important practical points in the submission which we would seriously recommend the Committee pay attention too. They will not be detailed by us in this executive summary but we will here provide a brief overview of our submission and key points.

1. This submission re the Heads of Bill has been agreed by the Council, the elected decision making body of the College of Psychiatrists of Ireland. We know that in a College with over 864 members there will be a wide range of opinions with regards to the sensitive issue of abortion, reflecting the deep divisions in society about this issue. Therefore we are confining our comments to the general scheme of the Heads of Bill rather than any overall comment about abortion.

2. We recognise that the current Bill, in legislating for the X Case, a 14 year old girl, and referring only to circumstances where the life of the mother is at risk, rather than to her mental health, is restrictive. The vast majority of women who have an unwanted pregnancy, whether they are mentally ill, and/or suicidal or not, will still travel, if they can, out of the Republic of Ireland to have that abortion, or in some cases purchase medications in an attempt to end the pregnancy themselves, rather than present to psychiatrists here so as to seek an abortion through this proposed legal process. The vast majority of women who are depressed and/or suicidal in pregnancy and who do present to their doctors for help, want treatment for their depression or distress or suicidal feelings and are not seeking abortions. We are of the opinion that the number of women who have will have an unwanted pregnancy, and have active suicidal intent, and who believe that an abortion will end their suicidal intent, and who wish to seek to have that termination in this state on the basis of the risk of self destruction is likely to be small. However, any woman who does have suicidal ideation in pregnancy must be enabled to avail of expert psychiatric assessment.

3. Pregnancy is a particularly vulnerable time for the mental health of women, and the early post partum period even more so. Mental health problems at this time are potentially devastating for the mother and for her foetus or child and for her family. At the extreme end in pregnancy is suicide (1 in 500,000) where the woman and foetus will die, and after birth, suicide and infanticide are potentially tragic risks. Untreated mental health difficulties can also damage the mother in many other ways. In addition, high levels of stress and depression in pregnancy can also cause developmental problems for the growing foetus, and after birth there is a significant risk of long term mental health, attachment and behavioural problems for the child. Providing appropriate and specialist mental health services which should be available for all pregnant women, must be a priority. We want to save the lives of women and their children and to prevent long term damage occurring to women and their children.

4. There is currently a significant lack of appropriate psychiatric services available to maternity units throughout the country. This lack will cause significant difficulties for the implementation of the proposed bill. We make specific comment about the requirement under Head 4 that one of the psychiatrists involved in the process must be attached to the institution where an abortion can take place. We wish to note here that there are only three perinatal psychiatrists currently employed in Ireland, all are part time, and when their scheduled sessional commitments to the 3 Dublin Maternity Hospitals are added together this is still less than one whole time post. In addition, attached to this submission as Appendix 2 is the current situation with regards to psychiatric cover for the 19 Obstetric Units in the country. Many have no named psychiatrist attached to them at all but depend on a general on call emergency service only, which may or may not be a Consultant Psychiatrist on the Specialist Register. We list many other practical difficulties which need to be considered. Therefore the Department of Health will need to engage with the College and the profession with regards to the deficits in these units throughout the country.

5. There are specific issues with regards to children who are pregnant and the role of Child and Adolescent Psychiatrists. The X Case was about a child. These must be recognised. The term “child” is not defined in the heads of bill. We have attached a document (Appendix 1) describing the overall issues with regards to children accessing psychiatric services. This document particularly highlights issues with regards to the definition of a child, the specific complexities with regards to consent and confidentiality when working with children, the difficulties for children in care and other practical issues. We strongly advise that close attention be paid to these issues when the final bill is being drafted.

6. The unique role of the General Practitioner is acknowledged. As they are most frequently the doctor who first sees a woman with a crisis pregnancy, confirms pregnancy and assesses the mental state and the level of distress, it is important that nothing in the legislation would subvert the usual pathways of care including the provision of non directive counselling and the appropriate provision of information or referral to obstetric or psychiatric services.

7. It is very important that all aspects of the final legislation will be compatible with other legislation, particularly requirements under the Mental Health Act, the Criminal Law (Insanity) Act or the proposed new Capacity legislation.

HEADS OF BILL: We have made a number of detailed points on the heads of bill. This is a brief summary.

Head 1: The term "child" must be included and defined. The term psychiatrist must also clearly encompass all the specialties of psychiatry.

Head 4:

a) Psychiatrists are trained to assess mental states, mental illness and suicidal risk and if trained to Specialist level are competent to do so. These assessments form part of our everyday work. In difficult clinical situations, seeking a second opinion from another Specialist Psychiatrist is a normal and appropriate practice. We accept that there are, to quote from the general scheme of the Bill, "clinical challenges in accurately assessing suicidal intent". However the addition of the words "absence of clinical markers" is incorrect. There is an absence of biological markers, but clinically there are many key symptoms and signs which, while not absolute, are reliably used in everyday clinical practice to diagnose or exclude the diagnosis of mental disorders.

b) This Head specifies that " both of the psychiatrists shall be employed at a centre which is registered by the Mental Health Commission, and one of whom shall be attached to an institution where such a procedure is carried out" This is impractical and we advise a detailed study of our submission to understand the reasons for this. This is particularly important for Child and Adolescent Psychiatrists, but for others also.

c) Obstetricians are trained and competent to specialist level in the management of pregnancy. Psychiatrists are trained to a specialist level in the assessment of suicidal risk. Specialists must work together to provide cross specialty care, but neither must be expected or permitted to make assessments beyond their level of competency or expertise.

d) We fully support that the 2 psychiatrists must come to an agreed decision about the women if a termination is going to be considered, and that the obstetrician is in agreement re the medical aspects of the procedure.

Heads 6 and 7: We agree that a formal medical review procedure should be in place, if requested by the mother, in the event of her request for a termination being turned down and that the mechanism would be independent and competent, and that the woman would have the possibility of being heard and that a timely written opinion be given. We would wish to ensure that it is stated in the act that it is the responsibility of the executive to inform the woman of her right to appeal the decision.

Head 8:

a) If the original decision to refuse termination was on obstetric grounds, a further obstetric assessment could be sought by the woman. It would not be necessary for any psychiatrist to be involved if the first two psychiatrist's opinions were unanimous. Clearly the ongoing care of the mental health of the mother would be particularly important here but a review committee including two independent psychiatrists would not be necessary and could potentially be damaging.

b) If the original decision to refuse was on psychiatric grounds, the woman would have the right to appeal for a psychiatric review, and if those psychiatrists were in agreement that there was a serious risk of suicide for which a termination of pregnancy was to be considered, then obstetric assessment should be sought.

Head 20: We are concerned that different days may be appointed under this head for different purposes or different provisions of this Act. Clarity for women and doctors are required. A piecemeal introduction of legislation is unlikely to provide this.

We again thank you for inviting this submission and recommend again that very careful attention be paid to the details of our submission which have only been briefly summarised here.

College of Psychiatrists of Ireland

Comment on

General Scheme of Protection of Life during Pregnancy Bill 2013

The College of Psychiatrists of Ireland welcomes the invitation from the Joint Committee on Health and Children to make a written submission on the *Protection of Life during Pregnancy (Heads of) Bill 2013*. We also wish to express our interest as a College in attending and giving evidence at the forthcoming hearings.

We recognise that the submission should be detailed on a "Head by Head" basis only. However, there are a number of general points which are important to make.

1. Throughout the Heads of Bill, the title Irish College of Psychiatry is used. This is incorrect. The correct title is the College of Psychiatrists of Ireland.

2. This submission re the Heads of Bill has been agreed by the Council, the elected decision making body of the College of Psychiatrists of Ireland. We know that in a College with over 864 members there will be a wide range of opinions with regards to the sensitive issue of abortion, reflecting the deep divisions in society about this issue. Therefore we are confining our comments to the General Scheme of the Heads of Bill rather than any overall comment about abortion.

3. We recognise that the current Heads of Bill, in legislating for the X Case, and referring only to circumstances where the life of the mother is at risk, rather than to her mental health, is restrictive. The vast majority of women who have an unwanted pregnancy, whether they are mentally ill and/or suicidal or not, will still travel, if they can, out of the Republic of Ireland to have that abortion, or in some cases purchase medications in an attempt to end the pregnancy themselves rather than present to psychiatrists here so as to seek an abortion through this proposed legal process. The vast majority of women who are depressed and/or suicidal in pregnancy and who do present to their doctors for help want treatment for their depression or distress or suicidal feelings and are not seeking abortions. It is important to note that we are of the opinion that the number of women who have an unwanted pregnancy and have active suicidal intent, and who believe that an abortion will end their suicidal intent, and who wish to seek to have that termination in this state on the basis of the risk of self destruction, is likely to be small. However, any woman who does have suicidal ideation in pregnancy must be enabled to avail of expert psychiatric assessment.

4. Pregnancy is a particularly vulnerable time for the mental health of women, and the early post partum period even more so. Mental health problems at this time are potentially devastating for the mother and for her foetus or child and for her family. At the extreme end in pregnancy is suicide (1 in 500,000) where the mother and foetus will die, and after birth, suicide and infanticide are potentially

tragic risks. Untreated mental health difficulties can also damage the mother in many other ways. In addition, high levels of stress and depression in pregnancy can also cause developmental problems for the growing foetus, and after birth there is a significant risk of long term mental health, attachment and behavioural problems for the child. Providing appropriate and specialist mental health services which should be available for all pregnant women, must be a priority. We want to save the lives of women and their children and to prevent long term damage occurring to women and their children.

5. We wish to note here that there is a serious lack of specialist perinatal psychiatry services in Ireland. There are only three perinatal psychiatrists currently employed here, all in Dublin and all part time. When their scheduled sessional commitments to the three Dublin Maternity Hospitals are added together this is still less than one whole time consultant post in the country. Although it is not proposed in this legislation that every woman applying for a termination under this legislation should see a specialist perinatal psychiatrist, the expectation that the College, and therefore the perinatal specialists, would be requested to develop guidelines and ongoing training with regards to this legislative process does point to the need for extra resources in this area.

6. There are specific issues with regards to children who are pregnant and the role of Child and Adolescent Psychiatrists. The X Case was about a child, a 14 year old girl. These must be recognised. We have attached a document (Appendix 1) describing the overall issues with regards to children accessing psychiatric services. This document particularly highlights issues with regards to the definition of a child, the specific complexities with regards to consent and confidentiality with children, children in care and other practical issues. We advise close attention be paid to these issues when the final bill is being drafted. It is recommended that in any place where the word woman appears in the legislation, consideration should be given to the alternative "woman/child".

7. It is very important that the final legislation will be compatible with other key legislation, specifically, the Mental Health Act, the Criminal Law (Insanity) Act or the proposed Capacity legislation. Capacity issues, such as those relating to children, vulnerable adults, those with Intellectual Disability and Brain Injury must be considered.

8. The unique role of the General Practitioner is acknowledged. As they are most frequently the doctor who first sees a woman with a crisis pregnancy, confirms pregnancy and assesses the mental state and the level of distress, it is important that nothing in the legislation would subvert the usual pathways of care including the provision of non directive counselling and the appropriate provision of information or referral to obstetric or psychiatric services.

HEADS OF BILL

Head 1:

We agree that a psychiatrist must be on the specialist register of the Medical Council if involved in the assessment of women in these circumstances. The definition of "psychiatrist" under Head 1 must be clarified to ensure that all of the four specialties of psychiatry are covered under the legislation. The term "child" should be included and the term defined.

Heads 2 and 3:

Not applicable.

Head 4:

We wish to make a number of points here:

a) Psychiatrists are trained to assess mental states, mental illness and suicidal risk and if trained to Specialist level are competent to do so. These assessments form part of our everyday work. There are particular challenges in assessing patients where the outcome of the assessment may be a pre-ordained intervention, so specific consideration must be given in such circumstances to the complex interaction between the mental state of the person and the intervention requested. However, psychiatrists are trained to make such risk assessments.

b) In difficult clinical situations, seeking a second opinion from another Specialist Psychiatrist is a normal and appropriate practice. We accept that there are, to quote from the General Scheme of the Bill, "clinical challenges in accurately assessing suicidal intent". However the addition of the words "absence of clinical markers" is incorrect. There is an absence of biological markers but clinically there are many key symptoms and signs which, while not absolute, are reliably used in everyday clinical practice to diagnose or exclude the diagnosis of mental disorders.

c) We do wish to point out that there may be cases where a woman may have serious suicidal intent in the absence of mental disorder and psychiatrists who assess women in circumstances, such as those covered by this legislation, will need to be aware of this.

If a pregnant woman states that she is considering self destruction and requests a termination of pregnancy the Heads of Bill states that the risk of self destruction must be one that "can only be averted by termination of pregnancy". While the woman may be offered treatment and/or other supports at this time which might reduce this risk of self destruction, she may refuse these, and a person (assuming intact capacity) cannot be administered psychiatric treatment against their will in the absence of a Mental Disorder as defined in the Mental Health Act 2001.

In such a circumstance, where the person is not suffering from a Mental Disorder and does not wish to engage with alternative interventions, and continues to state that they intend self destruction it is unclear how other interventions to avert the risk of self destruction can be imposed without contravening the Mental Health Act 2001 and the assumption of autonomy therein.

d) Consulting with the woman's General Practitioner, where practicable, or other relevant professionals, is sensible and is supported.

e) This Head specifies that "both of the psychiatrists shall be employed at a centre which is registered by the Mental Health Commission, and one of whom shall be attached to an institution where

such a procedure is carried out". This section will present major practical difficulties and should be amended.

We attach (Appendix 2) a list of what we understand is the current psychiatric service provision to the 19 obstetric units referred to in the Heads of Bill. As can be seen from this list, many units have no attached consultant psychiatrists, and most are covered only by whichever consultant in the catchment area is on call for emergencies on that day. This might be a General Adult Psychiatrist or a Psychiatrist of Old Age, for example, neither of whom is formally attached to the unit in any way. For those units that do have a single named attached consultant, if that consultant objects to doing assessments for conscientious reasons there will be no attached psychiatrist.

While some units have excellent Liaison Psychiatric provision to the Obstetric Units as part of a General Liaison service to their hospital, many General Hospitals with maternity units have no Liaison Psychiatric services at all. Therefore the Department of Health will need to urgently engage with the College and the profession with regards to the deficits in these units throughout the country.

An additional issue is raised in the explanatory notes for Head 4. It is proposed that both psychiatrists must be employed in a hospital or other in-patient facility. Many psychiatrists, particularly Child & Adolescent Psychiatrists, Learning Disability Psychiatrists, some Adult Psychiatrists and one of the Perinatal Psychiatrists, are not employed by and have no attachment to a hospital or inpatient facility. We recommend that national panels be set up of competent specialist psychiatrists to carry out assessments in these circumstances. It is important that these panels include psychiatrists from each of the required specialties of psychiatry.

f) There are particular issues with regards to children who may be pregnant and the challenges for Child and Adolescent Psychiatrists. These difficulties are detailed in the attached Appendix 1. We recommend close attention must be paid to the issues raised.

g) Obstetricians are trained and competent to specialist level in the management of pregnancy. Psychiatrists are trained to a specialist level in the assessment of suicidal risk. Specialists must work together to provide cross specialty care, but neither must be expected or permitted to make assessments beyond their level of competency or expertise.

h) We fully support that the two psychiatrists must come to an agreed decision about the women if a termination is going to be considered, and that the obstetrician is in agreement with regard to the obstetric aspects of the procedure.

Head 5:

No comment.

Heads 6 and 7:

We agree that a formal medical review procedure should be in place if requested by the woman, in the event of her request for a termination being turned down and that the mechanism would be independent and competent, the woman would have the possibility of being heard and that a timely written opinion be given. We would wish to ensure that it is stated in the act that it is the responsibility of the executive to inform the woman of her right to appeal the decision.

The time interval of seven days allowed for the convening of a panel and another seven days to review the case seems excessive. We are of the view that 72 hours for each should be sufficient, because, if the woman is in severe distress, an interval of 14 days may increase the risk of suicide.

We also wish to draw attention to subhead 2 of the explanatory notes for this head. While recognising that there may be another person who has rights to exercise with regards to access to the courts to challenge a decision which they believe to be wrong, there is a possibility here, which must be considered, that again a prolonged delay may increase the risk to the woman's life and therefore also the life of the unborn.

Head 8:

We would make many of the same points here as we did with regards to the first group of three doctors involved in cases where the risk of loss of life is through self destruction (Head 4). We do not need to repeat the specific issues with regards to the availability of doctors as designated under Head 4. However we would like to make additional comments.

a) If the original decision to refuse termination was on obstetric grounds, a further obstetric assessment could be sought by the woman. It would not be necessary for any psychiatrist to be involved if the first two psychiatrist's opinions were unanimous. Clearly the ongoing care of the mental health of the mother would be particularly important here but a review committee including two independent psychiatrists would not be necessary and could potentially be damaging.

b) If the original decision to refuse was on psychiatric grounds, the woman would have the right to appeal for a psychiatric review, and if those psychiatrists were in agreement that there was a serious risk of suicide for which a termination of pregnancy was to be considered, then obstetric assessment should be sought.

Heads 9 and 10:

No comment.

Head 11:

We welcome that it is not intended that the Freedom of Information Act 1997 will apply to these records. There are concerns amongst psychiatrists about this aspect however, and further clarification will be sought as to the degree of protection and anonymity afforded doctors who agree to carry out assessments.

Head 12:

We support any doctor's right to conscientious objection to undertaking these procedures but support the Medical Council of Ireland's advice in this area. Point 2 states that this shall not affect any duty to participate under Head 4. We assume that this should refer to Head 3 only and are seeking clarification about this.

Section (3) refers to third parties. This term should be clarified.

Heads 13 to 19:

No comment.

Head 20:

We are concerned that different days may be appointed under this head for different purposes or different provisions of this Act. Clarity for women and doctors are required. A piecemeal introduction of legislation is unlikely to provide this.

Appendix 1

Comment on Protection of Life during Pregnancy (Heads of) Bill 2013

from a Child and Adolescent Psychiatry perspective

Specific Issues with regard to: Children who are pregnant, the role of Child and Adolescent Psychiatrists, Consent, Children in the Care of the HSE, Confidentiality and other comments on the Heads of Bill.

CHILD & ADOLESCENT PSYCHIATRISTS

Consultant Child & Adolescent Psychiatrists are medically trained specialists who are on the Specialist Register maintained by the Medical Council. There are approximately 90 such consultants in the country, working in approximately 66 multi-disciplinary teams. The recommendations of *'A Vision for Change (2006)'*, the policy document looking at the future development of mental health services (2006), are that there is a need for 100 consultant led multi-disciplinary teams for the provision of quality Child Psychiatry services for our population.

The majority of Child & Adolescent Psychiatrists work in catchment area based services in the community.

There are five Approved Centres in the Child and Adolescent Sector with 60 beds, although not all these are operational. There are six Consultant Child & Adolescent Psychiatrists working in these in-patient units. The recommended number of beds for the mental health needs of the child and adolescent population is 110 (as per *'A Vision for Change 2006'*). It should be noted that there is no emergency access (i.e. within 24 hours) for children and adolescents with acute, severe mental health disorder.

CONSENT

The Child Care Act of 1991, the Children's Act 2001 and the Mental Health Act 2001 define a child as a service user under the age of 18 years other than a service user who is married.

Section 23 of the Non-Fatal Offences against the Person Act 1997 provides that a person over the age of 16 years can give consent to surgical, medical or dental treatment and it is not necessary to obtain consent from his or her parent(s) or legal guardian(s)

The law is silent on the issue of psychiatric assessment, and has been interpreted on legal advice to the HSE as meaning that those who reach the age of 16 are not in a position to legally consent to a psychiatric assessment, and as such require consent from their guardians.

In practice, this means that when a person under the age of 18 is referred, consent is sought and required from anybody who has guardianship.

Children in the care of the HSE

The issue of consent is more complex. It requires consent on the part of the HSE. If the child is in voluntary care, consent needs to be obtained from the other guardians.

Admission to an in-patient unit for Mental Health Assessment and Treatment

The child's guardians can sign the admission form on behalf of the child, assuming that the relevant guardians are happy to do so.

In the absence of this consent, if a determination has been made that a child requires admission to an inpatient unit, either for assessment or treatment, then recourse is made to the Mental Health Act 2001.

In addition, if a child is in the care of the HSE and admission is sought, the practice is, based on legal advice, that the protection of the Mental Health Act is sought. In addition, in cases where a child is 16 or 17 years old, and very explicitly stating that they do not wish to be admitted, while their guardians are keen that they are admitted, it has been deemed prudent to seek the protection of the Mental Health Act in case a situation arises where the treating team may have to physically administer medication against the will of the young person.

The overriding principle is that "the welfare of the child is paramount" but it is the appropriate adults who determine what is in fact in a child's best interests.

CONDFIDENTIALITY

The issue of confidentiality is also quite complex. Generally, when a young person is first seen by a Child & Adolescent Psychiatrist they are informed that what they say will remain confidential unless the information disclosed constitutes a risk to themselves or to others.

This may well result in the young person censoring what they say. This is particularly true in the area of sexual activity.

The age of consent to sexual intercourse remains at 17 years old and in certain circumstances there may be a legal obligation to report sexual activity due to the age of the young person.

SUICIDAL IDEATION & SUICIDAL INTENT

Consultant Child psychiatrists are by their training and experience best positioned to assess, diagnose and treat children and adolescents presenting with serious mental health issues.

Some children are referred with suicidal ideation or intent. The role of the Child & Adolescent Psychiatrist is to determine whether there is an underlying psychiatric disorder or whether the presentation reflects a response to a number of psychosocial stressors. In some cases psychosocial stressors may trigger or exacerbate a mental disorder.

PREGNANCY in the context of a CHILD & ADOLESCENT MENTAL HEALTH SETTING

While there are no figures available, the occurrence of pregnancy within a population attending a Child & Adolescent Mental Health Service is rare.

It is also very unlikely that parents of pregnant girls will seek advice from a Child & Adolescent Psychiatrist as to whether or not to proceed with a termination of pregnancy, whether she is or is not suicidal or suffering from a mental disorder.

What may happen is that in the case of a young girl who is in the care of the HSE, who becomes pregnant and who indicates a wish to have a termination of pregnancy on grounds of suicidality, the HSE, acting ***in loco parentis***, may well seek the advice of a Child & Adolescent Psychiatrist in making that decision. This is probably the main group of pregnant teenage girls for whom the proposed legislation will, in effect, apply.

COMMENTS - HEADS OF BILL

Head 1:

We propose that the word "child" would be included and defined.

Head 4, subsection 4:

We see a difficulty in the case of a child "always" being capable of deciding to proceed or otherwise with any procedure e.g. children presenting with acute psychosis or significant intellectual disability.

Our interpretation of the Non Fatal Offences against the Person's Act is that a child may not refuse treatment as they are not viewed as having the capacity to refuse, therefore the child may find herself undergoing a procedure that is potentially life threatening.

It is unclear who can appeal on behalf of the minor.

While there is a review procedure, should a panel disagree among themselves on a course of action there is no equivalent appeal mechanism for disputing guardians.

Head 11:

We are concerned that the medical practitioners would be identified under FOI requests and/or other reports.

Appendix 2

Maternity Unit/Hospital	Psychiatry service available
Cavan General Hospital	Use the psychiatry services available at CGH. NCHDs on call out of hours or general adult or old age psychiatry during hours.
Cork University Maternity Hospital	Liaison psychiatry service available.
Coombe Women's Hospital	Perinatal Psychiatry service available.
National Maternity Hospital	Perinatal psychiatry service available.
Rotunda Hospital	Perinatal psychiatry service available.
Donegal General Hospital	Use psychiatry service available on site.
Drogheda - Our Lady of Lourdes	Use Ardee Hospital which is off site. Provides half day service (NCHD), three times per week, no service out of hours.
Galway - University Hospital	No dedicated liaison psychiatrist. Use psychiatry service on site, either Consultant (general adult or old age) or NCHD. NCHD cover after hours.
Galway - Portiuncula Hospital, Ballinasloe	Use St Brigid's Hospital - either consultant (general adult) or NCHD, no out of hours service.
Kilkenny - St Luke's General Hospital	Use Psychiatry services attached to main hospital and provide on-call.
Kerry - Tralee General Hospital	Use the psychiatry service in the hospital, NCHDs on call out of hours or general adult during hours.
Laois - Portlaoise General Hospital	Use the psychiatry services in the hospital, maternity unit also has a liaison psychiatry nurse who assesses and refers.
Limerick Regional Maternity Hospital - St Munchin's	Use psychiatry services in the general hospital. Referrals through the liaison psychiatry department with consultant and CNS with dedicated phone line.
Mayo General Hospital (Castlebar)	Use the psychiatry service acute unit in the hospital. Consultant during hours (general adult/old age), NCHD out of hours.
Sligo General Hospital	No psychiatry service in regional hospital. Use the psychiatry liaison nurse in St Columba's Hospital who covers ED (core hours). Otherwise out of hours urgent consults covered by Adult MHS.
Tipperary - St Joseph's Hospital	Use Psychiatry service located on same campus. Consultant during hours. Psychiatry liaison nurse assesses and refers out of hours. NCHD provides cover after 9.00 pm.
Westmeath - Midland Regional Hospital	No psychiatry service on site. Psychiatry liaison nurse (from St Loman's) attends every day. Out of hours/urgent consultations provided from St Loman's.
Wexford General Hospital	Nurse-led liaison service during hours who refers on to the relevant consultant. Out of hours referrals on to Waterford Regional Hospital.
Waterford Regional Hospital	Use psychiatry service in hospital and NCHDs out of hours.

Opening statement: Dr. John Sheehan, Rotunda hospital, Dublin

As a Perinatal Psychiatrist working in the Rotunda hospital, Dublin, I was one of the three Perinatal Psychiatrists in Ireland invited to give evidence to the Oireachtas Health Committee in January, 2013. I also work as a Liaison Psychiatrist in the Mater Misericordiae University Hospital, Dublin which has one of the busiest Emergency Departments in Ireland and which recorded 841 deliberate self harm attendances in 2011.

I will confine my comments to those aspects of the Bill that are pertinent to psychiatry.

Head 4

Head 4 is concerned with the risk of loss of life from self destruction. It has major implications for Psychiatrists.

1. If enacted, psychiatrists will be asked to determine if there is a real and substantial risk to the life of the mother in order to enable the mother procure a termination of pregnancy. This is a role that Irish psychiatrists have not been involved with to date. I believe that many Irish psychiatrists will not see this as an appropriate function as medical practitioners. Psychiatric practice relates to assessment and treatment rather than assessment and adjudication.
2. In my opinion, it most likely will change the patient profile currently seen by Irish psychiatrists. In the submission to the Oireachtas Health Committee, the three Irish Perinatal psychiatrists stated that with over 40 years of combined clinical experience, they had not seen a single case where termination of pregnancy was the treatment for a mental disorder. This is not surprising, as the women attending perinatal psychiatrists are generally those women who are continuing their pregnancies. I believe it is likely that the women referred under the proposed legislation to psychiatrists will be a different population to those currently referred. I believe that the referred women are likely to be from those who currently travel for termination of pregnancy. The extent of mental health problems and suicidal ideation among this population is unknown and hence, the utilization of the proposed legislation on this population is unknown. Will there be many? Will there be few? Quite honestly, I do not believe that anyone can answer these questions in an informed and accurate way.
3. In obstetrics, medical emergencies and psychiatric emergencies require very different interventions. In a medical emergency, speedy delivery of the baby is required. In a psychiatric emergency, speedy delivery of the baby is contraindicated as it is likely that the patient has impaired capacity and should be advised not to make irrevocable decisions in such a state. This is particularly relevant in cases of depression where a person may have developed a transient negativity, pessimism, hopelessness or despair, all of which with treatment is generally resolved.
4. In the Explanatory notes, it states that “it is not necessary for medical practitioners to be of the opinion that the risk to the woman’s life is inevitable or immediate”. The risk of a woman dying by suicide in pregnancy is between 1 in 250,000 to 500,000 live births. In practice, it is impossible for any psychiatrist to accurately predict which woman will die by suicide in pregnancy. Being unable to predict who will die by suicide is likely to lead to

multiple “false positives”. As psychiatrists, we are trained to assess and treat not to predict the future.

5. There is no time limit set in the Heads i.e. termination could theoretically occur up to the time of delivery. Late abortion could potentially have very deleterious effects on a mother’s mental health.

Opening Statement to the Hearings of the Joint Committee on Health and Children on the Protection of Life during Pregnancy (Heads of) Bill 2013

May 20th 2013

Dr Yolande Ferguson, Consultant in General Adult and Community Psychiatry, Dublin South Central Mental Health Service

I am a graduate from the Royal College of Surgeons. I hold memberships of the Irish College of Psychiatrists, the Royal College of Psychiatrists and Royal College of Physicians in Ireland. I also hold a Masters Degree in Psychoanalytic Psychotherapy. I have eighteen years experience in psychiatry and have been a consultant for the last seven years. I work in an urban community based mental health team that has a wide socio-demographic span.

I am a member of the Faculty of Adult Psychiatry Executive in the Irish College of Psychiatry and a member of the Joint Forum on Mental Health between the Irish College of Psychiatrists and the Irish College of General Practitioners.

I thank the Committee for this opportunity and welcome this legislation.

Psychiatrists are unique among medical practitioners in that we deal with legislation as part of our routine clinical practice in the form of the Mental Health Act 2001. We have extensive experience in performing assessments to ascertain whether our patients meet the legal criteria set down in that act. We also routinely defend those decisions in Mental Health Tribunals. We will bring that expertise and experience to the enactment of this legislation.

I will restrict my statement to Heads 4, 6 and 8.

I believe the constitution of the assessment group in Heads 4 and 8 requires revision.

These Heads addresses an infrequent circumstance. For the most part this represents a woman/child in the early stages of pregnancy who is distressed because she is pregnant and generally does not have a mental illness. They are most likely to present to their general practitioner in the first instance. If the doctor dealing with them is sufficiently concerned they then make a referral to the appropriate local psychiatric service. Psychiatric services in Ireland, like most other countries, are arranged on a geographical basis with community mental health teams addressing the needs of the local community. There are also specialist teams who provide for the needs of children and those with intellectual disability. The Psychiatrists who are the clinical leads for these teams are expert in assessing suicidal risk, whatever the circumstance. The General Practitioner has been assigned a peripheral role in this legislation. They should have a central role, as they do with the 2001 Mental Health Act. Only one psychiatrist which would not differentiate psychiatry from other medical specialties in this Legislation.

The assessment group in both Heads is made up of an obstetrician and two psychiatrists. Firstly there is a requirement that both psychiatrists are attached to an institution registered with the Mental Health Commission. This does not reflect psychiatric practice. Child and Adolescent Psychiatrists are rarely attached to such an institution. Some General Adult Psychiatrists who provide community based care are also not attached to an institution as their organisation separates those roles. I suggest that this be replaced by 'a Psychiatrist who is entered on the Specialist Register with the Medical Council'. The Head also states that one psychiatrist must be attached to an obstetric unit. The Head and the explanatory note contradict one another in that the Head states attached to *'an* appropriate place' and the note to '*the* appropriate place'. While clarification is required as to whether the Head specifically demands that the psychiatrist must be attached to the unit in which the procedure would take place, I recommend this requirement be removed. These are women/children who cannot contemplate reaching the point of the booking appointment for an obstetric unit that is the usual entry to perinatal psychiatry. This requirement imposes an unnecessary restriction. Their needs can be accurately assessed by an appropriate specialist, such as a General Adult or Child and Adolescent Psychiatrist. I echo my colleagues' proposals that a Panel be established by the Executive much as the Mental Health Commission form a Panel for the workings of the Mental Health Act. Ideally the psychiatrist who is involved in their care would be on the Panel to provide the psychiatric opinion. I should add that an Obstetrician should not be expected to perform assessments out of their area of expertise. It is also proposed that a consensus must be reached between all three doctors. Could the Obstetrician be placed in a position that they could veto the assessment of two psychiatrists on the assessment of risk of suicide?

As the Head is currently written the woman/child will in fact have seen four doctors including her general practitioner at the end of the assessment process. If the case proceeds to an appeal she will have been seen by a total of seven doctors.

Finally the time period for the appeal process set out in Heads 6 and 8 should be shortened to 72 hours for each stage of the appeal.

In conclusion this legislation must serve to serve to alleviate rather than add to the distress of the women and children for whose needs it seeks to address.

Thank you.

Dr Yolande Ferguson

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Consultant Psychiatrist

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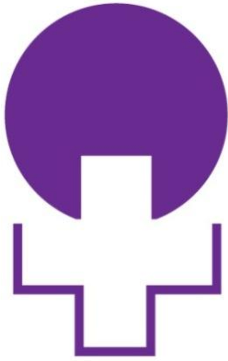

Doctors for Choice
Ireland

Opening Statement to the Joint Oireachtas Committee on Health & Children Public Hearings on the Protection of Life During Pregnancy (Heads of) Bill 2013

by

Dr Peadar O'Grady
Consultant Child and Adolescent Psychiatrist

Doctors for Choice
May 20th 2013

Dr Peadar O'Grady is a Consultant Child and Adolescent Psychiatrist and is a founding member of Doctors for Choice. Dr O'Grady has experience in certifying eligibility for an abortion under the terms of the Supreme Court judgment for a series of adolescents in care.

Opening Statement to the Joint Oireachtas Committee on Health & Children Public Hearings on the Protection of Life During Pregnancy (Heads of) Bill 2013

According to the World Health Organisation's 2012 document *Safe Abortion*: "In nearly all developed countries, safe abortions are legally available upon request or under broad social and economic grounds, and services are generally easily accessible and available."

In Ireland the proposed legislation to deal with access to abortion services arose out of the Supreme Court judgment in 1992 that a 14-year-old child had a constitutional right to have an abortion in Ireland because of the risk of suicide.

Doctors for Choice welcome any improvement in the care of women and children who choose to have an abortion; however we feel reassurance is needed that this Bill will in practice provide an 'effective and accessible' procedure in a situation similar to that of the 14-year-old child in the X case. The risk of suicide in the X case arose in a situation where a pregnant child became suicidal when she was unable to travel, having decided to have an abortion while pregnant as the result of rape by an adult neighbour.

The opinion of many psychiatrists and other doctors internationally is that the risk of suicide is increased by having access to abortion restricted. The internationally renowned psychiatrist Prof Robert Kendell, summed it up well in his 1991 review in the British Medical Journal: *Suicide in pregnancy…much rarer now thanks to contraception, legal abortion and less punitive attitudes*. In Ireland restricted access to abortion services is most likely to arise as a result of inability to travel. This means that women who are too sick, young, poor or disabled to travel are at particularly high risk. Women who are migrants or whose pregnancy involves a fatal fetal anomaly or arose as a result of rape or child sexual abuse also experience difficulty accessing abortions through impairment of their ability to travel.

Children are not specifically mentioned in the legislation even though they are more likely to experience difficulties in their ability to travel for an abortion and to be at increased risk of suicide as a result. The costs of travel for an abortion are higher for children as they usually require a parent/guardian to travel with them because of their greater requirements for practical and emotional support.

Doctors for Choice are particularly concerned that the Bill contains elements that will cause unnecessary delay to access to abortion services causing an unnecessary prolonging of an emergency level of risk and requiring more complicated procedures eg surgical instead of medical abortions.

In the case of eligibility for abortion on the basis of a risk of suicide, imposing a requirement for three doctors will cause unnecessary delay. There is no medical basis for differentiating between a medical emergency and a psychiatric emergency. All psychiatric emergencies are medical emergencies. Only one Psychiatrist or GP is required to certify eligibility for an abortion. Obstetricians should not certify eligibility in cases of suicide risk; this should be done either by a GP or a Psychiatrist.

The Bill requires the Psychiatrist certifying eligibility to be employed in an institution registered with the Mental Health Commission. Most Consultant Child Psychiatrists are not employed in this way. This is an unnecessary requirement. Specialists are required to be registered with the Medical Council and this should be the only stipulation. Specialists should not be required to be attached to any specific institution. Most abortions in developed health services are medical abortions and do not need any hospital facilities.

Women and children in situations of rape, child sexual abuse and fatal fetal anomalies will have to wait for further legislation to allow for the option of abortion in those cases. That this Bill does not provide for this is a serious limitation. There are also valid concerns about the potential for conscientious obstruction. The term 'reasonable opinion' should be replaced by the term 'opinion' and the term 'unborn' should be replaced by the medical term 'fetus'.

Finally, the inclusion of a criminal sanction of up to 14 years against women or doctors will hamper good practice and increase the risk of suicide in vulnerable patients through stigma and its emotional consequences: fear and distress. Fear of prosecution, a noted 'chilling factor', can only cause further delays in access. The notion that women who are forced to travel for an abortion in a situation of a fatal fetal anomaly are carrying out the *equivalent* of a gravely serious crime is particularly offensive. The prospect of prosecuting children and/or their parents or those carrying out a home abortion with medication bought on the internet is also very concerning. The overwhelming support in 1992 for the constitutional right to travel for an abortion confirmed that Irish people do not consider abortion a grave crime; as did the lack of any prosecutions before then for abortions 'procured' abroad. To our knowledge, criminal sanction has not been seriously advocated by any party to the debate on access to abortion services. As criminal sanction is dangerous, offensive and manifestly absurd, it should be removed from the Bill.

Finally, as there is a gross lack of expertise in Ireland on the provision of abortion services, the Joint Oireachtas Committee on Health and Children should take advice from a relevant healthcare agency that has experience in providing an abortion service. The British Pregnancy Advisory Service (BPAS) provides the majority of abortions availed of by women from Ireland every year and the BPAS has already offered their assistance to the Committee.

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Submission to the Joint Oireachtas Committee on Health & Children Public Hearings on the Protection of Life During Pregnancy (Heads of) Bill 2013

by

Doctors for Choice
May 8th 2013

Submission to the Joint Oireachtas Committee on Health & Children Public Hearings on the Protection of Life During Pregnancy (Heads of) Bill 2013

Executive Summary

 Doctors for Choice welcome any improvement in the care of women who choose to have an abortion however it remains unclear whether this Bill would provide an 'effective and accessible' procedure for a woman in the position of Savita Halappanavar or in the X case.

• The risk of suicide in the X case arose in a situation where a pregnant child became suicidal when she was unable to travel, having decided to have an abortion following a pregnancy which arose as the result of rape by an adult neighbour. The risk of suicide is increased by having access to abortion restricted and this restriction in Ireland is most likely to arise as a result of inability to travel. This means that women who are too sick, young, poor or disabled to travel are at particularly high risk. Women who are migrants or whose pregnancy involves a fatal foetal anomaly or arose as a result of rape or child sexual abuse also experience difficulty accessing abortions through impairment of their ability to travel.

• Children are more likely to experience difficulties in their ability to travel for an abortion and to be at risk of suicide as a result. The cost of travel for an abortion are higher for children as they may require a parent/guardian to travel with them because of their greater requirements for practical and emotional support.

 There is no medical basis for differentiating between a medical emergency and a psychiatric emergency. All psychiatric emergencies are medical emergencies.

 This Bill may not lead to clarity for women or doctors where the illness is not yet life-threatening, as highlighted in the case of Savita Halappanavar.

 In the case of the risk of suicide, imposing a requirement for three doctors would cause unnecessary delay and is in any case in excess of the maximum of two doctors recommended by the expert group. Only one Psychiatrist or GP is required to certify eligibility for an abortoion.

 Obstetricians should not certify eligibility in cases of suicide risk; this should be done by either a GP or a Psychiatrist.

 GPs manage early pregnancy, crisis pregnancy and most mental health problems in the State. They alone manage uncomplicated pregnancies until 16 weeks gestation. If a woman presents in early pregnancy with a crisis it will be GPs in liaison with psychiatrists who will be managing her care. Obstetricians will not and need not be

involved, as the pertinent issue will be mental health rather than obstetric health. GPs will not be “consulted” in clinical reality but will be the key clinician involved in the crisis pregnancy. Head 4 is therefore at odds with the clinical reality and what would happen in an X-case scenario. As it stands, it appears a woman could be seen by at least 4 doctors before being ‘certified’ as being eligible for an abortion. A GP and a Consultant Psychiatrist would be the most relevant combination if two doctors were required. We recommend that two doctors certify, or not, the procedure in the situation of a threatened suicide: a GP and a Consultant Psychiatrist.

 The Bill requires the Psychiatrist to be employed in an institution registered with the Mental Health Commission. This is currently not the case for most Consultant Child Psychiatrists. This is an unnecessary specification. Specialists are required to be registered with the Medical Council and this should be the only stipulation. Specialists should not be required to be attached to any specific institution. Most abortions in developed health services are medical abortions and do not need any hospital facilities.

 Women and children in situations of rape, child sexual abuse and fatal foetal anomalies will have to wait for further legislation to allow for the option of abortion in those cases. That this Bill does not provide for this is a serious limitation.

 The Bill does not clarify whether pregnant women that are unwell with severe heart disease or maternal cancer (requiring teratogenic treatment) will be entitled to access abortion services.

 There are valid concerns about the potential for conscientious obstruction.

 Fear of prosecution is a chilling factor and may make the legislation unworkable. It is unacceptable that doctors fear criminal prosecution when they are trying to act in the best interests of a patient. The inclusion of a 14-year prison sentence for women who have an abortion outside of these guidelines and describing that as due to the ‘gravity of the crime’ is particularly offensive. The prospect of prosecuting children and/or their parents or those carrying out a home abortion with medication bought on the Internet is also very concerning. This will encourage secrecy, terror and desperation and increase risk in vulnerable patients. Criminal sanction should be removed from the Bill.

- The term ‘reasonable opinion’ should be replaced by the term ‘opinion’ and the term ‘unborn’ should be replaced by the medical term ‘foetus’.

- The Joint Oireachtas Committee on Health and Children should take advice from a relevant health care agency that has experience in providing an abortion service. The British Pregnancy Advisory Service (BPAS) provides a majority of the abortions availed of by women from Ireland every year and the BPAS have already offered their assistance to the Committee.

- We believe that the safest way to protect all women in Irish society is to decriminalise abortion, leaving medical matters outside the criminal law. This way we avoid legalistic terms and sanctions, which have so far served solely to intimidate those who work in the field of medicine. Women should have the choice to access safe abortion services with fully informed consent. To achieve this we will need to repeal the 8th amendment.

Introduction

Doctors for Choice is an organisation that represents doctors in Ireland who support a woman's right to control their own reproductive health outcomes. The organisation represents many medical specialties including obstetricians, General Practitioners (GPs) and psychiatrists. In the exercise of that right the organisation respects the right of women to choose abortion.

Doctors for Choice, since 2002, has been a leading advocate for the Irish State to appropriately legislate for the Supreme Court decision of 1992, to provide for lawful abortion services if there is a real and substantial risk to the life of the mother, including the risk of suicide and situations where the risk is not imminent. Doctors for Choice provided one of three Amicus briefings that the European Court of Human Rights (ECHR) accepted in its deliberations in the ABC V's Ireland case.

Accordingly, Doctors for Choice would like to commend the government parties for their commitment, so far, to deal with the X Case, as we have been compelled to do by the ECHR. Though it is 21 years after the Supreme Court decision, Doctors for Choice would like to commend the government in providing the first draft of legislation that will give those women who have a life -threatening illness, and their doctors, clarity on whether a termination of pregnancy can be legally performed.

Mindful that the scope of the legislation is already restrictive, Doctors for Choice has concerns regarding the practical implications and limitations of this bill.

While Doctors for Choice welcome any improvement in the care of women who choose to have an abortion, it remains unclear whether this Bill would provide an 'effective and accessible' procedure for someone in the position of Savita Halappanavar or the X case.

Concerns and list of recommendations regarding the Protection of Life During Pregnancy (Heads of) Bill 2013

Head 2, 3 and 4

- There is no medical basis for differentiating between a medical emergency and a psychiatric emergency. All psychiatric emergencies are medical emergencies.

Head 2 and 3: Physical illness and emergency situations

- Doctors for Choice is of the opinion that both Head 2 and Head 3 are satisfactory when medicine is predictable and when cases are uncomplicated. The organisation however has concerns that this Bill will not lead to clarity for women or doctors whose illnesses are not yet life-threatening, as highlighted in the case of Savita Halappanavar.

- Medicine is by its nature unpredictable and has uncertainty at its heart; this uncertainty does not lend itself to regulation through legislatory semantics. At what point, along a nebulous grey line between ill-health and life-threatening illness does a "real and substantial risk" arise? Can a life threatening illness be demarcated from a condition that jeopardises health? This grey zone of uncertainty and unpredictability in medicine was shown with the case of Ms. Halappanavar. At what point did her condition become life-threatening and warrant a termination of pregnancy? Whilst the coroner's inquest mentioned system failures, which must be acknowledged, it was clear that Ms. Halappanavar would have survived had a termination been performed, as requested by her on the Monday or Tuesday of her admission. Both her treating obstetrician and Dr. Peter Boylan, who provided expert evidence at the coroner's inquest, highlighted that the staff felt unable to proceed to a termination as the Rubicon of a "real and substantial risk" had not been crossed. Despite being an inevitable miscarriage, the law in Ireland prevented action until the last minute and though system failures were present, this was too late to allow for a life-saving termination. Doctors for Choice has concerns that this legislation will not prevent another case like Savita Halappanavar's.

- Certain rare conditions in pregnancy, such as maternal cancer requiring teratogenic treatment or maternal cardiac disease which could deteriorate, can require the termination of that pregnancy. However those Irish women with these conditions have up to now been forced, in a state of ill-health, to travel abroad for abortion services. It is uncertain, as the explanatory notes on page 6 describe,

whether such women will be eligible for lawful abortion services, if they fall pregnant. This will have to be clarified.

Head 4: Risk of loss of life from self-destruction

Doctors for Choice has a variety of concerns pertaining to Head 4.

Subheading 1b:

- In the case of the risk of suicide, imposing a requirement for three doctors will cause unnecessary delay. There is no basis in medicine for differentiating between a medical and a psychiatric emergency. Only one doctor should be required as for medical emergencies.

Subheading 1b: Obstetricians

- Obstetricians should not be one of the doctors that certify a woman's eligibility for a termination where there is a) a real and substantial risk to the life of the woman arising from suicide risk, and b) this risk can only be averted by the termination of her pregnancy. Only psychiatrists and GPs are appropriately trained to manage mental health problems and assess suicide risk. Obstetricians do not normally provide an expert opinion on the risk of suicide and indeed may not be indemnified to provide such an opinion.

- That an obstetrician could veto the decision of a psychiatrist leading to a review will serve only to restrict access and cause delay.

Subheading 2a: Primary Care:

- Doctors for Choice acknowledges that the role of the GP is mentioned in the explanatory notes on page 11 (As the Expert Group's Report indicated General Practitioners often have a long-term relationship with their patients and therefore have in-depth knowledge of a patient's personal circumstances), however we think the role of primary care in this Bill is not developed enough.

- Almost all ante-natal care up to 16 weeks gestation is undertaken by GPs alone in Ireland. Only from 16 weeks onwards do most women have their first scheduled hospital based obstetric appointment.

- Women with crisis pregnancies first seek medical help in a primary care setting. GPs have a long-term continuity-of-care relationship with their patients, often understand the events that precipitated the crisis, and should therefore be integral to any decision making process. The sentence on page 11: "*Therefore, it may be appropriate that GPs are consulted as a matter of best practice in the course of the diagnostic process*" is at odds with the clinical reality of a crisis pregnancy and what would happen in the case of X.

- If a woman presents in early pregnancy with a crisis it will be GPs in liaison with psychiatrists who will be managing her care. Obstetricians will not and need not be involved as the pertinent issue will be mental health rather than obstetric health. The sentence on page 11 ".. *it may be appropriate that GPs are consulted as a matter of best practice in the course of the diagnostic process"* is at odds with the clinical reality of a crisis pregnancy and what would happen in an X-case scenario**.**

- In reality therefore a woman could be seen by at least 4 doctors before being 'certified' as being eligible for an abortion. A GP or a Consultant Psychiatrist would be the most relevant doctors to certify in cases of a risk of suicide.

<u>Subheading 3:</u> The location of the procedure in the case of Head 4

- Subheading 2 in Head 2 outlines the *"professional expertise of the relevant certifying medical practitioners."*
  The explanation states: *"Except in emergency circumstances, an obstetrician/ gynaecologist will always be one of the certifying medical practitioners. This provision is deemed appropriate for two reasons. Firstly, in accordance with current clinical practice, an obstetrician/ gynaecologist is obliged to care for the pregnant woman and the foetus and, therefore has a duty of care to both patients and to have regard to protecting the right to life of the unborn and to bring that to bear on the care of the woman and her unborn child. Secondly, a termination of pregnancy will most likely be carried out by, or under the care of, an obstetrician/ gynaecologist, and therefore their inclusion here should be central in accessing services and ensuring patient safety."*

  When a case under Head 4 arises in Ireland, eg a child of 14 who cannot travel and is thinking of killing themselves if they are refused access to an abortion as in the X case, where possible an early, medical abortion, could and should follow international best practice and take place in a general practice setting with medical supervision being provided by GPs (with the licensing of mifeprostone).

  In this regard, Subhead 2 should be amended to reflect the nature of crisis pregnancy management and primary care. Any proposed legislation must have at its centre General Practice-based care and should regulate for GPs to be primary abortion providers in early pregnancy.

<u>Note about medical practitioners:</u>

Specialists should not be required to be attached to any specific institution. Most abortions in developed health services are medical abortions and do not need any hospital facilities.

The Bill also requires the certifying Psychiatrist to be employed in an institution registered with the Mental Health Commission. This is currently not the case for most Consultant Child Psychiatrists. This is an unnecessary specification.

Specialists are required to be registered with the Medical Council and this should be the only stipulation regarding their suitability.

Head 6: Formal medical review procedures

Subheading 2: (See comment under Head 12)

Subheading 3:

- The review panel should include General Practitioners on account of the reasons outlined above. The total time taken from referral to review decision should not exceed 3 days. Delays mean more distress and more complications for later abortions which should be avoided.

Head 8: Review in the case of risk of life through self -destruction

Subheading 1:

- The "committee established by an authorised person" should include a General Practitioner, for the reasons outlined above.

Head 12: Conscientious Objection

- Doctors for Choice welcomes the 4 subheadings in Head 12. However there are valid concerns about the potential for conscientious obstruction.

Head 19: Offence

- Fear of prosecution is a chilling factor and may make the legislation unworkable. It is unacceptable that doctors fear criminal prosecution when they are trying to act in the best interests of a patient. The inclusion of a 14-year prison sentence for women who have an abortion outside of these guidelines and describing that as due to the 'gravity of the crime' is particularly offensive. The prospect of prosecuting children and/or their parents or those carrying out a home abortion with medication bought on the Internet is also very concerning. Every day more than a dozen women will have an abortion outside of these guidelines; only in a different country. The right to travel for an abortion means that no-one in Ireland believes that choosing to have an abortion is a grave or serious crime and this particularly inappropriate section on criminal punishment should be removed. UN Special rapporteur on the Right to Health, Anand Grover, has emphasized the 'chilling effect' of criminalisation on access to services causing stigma and a loss of dignity for women accessing abortion services. Criminalisation will encourage secrecy, terror and desperation and increase

risk in vulnerable patients. Criminal sanction should be removed from the Bill. Oversight of good practice should remain with the post-graduate colleges and the Medical Council who should explore and implement good practice guidelines in the provision of abortion services as such expertise is lacking in Ireland.

- Doctors for Choice advocates the decriminalisation of abortion in Ireland with the subsequent regularisation of its provision in a publicly funded health service. As an organisation we suggest the Canadian model be followed. Canada has not had any criminal legislation on abortion since 1988. It has a regulated, publicly funded abortion service provided through the general health service. The abortion rate in Canada continues to fall and is one of the lowest in developed countries.

Regards,

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Dr Mary Favier is a Founder member of Doctors for Choice. She is a GP in Cork. She was principal author of the Doctors for Choice submission to the Oireachtas committee hearings on A,B and C vs Ireland (Jan 2013).

Opening Statement
of
Veronica O'Keane, Professor in Psychiatry, Trinity College Dublin & Consultant Psychiatrist, Tallaght
for the
Joint Committee on Health &Children for Public Hearings on the
PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013

Date 09/05/2013

The sole purpose of this legislation is to provide clarification on the narrow terms of the law as established in the Supreme Court ruling in the X case: namely, to provide a service for women who, unless they have an abortion, are in danger of dying. A woman's right to this service has been established in Ireland, in our law and our constitution, and in Europe. This Heads of Bill is being discussed despite the vigorous campaigning against the right for women to have their lives protected during pregnancy.

Our role, as psychiatrists, is to facilitate in the provision of this proposed service for women who express suicidal intent and request an abortion in this context. Women who are suicidal because of an unintended/unwanted pregnancy will be the main users of this service, given the extreme rarity of requests for abortion in women who are mentally ill during pregnancy.

Primary Care, Adult and Child Psychiatrists, rather than specialist services, will be the main service providers.

The service should be "accessible and efficient". To this end, I think that a national Panel of those prepared to lawfully engage with this process should be established and an efficient Executive put in place to administer requests for termination of pregnancy.

The GP should make the recommendation for an abortion and one psychiatrist assess the suicidal risk. Details of the practical implementation of these recommendations are contained in my Oireachtas Submission.

Some legislators may continue to hold, and express, views about the "suicide" clause. A consistent argument is that "allowing" the suicide clause will remove the only effective barrier to "abortion on demand"; and will provide a mechanism for women who want an abortion to get one, even if they are not genuinely suicidal. Pro-choice doctors, the argument goes, will be complicit in this manipulation of the system. Another argument is that abortion is not good for your mental health and is not a treatment for suicidal intent.

Underlying all these arguments are deeply problemetic assumptions about the credibility of women; the realiability of psychiatry as a medical discipline; the meaning, and management of, expressed suicidal intent; and the concept that doctors have the power to control women's reproductive autonomy.

Some of these points require clarification as their proponents may try bring a spirit of obstruction to the discussions of the Heads of Bill.

First, we do not practice psychiatry by disbelieving patients. A key ethical principle underlying all medical care is the relationship of trust that is taken to exist between a doctor and their patient. We regard all patients who we see, in the first instance, as being truthful and credible.

Second, the difficulty with evaluating suicidal ideation has been exaggerated. We measure suicidal intent using clinically established markers. The diagnostic certainties that are assumed to exist in other branches of medicine are also exaggerated. The expression of sudden-onset suicidal intent means that that person is at a high risk of killing themselves. The vast majority of people who kill themselves tell someone that they intend to do so, and therefore should be believed.

Third, suicide accounts for 20% of deaths among young Irish women: at an age when women are most likely also to have an abortion. Suicide is a recognized public health problem. The message that suicidal intent is difficult to assess and manage is untrue, and is one that we are trying to counter in our attempts to reduce the national suicide rate.

Fourth, psychiatrists do not treat suicidal ideation/intent. We assess risk and manage the issues underlying that risk. In relation to this legislation we will assess risk and then certify eligibility, or not, for an abortion. It is the woman, not the psychiatrist, who is requesting the treatment: the psychiatrist is only determining eligibility. Therefore psychiatrists do not treat suicidal intent with abortion: a woman chooses this "treatment" herself.

Fifth, the studies about whether abortion is bad, or not, for a woman's mental health have been taken out of context. The studies that have been the subject of public debate have all taken place in situations where there is a choice of continuing the pregnancy, or of having an abortion. In situations where abortion services are *not* available, unwanted pregnancy is a leading cause of suicide.

Abortion legislation was introduced in the UK because unsafe illegal abortion was the leading cause of maternal mortality in the12 years prior to the introduction of the 1967 Act. In 1950's Ireland 10% of Irish women who killed themselves were pregnant.

Irish women do have an abortion service. It needs to be acknowledged that women in Ireland have abortion rights that they exercise as cognisant citizens through their right to travel. This legislation is just a small concession to this reality in that it provides for the right to an abortion within our own health services when a woman is too sick or too distressed to travel abroad.

Lastly, the constituency who are opposed to this legislation have spoken about suicide and abortion in abstract moral terms. Irish women have often been portrayed as passive, unreliable and sometimes manipulative. This language should be recognized as obstructive to the process that is taking place about service provision for Irish women of reproductive age.

Written Submission to the
Joint Committee on Health &Children for Public Hearings on the
PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013

By **Professor Veronica O'Keane,**
Trinity College Dublin & Tallaght Mental Health Services

Introduction
I am an academic in the School of Medicine, TCD, a consultant psychiatrist and an Irish citizen who has been involved in this debate at a national level since 2002. I was a witness at the Public Hearings on the Implementation of the Government Decision following the publication of the Expert Group Report into matters relating to A,B,C vs Ireland, expertly chaired by Gerry Buttimer. I prepared a written submission, and subsequently gave evidence at the hearings, relating to the *implementation* of the legislation, as based on the findings of the Expert Group. The discussion then, and since, has been dominated by the issue of whether, or not, we should legislate for the "suicide clause". I very much welcome the Heads of Bill, and anticipate a debate that will be restricted to facilitating the procedures that will make lawful abortion efficient and accessible for women whose lives are at risk because of being suicidal.

As directed by the Committee, I have below (1) given a brief outline of my experience and work relevant to this issue; (2) listed my recommendations addressing the "Head by Head" points that are relevant to my area of expertise, in the draft Bill. I have confined this submission to a 2-page Executive Summary in deference to the amount of material that the Committee will likely have to assimilate. These comments mostly relate to the psychiatric aspects of the Bill and are written as my opinion, although this is not repeatedly stated.

Expertise & experience relevant to this submission

- I am a professor of Psychiatry in TCD, a consultant psychiatrist in the HSE (Tallaght Hospital) and I run a research programme in perinatal depression.
- I led a National Perinatal Psychiatry Service in London for five years in the Maudsley Hospital serving all of the UK (2002-2007).
- I was concurrently head of Perinatal Psychiatry in King's College Medical school from where I led a research programme in perinatal depression.
- I have published extensively in the scientific literature on the epidemiology, clinical treatment and neuroendocrinology (hormone-brain changes) in perinatal depression. [1,2,3,4,5]
- I have written a book Psychiatric Disorders during Pregnancy (2007: Taylor & Francis, London. O'Keane V, Marsh M & Seneviratne G)
- I have co-authored the standard clinical assessment tool for perinatal psychiatric disorder.[6]
- I was an expert for the NICE UK (National Institute for Clinical Excellence: the DoH guidelines for clinicians in different medical specialties) for the management of perinatal depression. [7]
- I have set up two General Hospital Psychiatric services: this includes the Suicide Prevention Service in Beaumont Hospital (1998-2002).
- I have researched and published on the topic of suicide assessment. [8]

2-page Executive Summary of comments listed on a "Head by Head" basis

Head 1 Interpretation

1. "Reasonable opinion means an opinion formed in good faith which has regard to the need to preserve the unborn life as far as practicable" (p 5). The inclusion of this definition "is influenced by the Twenty-fifth Amendment to the Constitution Bill 2001 (section 1)." This amendment states that where a woman's life is in danger abortion can be permitted "...to prevent a real and substantial risk of loss of the woman's life other than by self destruction".

Recommendation: Given this, should a "reasonable opinion" influenced by this Amendment not be expanded on to include the risk to the life of the woman?

2. Definition of "unborn" should be altered to reflect viability. The conceptus is formed after the egg and sperm unite. Following implantation and up to 8 weeks of pregnancy, the conceptus is know as a fetus.

Recommendation: Perhaps "fetal viability" is a more appropriate line of demarcation. A definition of viability would allow for a fetal life to be saved at an earlier stage of pregnancy, as advances in obstetric and neonatal care emerge.

Head 4 Risk of loss of life from self-destruction

1. This Head outlines procedures for certifying a woman to have an abortion where her life is at risk from "self-destruction". I think that having **two psychiatrists** to certify that a woman is suicidal is excessive for the following reasons:

(a) In routine clinical practice one psychiatrist assesses suicidal risk. This is never considered to be inadequate. All doctors are trained in suicidal assessment and risk from their early undergraduate years. Psychiatrists undergo further trained and by the time they are on the Specialist Division of the Irish Medical Council, they have had a minimum of 7 years experience in the assessment of suicidality.

(b) Psychiatrists are also competent in, and familiar with, the assessment of suicidal risk in relation to legal procedures. A single psychiatrist can certify that an individual is at risk of "harm to themselves or others" within the procedures laid down in the Mental Health Act 2002.

(c) A suicidal individual is distressed and presents as an emergency, requiring prompt intervention and reassurance. Having two psychiatrists interviewing a woman who is suicidal could cause unnecessary emotional distress because of the repetition and also could cause unnecessary delay in providing a decision.

Recommendation: The unique role of the woman's GP in relation to having "knowledge which might be particularly useful when assessing a real and substantial risk to life through suicide" is acknowledged (p 11). Furthermore, at least one of the "three medical practitioners....shall consult with the pregnant woman's GP where practicable", (Subhead 2). Given that a "specific referral pathway" for this procedure has not been set down, attendance at the applicant's primary care practice chould be inserted as a requirement for the referral pathway. The first, and necessary, function that the GP could perform would be to confirm the pregnancy. The second would be to counsel the pregnant woman in relation to the crisis pregnancy. This would then result in either referral to the assessment panel or to a woman deciding to proceed with her pregnancy. Without this initial screening, it could be argued that it would be premature to be screened by "the Panel" for an abortion.

2. Under "explanatory notes" (p 10) it is stated that there is an absence of "objective clinical markers" in relation to the assessment of suicide risk. This is not the case: suicidal intent is measured along several established parameters of risk, for example a previous attempt, a family history of suicide, plans for the method of suicide, writing a will, etc. This explanatory note should be removed.

3. In the case of a child, an opinion from a Child & Adolescent Psychiatrist (CAP) would be required. The majority of CAPs do not work in Approved Centres, as defined under the Mental Heath Act. Subhead 1(b) needs to be changed to allow such exceptions.

4. The last sentence in the penultimate paragraph on page 11 is confusing and open to different interpretations. The issues are clarified in the paragraph that follows, and I would advise omitting this sentence.

Head 6 Formal Medical Review Procedures

Subhead 2: the last sentence implies that the medical practitioner in the initial certification procedure need "not give an opinion". If a medical practitioner is unable to give an opinion, should an alternative practitioner not be called upon to give an opinion? The Medical Review Procedure should exist for the woman to challenge a decision not in her favour. The woman should not have to appeal to have a decision made. In Head 4 (p 11) it is stated that "It is expected that a decision would be reached…in accordance with medical best practice", *(presumably, best medical practice)*. There is thus no provision in Head 4 for a decision not to be made. In Head 6 there is no stated obligation to make a decision, rather there has to be an "outcome". There is further inconsistency in Head 8, where it is stated that the Review Committee will form an opinion "as to whether or not there is a substantial risk to the life of the pregnant woman.."

Recommendation: I would recommend stating that it is the responsibility of the medical practitioners involved in the initial committee to certify, or not, whether in their opinion an application for an abortion is lawful. The woman, or an agreed person, can then appeal this decision at the Medical Review stage; where a decision also should be forthcoming.

Subhead 5 & 6 : these subsections set a limit of waiting for 7 days for the Executive to convene a review committee, and another 7 days for the review committee to come to a decision. The woman may thus have to wait for 2 weeks to receive a decision. This could mean that a woman may go from a situation where an abortifacient tablet could suffice (up to 9 weeks), to requiring a surgical procedure to terminate the pregnancy. This cannot be considered to constitute "timely" access, as recommended by the Expert report and the ECHR.

Recommendation: I recommend that the Medical Review committee be formed within 48 hours from the panel of experts, and give a decision within a further 48 hours. The timetables that medics operate within facilitate emergency work.

Subhead 2, explanatory notes: allows for the right of access of "any person" to the courts to challenge a medical decision, intended for a pregnant women. This contradicts Subhead 2 stating that only those "with her consent" may attend the court, and underlies her autonomy, respect and privacy as an individual patient.

Head 8 Review in case of risk…through self-destruction

Subhead 6 & 8: Medical experts involved in the Review Committee should receive allowances for expenses, but not renumeration.

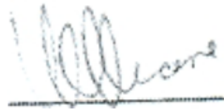
Head 12 Conscientious Objection

Given the opinions expressed during the public debate, I think that medical professions applying for positions on the expert Panel should be required to state formally that they will work to make the service, which is the subject of this Bill, available to women who meet the criteria as set down in Heads 2, 3 & 4.

Head 19 Offence

Subsection 1, should have the caveat, after first sentence, "except within the provision of this Bill", or words to that effect.

Signed



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Joint Committee on Health and Children

Public Hearings on the Protection of Life during Pregnancy (Heads of) Bill 2013

Dr Eamonn Moloney – Opening Statement

Monday 20th May 2013 at 12.15

I am clinical director of the mental health service which has its inpatient unit/approved centre base at Cork University Hospital (CUH) and Cork University Maternity Hospital (CUMH), one of the busiest maternity hospitals in Ireland with over 9,000 deliveries per annum. There are over 600 people seen for emergency psychiatric assessment following suicidal behaviour at CUH on an annual basis and many more with suicidal ideation.

As clinical director of a busy, community mental health service serving a catchments area of 190,000, I have overseen the implementation of new legislation in the form of the Mental Health Act 2001 within the service over the past six years and have an ongoing responsibility to ensure that the appropriate legislative procedures are followed. My comments on the Heads of Bill are from the perspective of a clinical director/consultant psychiatrist and primarily relate to the practical application of this proposed legislation. The current operation of the Mental Health Act 2001 leads me to believe that this legislation could be practically implemented but I will suggest some areas where amendments would ensure that a suicidal woman with a crisis pregnancy is managed in the most appropriate, humane and timely manner. The relevant care pathway is described.

Head 4: Two Medical Opinions/Possible Care Pathway

The requirement for two psychiatrists and an obstetrician/gynaecologist to certify that a woman is eligible for a termination of pregnancy is excessive. Two medical opinions should suffice.

One of these medical opinions should ideally be the pregnant woman's general practitioner. The importance of the general practitioner is recognised in the explanatory notes on (2)(a)(1) by virtue of his/her "long-term and in-depth knowledge of the woman" and he/she will have a unique perspective of the woman's particular circumstances in relation to, for example, her social supports, relationships, previous pregnancies, any history of sexual assault or abuse and family background.

It is likely that the woman will consult her general practitioner in the first instance for confirmation of pregnancy and discussion of the options for what may be a crisis pregnancy. The woman's general practitioner can carry out an assessment of the woman's mental state or, perhaps more than one assessment over the course of several days.

He/she may certify that the patient is acutely suicidal, that there is a real and substantial risk to her life and that this risk can only be averted by a termination of pregnancy. A general practitioner is likely to have considerable experience of assessing suicide risk and of making medical recommendations for detention of persons under the Mental Health Act 2001 and so is well placed to carry out a similar type of certification process under the proposed legislation. If the general practitioner is certifying that the woman satisfies the appropriate criteria under the act, he/she will inform the executive which will confirm or arrange an assessment by a consultant psychiatrist

The second medical opinion should be by a consultant psychiatrist. This doctor should be drawn from a panel of consultant psychiatrists who are agreeable to operate the enacted legislation. This process is again similar to the pathway for hospital admission under the Mental Health Act where a consultant psychiatrist must assess a person brought to an approved centre following appropriate application and medical recommendation by the general practitioner. A consultant psychiatrist has a particular expertise in assessing suicide risk so it is appropriate that he/she would carry out this assessment.

This process of consultation with a general practitioner and referral to a consultant psychiatrist for further assessment reflects the ideal care pathway for all suicidal patients and also the pathway for admission to an approved centre under the Mental Health Act. It is likely to be the least distressing process for the pregnant woman, the most appropriate way of accessing the assessment and care that the woman needs and is a process that is practical, as evidenced by the current operation of the Mental Health Act.

A further medical opinion is not necessary and indeed the explanatory notes for Head 2(3) refers to the Mental Health Act 2001 to support the need for only two medical opinions where there is a risk of loss of life from physical illness. The assessment of suicidal intent is one of the core skills of consultant psychiatrists who are carrying out such assessments on a daily basis.

The relative rarity of completed suicide and the inability to determine the number of people saved from death by suicide following appropriate suicide risk assessment and intervention means that an exact calculation of the accuracy of assessing suicidal intent is not possible. This does not mean that suicide risk assessments carried out by a woman's general practitioner and a consultant psychiatrist are inaccurate.

The involvement of an obstetrician/gynaecologist in the assessment of risk of death by suicide is not appropriate as it is outside their area of expertise.

It should not be necessary for the consultant psychiatrist to be “attached to an institution where such a procedure is carried out” as this would unnecessarily restrict access to an appropriate and timely assessment which could be done by a consultant psychiatrist not attached to the maternity hospital.

Head 6:

(5) and (6): the timescale proposed of up to seven days to convene a committee and up to a further seven days to form an opinion could lead to a potential delay of two weeks following a woman’s appeal to a decision being made. This is likely to cause considerable distress which could be alleviated by shorter timeframes of 72 hours to the convening and 72 hours to a decision being made.

Head 8:

The requirement that one of the consultant psychiatrists “shall be employed at an appropriate location” is unnecessary. Most women at risk of suicide in the early stages of pregnancy would be most likely to be seen by a general adult community psychiatrist or a liaison psychiatrist, following self harm rather than a perinatal psychiatrist “employed at an appropriate location”.

The proposed timeframe is too long and a delay of up to seven days should be shortened to 72 hours.

The decision of the review committee should be by majority decision. This is the case for decisions made by the mental health review tribunal under the Mental Health Act where three persons on the tribunal decide on whether to revoke or affirm the detention of a person under the act. A simple majority is sufficient and this should also apply under this legislation.

The certification procedure proposed here ensures that the most appropriate and relevant medical opinions are obtained and that the usual care pathway and referral processes are followed in order to minimise any unnecessary, additional distress to the pregnant woman. This process is similar to current procedures under the Mental Health Act 2001 and so the practical application of the legislation can be assured.

Dr Eamonn Moloney MB,FRCPsych

Executive Clinical Director/Consultant Psychiatrist

South Lee Mental Health Unit

Cork University Hospital

Cork

15th May 2013

Ref: KMM/ONC **15 May 2013**

Mr Jerry Buttimer

Chairman

Oireachtas Committee for Health and Children:

Dear Chairman:

I have previously made a submission to the Oireachtas earlier this year. In the interest of brevity and hopefully clarity, I can summarize my points as follows as my opening statement to the Committee, and upon which I can elaborate during questions:

1. The legislation, which is based on the outcome of a 20 year old risk assessment of suicidality, excludes 50% of the population, and such a focus in excluding men in relation to legislation about "suicidality" further eclipses the problem of male suicide in Ireland. I am publishing a Research Report on Suicide on May 20th at RCPI, wherein the question of marginalization and young male suicide rates is analyzed. Suicidality is already a significant problem in Ireland, accounting for over 12,000 A&E presentations annually (where male attempted suicide rates are climbing). Such legislation could inadvertently accelerate suicide rates in younger men in Ireland (where the real problem lies) through a macro-marginalisation effect. So, contrary to the notion of "saving lives" (extremely small number of females), it may be placing a greater number of young male lives at suicide risk than currently. Overall, at a macro-level, the effect of the legislation may be greater loss of life than life-saving. How will mental health literacy be taught in schools explaining that suicidality is legitimized for women in certain circumstances (pregnant woman suicide rate: 2/1,000,000), but not for young men (suicide rate: 350/1,000,000) in any circumstance.

2. Abortion is not a treatment for mental illness in any textbook of psychiatry. 4 Irish psychiatrists (McCarthy, Fenton, Sheehan and Malone) in cumulative clinical perinatal practice in the Dublin Maternity Hospitals for over 20 years have not observed one clinical case where abortion was the recommended psychiatric treatment- how can it suddenly become a recommended psychiatric treatment overnight in Ireland upon this legislation?

3. If the therapeutic alliance is to be preserved for psychiatrists and their patients, becoming clinically involved in a decision on abortion (one way or the other) compromises the therapeutic alliance, and is therefore clinically contra-indicated. Involving any kind of fee, further compromises this position.

Please also find a brief biography attached.

Sincerely

Prof Kevin Malone, MD, FRCPI, FRCPsych.

Dr. Bernie McCabe on behalf of Professor Patricia Casey

Submission on Protection of Life during Pregnancy Bill 2013

Oireachtas Health Committee May 2013

Bio for Dr. Bernie McCabe

UCD Graduate. Working since 2006 in General Audit Psychiatry in South Meath Mental Health Services.

Executive Summary

There is no evidence available suggesting that abortion is a treatment for those who are mentally ill and suicidal.

Claims have been made that some women are suicidal simply because of the pregnancy only and not because of any underlying illness. There is no scientific data on this group to assist in predicting suicide. Psychiatry has little to offer this group beyond saying that mental illness is absent.

Head 4 should be replaced by a clinical care pathway for suicidal women that does not include abortion, so that they can readily access treatment

In the event that legislation as planned progresses, there are several aspects to Head 4 of this bill and its explanatory note that require serious attention.

Submission to Oireachtas Committee on Abortion

Consideration of Heads of Bill Head 4

I will consider Head 4 of this Bill since it is the only one that relates directly to psychiatry. Head 4 deals directly with the provision of an abortion in the case of threatened self-destruction.

The underpinnings of Head 4 (to be read in conjunction with the Appendix below)

In my opinion there is no scientific evidence to support the proposition that abortion is necessary to prevent the loss of life by suicide in pregnancy either in those who are suicidal due to mental illness or due simply to the pregnancy. No studies have been carried out in this regard.

Prof. David Fergusson of Otago University, Christ Church, New Zealand is a researcher who has carried out a number of studies into the relationship between abortion and mental illness (Fergusson 2013). In the course of an interview on Morning Ireland on Tues. May 7th 2013, he stated :

I think it would be misleading for anyone to state emphatically that abortion does or does not help suicidal women. So I'm really taking a position of sitting on the fence here, saying if the research hasn't been done, we really need to adopt a neutral position on this argument, until better information is available.

I have argued in detail in the attached Appendix that suicide intent in pregnancy is almost always due to mental illness and that this should be treated in the same way as suicide intent in any situation by assessment, possibly admission to hospital and treatment that involves medication, psychotherapy or both. No research has been carried out on those who are suicidal simply due to the pregnancy. Yet the Government is proceeding as if such evidence exists.

The test that there must be a real and substantial risk to the life of the women that can only be avoided by abortion cannot be met since suicide cannot be predicted, even in those with mental illness.

In those without mental illness there is absolutely no information on the risk factors or likelihood of suicide. Since this group are not mentally ill psychiatry has nothing to offer over

and above that of those not trained as mental health professionals and accordingly should not be involved. The role of psychiatrists in those who are not mentally ill has been addressed in Law (*P v Kehoe 1992*).

Offering a pregnant suicidal woman an abortion if she says that the pregnancy is the reason for this may seem to be common sense. However a large caution is required in this regard. Interventions that seem intuitively correct may not turn out to be so. The classic example of this is critical incident stress debriefing after trauma. It was be widely used in the 1980's and 90's only to be shown by subsequent research that not only did it not help in coping with trauma but it made the impact worse. The lesson in this is that interventions, particularly when the consequences are of such magnitude, are that we must rely on evidence rather than common sense. Abortion as an intervention is irrevocable both for the woman and for her unborn baby.

Conclusion: Head 4 as currently constructed should not be included in the current legislation. It should be replaced by a clinical care pathway that would assist women who are suicidal in accessing psychiatric assistance that is evidence based. Abortion as a "treatment" for suicidality is not evidence based.

And 120 consultant psychiatrists have signed a letter agreeing with the statement

> *As practising Psychiatrists we are deeply concerned at the Government's stated plan to legislate along the lines of the X-Case, as this will mean legislating for suicidality.*
>
> *We believe that legislation that includes a proposal that an abortion should form part of the treatment for suicidal ideation has no basis in the medical evidence available.*
>
> *We as Psychiatrists are being called upon to participate in a process that is not evidence based and we do not believe that this should be asked of the profession.*
>
> *Any proposal being considered by the Government must be based on a rigorous appraisal of the available psychiatric research and medical evidence.*

Fourteen of our colleagues who responded disagreed.

Explanatory note for Head 4 of Protection of Life in Pregnancy Bill 2013

In the event that Government disregards the above concerns and recommendations and proceeds to legislation I wish to outline my concerns about the current proposal.

1. The explanatory note (line 7, page 10) states that it is not necessary for the medical practitioner to be of the view that loss of life is inevitable or immediate. This in my opinion is a very low bar – how far into the future should one consider the risk to apply for? Should it be 6 months, 2 years, 10 years etc? This has the capacity to

sweep up almost anybody who threatens suicide since a psychiatrist can never be sure that at some time in the future the person will not harm themselves despite the rarity of suicide and the problem of prediction. The tendency of doctors to err on the side of caution when suicide is threatened on the grounds that nobody can say suicide will not occur leaves this legislation open to wide use and abuse.

2. In line 11 (page 10) the Explanatory Notes state that three doctors are required to more accurately assess suicide intent. There is little difficulty with assessing intent or in assessing risk factors and this is something that psychiatrists have competence in. It is the prediction of when and whether that intent will be acted upon that is flawed and it is not possible to predict this. The number of doctors used cannot improve an inherently weak methodology (see Appendix).
3. In the last paragraph of page 11 the explanatory note says that where the unborn may be potentially viable outside the womb *doctors must make all efforts to sustain life after delivery. However, that requirement does not go so far as to oblige a medical practitioner to disregard a real and substantial risk to the life of the woman on the basis that it will result in the death of the unborn…..it is a clinical assessment as to whether the mother's life….is threatened by a real and substantial risk that can only be averted by a termination of pregnancy.*

   This wording is ambiguous and I want to tease this out a bit more.

4. The legislation as currently proposed has no time limits and abortions could be carried out up to birth on physically healthy pregnant women and physically healthy unborn babies, in women without mental illness who are adjudged to be suicidal.

   Late term abortions are a major risk factor for subsequent mental illness in the woman. They are banned in most jurisdictions.

   On the other hand Minister James Reilly has stated that where a baby is potentially viable it will be delivered and its life sustained. He indicated that should the baby develop physical or intellectual disability as a result of prematurity that the State will take it into care. This has potential legal consequences for the state. The whole idea of delivering a potentially viable baby prematurely in a suicidal woman is preposterous. It also ignores the reality that the reason the mother is seeking the abortion is because she does not want the baby alive. Women do not seek abortion other than to ensure that the baby is born dead and the Royal College of Obstetricians and Gynaecologists has developed Guidelines to ensure that this occurs in late term abortions. The suggestion that a near viable/viable baby would be kept alive was clearly made as a way of diluting the reality that the legislation will allow abortions up to birth.

The time limits need to receive serious consideration in respect of suicide.
The possibility that this legislation will either allow late term abortions or the premature delivery of potentially viable infants with the attendant risks associated with this are both unconscionable prospects and induce revulsion. It points to the flaws in Head 4 of this legislation.

Relevant issues not considered in Head 4

1. **Selection of doctors**: There is no information on how doctors carrying out the assessments will be selected or on how they will consult with each other. The first doctor could potentially call on two likeminded colleagues (either obstructers or facilitators). How can this be avoided?
2. **Exclusion of doctors:** Will doctors with particular perspectives (facilitators or obstructers) be preferentially selected for the initial assessment and for the appeals panels? This has been suggested by some politicians and how will this be avoided?
3. **Names of doctors:** Will the names of doctors engaged in the assessments and in the panels be provided under FoI inquiries in respect of the annual reports?
4. **Information for reports:** It is crucial that information on age, level of suicide intent, prior treatments, gestation at time of abortion and so on is provided for the annual Abortion reports. The number of refusals and the reason must also be provided.
5. **Reimbursement of psychiatrists:** The proposed reimbursement psychiatrists are to receive for their work in respect of this legislation should be made public before the final legislation is published. As with all doctors working the public sector the reimbursements made to individual psychiatrists for this work should be made public annually.
6. **Benchmarking before legislation:** Those who say that abortion will be rare and only occasionally used need to provide information on the possible numbers of abortions likely to take place annually. Similarly, those who claim there are large numbers of suicidal women seeking abortions elsewhere need to provide possible figures. This data must be provided before legislation is enacted so as to act as a benchmark in allowing evaluating the use and impact of this service over time.
7. **Evidence of abortion as last resort**: What evidence will the assessing doctors have to provide concerning treatments before abortion is recommended? What will the test for the adequacy of these be – for example with it be sufficient to say that the person has seen a counsellor? Will a detailed report from the counsellor have to be provided? How can it be shown that abortion is the last line of treatment? These need to be addressed in the final legislation and specified in the legislation.
8. **Abortion as a treatment in mentally healthy people:** Following from 7 above, for those who are not mentally ill but are suicidal only because of the pregnancy there

will be no other "treatment**".** Psychiatrists will thus be expected to recommend abortion as a "treatment" for unwanted pregnancy. The psychiatric profession should have no role in this process beyond saying that the person has no mental illness. This is an abuse of the profession in order to facilitate the requirements of the State. Psychiatrists in the past have allowed themselves be used as a tool of the state by incarcerating in mental institutions those who were unwanted, who were single mothers, who were mentally handicapped or who were political dissidents. We must not now be used by the state to duck the ethical and constitutional issues that the X case ruling raises. Under the current proposals the reputation of the profession will once again come into disrepute.

Conclusions

There is a dearth of information on the value of abortion in suicidal pregnant women and it has never been studied. The Government is acting as though there is evidence to support this.

Psychiatrists should not be involved except in so far as we can treat pregnant women with mental illness. Psychiatrists must base their practice on evidence.

Should legislation proceed as proposed there are a number of concerns relating to Head 4 that must be addressed.

APPENDIX

The purpose of the proposed legislation is to **prevent suicide** in those who have **suicide intent** posing a **real and substantial risk** to the life of the woman that **can only be averted by an abortion.**

What is suicide intent as opposed to suicidal ideation?

Passive death wishes are thoughts of wanting to be dead but without any desire to bringing this about oneself. For example "If I died in my sleep I wouldn't mind".

Suicidal thoughts/ideation is defined as considering taking steps to achieve this. They may manifest as thoughts of self-harm e.g. I thought I might take an overdose" or "I would like to end it all but I have no plans" or more persistent ideas.

Suicide intent is a measure of the extent to which a person wishes to take their lives and its assessment involves an evaluation of the extent to which a clear plan to achieve this has been formulated along with the person's view of the future, personal supports and so on.

The current legislation is in respect of suicide intent as distinct from suicidal ideation (thoughts). There is little comfort in this since intent fluctuates and when a person is in crisis it may be elevated only to reduce rapidly as distress falls. Its assessment depends on what the person tells the doctor and how the person behaves. Anybody having high intent should be hospitalised in order to ensure safety, to facilitate assessment of triggers and to arrive at a diagnosis and management plan.

Is there evidence that abortion prevents suicide?

There is no evidence that abortion prevents suicide.

1. No textbook of psychiatry or of perinatal psychiatry says this. These include:

    Modern Management of Perinatal Psychiatric Disorders (2009) Henshaw et al

    Seminars in Liaison Psychiatry (2012) Guthrie et al

    Handbook of Liaison Psychiatry (2007) Lloyd and Guthrie

    Seminars in General Adult Psychiatry (2007) Stein and Wilkinson

    Comprehensive Textbook of Psychiatry (2009) Kaplan and Sadock

New Oxford Textbook of Psychiatry (2012) Gelder et al

2. No studies have examined the role of abortion in preventing suicide in women who are suicidal during pregnancy. In the proposed legislation psychiatrists are being involved in an assessment process for a procedure that has no research to ground it. We are being asked to decide that a woman's life may be saved by an abortion and only by this.

   Prof. David Fergusson of Otago University, Christ Church, New Zealand is a researcher who has carried out a number of studies into the relationship between abortion and mental illness (Fergusson 2013). He is a self-described pro-choice atheist. In the course of an interview on Morning Ireland on Tues. May 7th 2013, he stated the following:

   I think it would be misleading for anyone to state emphatically that abortion does or does not help suicidal women. So I'm really taking a position of sitting on the fence here, saying if the research hasn't been done, we really need to adopt a neutral position on this argument, until better information is available.

   In email correspondence with me on Sun. May 5th (published with his agreement) he wrote:

   Hi Patricia,

   Thanks for your email. In response to your comments, I think that it is drawing a long bow to claim that abortion may be an effective response to suicidal thoughts in pregnancy. As far as I know there is no evidence to support this view and claims of indirect evidence seem farfetched.

Both of these statements clearly urge caution as there is an absence of research to justify abortion to prevent suicide yet the Government is proceeding as if there is evidence that abortion helps in this.

Suicide intent in those with mental illness

High suicide intent most commonly occurs in those with mental illness such as depressive illness, schizophrenia, bipolar disorder and so on. The management of this is in the usual way, with admission to hospital for safety and assessment. The CMACE report from Britain (reports of maternal mortality) (2011) show suicide in pregnancy is rare. Overwhelmingly it occurs in women with mental illness that is under treated or undiagnosed. These reports point to the vital importance of early diagnosis and treatment with pharmacological, social

and psychological interventions. These reports also demonstrate that women die by suicide in pregnancy even in countries where abortion is readily available.

<u>Suicide intent in those without mental illness</u>

We do not know the size of the group who are suicidal in pregnancy with no mental illness. Current data shows that around 4,000 women travel to Britain (and it is claimed also to Holland) for abortions every year. It is presumed that amongst these are women who are suicidal. However there is no data to substantiate this claim since the UK abortion figures do not include suicide as a specific ground.

No studies have been carried out on those who are suicidal but are not suffering from mental illness. So the proposal to legalise abortion in this group is being enacted in a research vacuum. For example we have no information on the risk factors for suicide in this group let alone on our ability to predict who might actually die by suicide.

Moreover the suicidal thoughts/intentions in those with no mental illness could be driven by other considerations such as having an abusive spouse or being coerced. In the recent past I saw two such women who presented the Emergency Department of the Mater Hospital having taken an overdose. In both instances they presented as wanting an abortion. On assessment they both admitted they were happy with the pregnancy but were being coerced, under threat of being abandoned (one by a parent, the other by a partner) unless they aborted the baby. The distress of this led to the episode of self-harm. One, at the time of the overdose, had selected a possible name for the baby. With support, both continued the pregnancy and gave birth.

Psychiatrists have no particular provenance in dealing with those who have no mental illness over and above those with no mental health training. This issue was adjudicated upon in *People (DPP) v Kehoe (1992)* who said in the particular case "Jurors do not need psychiatrists to tell them how ordinary folk who are not suffering from any mental illness are likely to react to the stress and strains of life". To involve psychiatrists in an area in which they have no special expertise, apart from assessing the presence or absence of mental illness, is a misuse of the profession.

Is there ever a situation where abortion is the only way to prevent suicide?

At the Oireachtas Hearings all three perinatal psychiatrists said that they have never seen a suicidal pregnant woman for whom abortion was a treatment

In addition the submissions to the Health Committee in Jan 2013 of Prof. Kevin Malone UCD, Prof. Lucey representing St. Patrick's Hospital, Dr. Sean O'Domhnall and I all wrote/stated that there was no evidence that abortion was a treatment for those who are suicidal in pregnancy.

The only evidence that has been presented to suggest abortion has a role in treating suicidal intent in pregnancy comes from studies of the numbers of women dying by suicide in pregnancy in decades past (Weir 1984) or in developing countries. The latest example of this was a recent comment by a psychiatrist in the media that 10% of women dying by suicide before the 1950's were pregnant. This claim was rebutted in a letter to the Irish Times on May 7th 2013Dr. Dermot Walsh, retired Inspector of Mental Hospitals responded:

> *The claim that from 1900 to 1950 10 per cent of Irish women of child-bearing age dying by suicide were pregnant at death, recently reported in the media, rests on no secure ground of which I am aware. In fact the first comprehensive survey of suicide in Ireland of the modern era, although limited to Dublin, which I co-authored, covering the years 1954-1963 appeared in the British Medical Journal in 1966. Coroners' inquest records and post mortem reports did not allude to pregnancy in any of the 58 females of child-bearing age identified as dying by suicide. This does not exclude pregnancy in these cases, given the cultural mores of the time. Nor do we know the pregnancy status of the 66 similarly aged women recorded as dying by suicide in Ireland in 2011.*
>
> *Finally the ability of psychiatrists to determine the likelihood of transition from suicidal threat to suicide itself, in the absence of any reliable biological marker, is fragile at best.*

No convincing evidence has been produced that abortion is necessary to treat suicidal women in pregnancy yet despite this the legislation appears to be proceeding. And as stated by Professor Fergusson no studies have been carried out to assess this.

How can a Real and Substantial risk be demonstrated?

The real and substantial test required by this legislation can never be met since we cannot predict suicide due to it its rarity. While we can identify the risk factors associated with suicide, turning these into predictors of who will die by suicide is impossible since these same risk factors are also present in those who do not die by suicide (Owens 2005). Research into this shows we over predict suicide even in high risk groups such as those with mental illness (Pokorney 1983).

In those who are not mentally ill and saying they are suicidal because of the pregnancy alone prediction is impossible – we have no idea of the risk factors for suicide in this group and no tools to aid us in deciding who will and will not take their lives. So a test of what is real and substantial is impossible since there is no information on suicide in those pregnant women without mental illness.

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Submission to the Oireachtas Hearings May 20th 2013 , Dr Jacqueline Montwill

Introduction:

Chairman, members of the committee, ladies and gentlemen, thank you for the opportunity to address your committee, on this important issue.

Head 4 of the proposed Bill, "risk of loss of life from self-destruction", is seriously flawed ; the treatment it proposes is not a treatment , the treatment it proposes is never the only treatment , and if truly suicidal with mental illness, the patient may not be able to give a valid consent .

1) **The treatment it proposes under law is not an Evidence based treatment .**

   There is no evidence to support the view that Abortion has any mental health benefits, there is evidence to support that in some women Abortion may be associated with small to moderate increases in risks of mental health problems including suicidality. There is an ethical problem in offering a procedure as a life saving treatment to a suicidal woman, where that intervention also poses risks of suicidality as an outcome.

2) **It is absolutely incorrect to say that Abortion could ever be the <u>only</u> treatment for stated suicidal intent.**

   Suicidality is multifactorial. Our treatment packages are multifactorial. We have worked in Multidisciplinary teams for over 20 years and the different skills from all our team members are essential for the full assessment and treatment of our patients. Best Practice treatment for mental illness is, and always will be ; appropriate full assessment, psychological support or intervention , and medication if needed.

   Remember we have social workers, occupational therapists and psychiatric nurses who work with people in their own homes and

communities. When discharged from hospital, we continue to work with the patient in the community as long as it's needed. The proper care of a suicidal pregnant woman will entail support and treatment throughout her pregnancy , delivery and in the post partum period. Longer term intervention may be required , depending on the circumstances.

We are very aware that Mental Health Intervention must include assessment of all the stressors in the patient's life at the time in question .

These stressors can include relationship difficulties , poverty , unemployment or lack of occupation during the day , accommodation issues , difficult dynamics within the family currently or in the past , and lack of other supportive relationships .

It is within this holistic view that the treatment package for a suicidal pregnant woman would be appropriately assessed and delivered.

Therefore , it is completely illogical to say that the only treatment for suicidal intent during pregnancy would be an Abortion.

3) **Valid consent to an Abortion may not be possible while acutely suicidal due to mental illness.**

- It is most important to outline to you clearly that a Psychiatric Emergency or Crisis is fundamentally different to any other medical or surgical emergency. This is because of the nature of the Disorder**. In a true Psychiatric Emergency, the patient's judgement is frequently impaired.** Our role at that time is to administer the most appropriate psychiatric treatment and support. It would be highly inappropriate to impose an irrevocable intervention at that time, when the patient may not have sufficient mental capacity to give a valid consent to that intervention. The patient 's right to bodily integrity is paramount . It cannot be argued that a Termination is a life saving procedure in suicidal states in mental illness, as suicidality responds to

other treatments .It can also never be argued that a Termination must occur at that time , as suicidal intent can fluctuate over time , and resolve. There is no inevitable decline to suicide that can be accurately predicted.

- It is my view that if a Termination was prescribed and given at that time ; the patient would be in a strong position to accuse their treating team of failure in their duty of care . It could be rightly claimed that we as Psychiatrists, failed in our duty to adequately protect the patient during a period of mental illness. Do not forget that **mental illness responds to treatment**. Acute crises respond to treatment and they settle down, often in a short period of time. Any impairment of judgement in these situations will resolve with treatment.

- Even in mild Depression, not necessarily in a suicidal state , a patient can have very negative thoughts about their life. During such periods, we routinely tell our patients: "Do not dump your boyfriend. Do not leave your job at this time. Do not make any major life decisions now. When your mood has lifted in a few weeks time, you will see things differently." In a state of true suicidal intent, these negative feelings are exaggerated even more , but with treatment and time , they will also resolve.

  A particularly effective Psychological treatment that works for patients who feel hopeless and helpless in their life is CBT, "Cognitive Behavioural Therapy. " which teaches Patients to recognise how their mood affects their thoughts and behaviour, and how to change this . This is an example of how psychological intervention for a brief period of time , empowers the patient to have a marked role in their recovery.

With this law, the focus will be directed away from a full and proper assessment of the patient and directed instead to an assessment for a direct Abortion. As treating Psychiatrists , we do not assess suicidality for any reason other than to prescribe the appropriate psychiatric treatment. Society should do the same. Society should validate an expression of extreme psychological

distress, not normalize it. Mental illness is just as important as physical illness , perhaps even more so . Because it affects your thinking , your relationships and your ability to function .It is exceptionally important to state : The proper response to stated suicidal intent should always be appropriate evidence-based clinical treatment. **Direct abortion is not a clinical treatment , it is a social solution.**

- We must be very clear, this law will do damage way beyond the boundaries of simply legislating for a medical treatment that is without the foundation of medical evidence and good clinical practice. It will directly target and **profoundly damage the very nature of the doctor-patient relationship**. The interaction will change from therapy to judgement interviews for an Abortion . It will put the patient in an impossible situation where outside demands will impact on her treatment , taking her out of the proper therapeutic alliance with her psychiatrist and treating team.

  We have discussed where patients have mental illness with suicidal ideation and intent . It has been correctly stated that suicide in pregnancy is very rare. When it occurs it is due to mental illness, and the appropriate treatment , not an Abortion , would have saved those lives . However , in my opinion , these are not the patients who will be asking for an Abortion under the proposed Law . The majority of patients who will avail of Abortion in this way are most likely to be those who have no mental illness , and do not wish to be pregnant. We have no tools to predict who will kill themselves . It is likely that requests from these patients will be processed through the proposed Law , and this will result in widespread direct Abortion .

  In conclusion ; for those patients with Mental Illness ;
  There is no evidence that Abortion is a treatment for suicidal intent ,

there is no situation where it would be the only treatment indicated , and the issue of valid consent to an Abortion while truly suicidal due to mental illness, poses serious ethical concerns.

In my opinion, the patients who will avail of termination of pregnancy through this law are most likely to be those patients who have no mental illness, but who do not wish to be pregnant.

Dr Jacqueline Montwill , MRCPsych
Consultant Psychiatrist

My name is Dr Jacqueline Montwill, I have worked in Psychiatry for 17 years , over 8 years at Consultant level. I am a Member of the Royal College of Psychiatrists and I am on the Specialist Register for Psychiatry of the Medical Council of Ireland and the General Medical Council (UK).

I have worked in services both in Dublin and outside Dublin . I have provided a Consultant liaison service to the Obstetric departments in the Hospitals I have worked in , and would also have managed many patients in our clinics throughout their pregnancies , before and after delivery .

I have worked in Addiction services in Ireland and the UK , and been involved in the management of pregnant women with Addiction disorders and mental illness . I have also worked very briefly as a Consultant in a Perinatal Psychiatric Service.

Treatment plans and delivery of psychiatric care always involve the Multi-Disciplinary Team . Routine practice for Consultant Psychiatrists working in services where there are no Perinatal Psychiatry services would include accepting referrals from GPs , Public Health Nurses and Obstetricians & Gynaecologists .Conditions assessed and treated would include women considering pregnancy or in any of the Trimesters of pregnancy presenting with Anxiety Disorders , Mood Disorders and Psychosis . Occasionally women are referred who have been traumatised by previous difficult or distressing pregnancies or deliveries. These patients are managed through their next pregnancy and often have a very good outcome .

Written Submission to the Oireachtas Committee for Health and Children with regard to the Protection of Life during Pregnancy Bill .

My name is Dr Jacqueline Montwill, I have worked as a Consultant Psychiatrist in General Adult Psychiatry for over 8 years . I am a Member of the Royal College of Psychiatrists and I am on the Specialist Register of the Medical Council of Ireland for Psychiatry .

I have worked in services both in Dublin and outside Dublin . I have provided a Consultant liaison service to the Obstetric departments in the Hospitals I have worked in , and would also have managed many patients in our clinics throughout their pregnancies , before and after delivery .Treatment plans and delivery of psychiatric care would involve the Multi-Disciplinary Team . Routine practice for Consultant Psychiatrists working in services where there are no Perinatal Psychiatry services would include accepting refererrals from GPs , Public Health Nurses and Obstetricians & Gynaecologists .Conditions assessed and treated would include women considering pregnancy or in any of the Trimesters of pregnancy presenting with Anxiety Disorders , Mood Disorders , Psychosis , and occasionally women traumatised by previous difficult or distressing pregnancies or deliveries.

Recommendations

Head 4 : Risk of loss of life from self – destruction

1) (b) (ii) There is no situation when a patient presents with suicidal ideation during pregnancy where the risk of suicide can be averted only by termination of pregnancy . The reason for this is that the appropriate treatment for any suicidal patient is :
    1) Ensure the patient's safety (in hospital or at home)
    2) Psychological support / Counselling
    3) Psychotropic Medication

ALSO : There is no evidence to support Abortion as a treatment for Suicidal ideation or threats .

2) It is stated that it will always be a matter for the patient to decide if she wishes to proceed with a termination following a decision that it is permissible under the Act . Unfortunately there is no stated time frame in which this decision is to be made. It must be noted that suicidal feelings and thoughts can change and disappear with the appropriate intervention and support. Therefore it is possible that at the time of the Medical Procedure, that the patient would no longer be suicidal. Would the Termination following this be lawful under the Act, seeing as the potential risk to life of the Mother is no longer present.

3) This also raises the question of whether Termination of Pregnancy under this Bill will be lawful up to 38 weeks' gestation and longer . There is evidence that women who have late abortions have worse mental health outcomes. It is clear that from possible viability the right of the unborn should surely prompt early delivery as the most ethical way of terminating the pregnancy .

4) In the Explanatory notes it is described that " The decision would be reached following a multidisciplinary discussion in accordance with medical best practise "

   - This does not seem to be possible, as the procedure indicated is in itself not best medical practice.

5) <u>CONSENT</u>

   A patient must give their consent for any medical procedure. In the cases of Psychiatric Emergency, or Acute distress, frequently a patient's judgement is impaired. The duration of this impairment can vary, and resolution occurs with appropriate treatment . It would be unethical to impose a procedure on a patient, when it is not seen as an essential, best practise life saving treatment; and also when the patient may not have full mental capacity to give a valid consent to such a procedure. In a case where a patient's judgement is impaired, and where it could rightly be seen to affect the patient's capacity to

consent to the procedure, their right to bodily integrity would be violated. It could also be argued that the treating Doctors failed in their duty to adequately protect the patient during a period of mental illness.

6) It has not been stated that patients who are detained for treatment under the Mental Health Act 2001 (MHA) will not be eligible for this Bill. Abortion is not a Psychiatric treatment and could not be given to a patient who is detained in hospital under the MHA for treatment of their mental illness / mental disorder.

7) There is no evidence to support the view that Abortion has any mental health benefits, there is evidence to support that in some women Abortion may be associated with small to moderate increases in risks of mental health problems including suicidality. There is an ethical problem in offering a procedure as a life saving treatment to suicidal women, where that intervention also poses risks of suicidal ideation as an outcome.

8) It has been correctly stated that suicide in pregnancy is very rare. In these cases suicide is a symptom of mental illness, and will resolve if the patient has appropriate psychiatric treatment.

9) In my opinion , it has been incorrectly stated that Abortion will " save many lives that would otherwise be lost " – this is because an assumption has been made that patients who choose to travel to have an Abortion abroad do so when they are suicidal . There is no data to support this, other than the fact that over 95% of Abortions in the UK are done on "Mental Health Grounds ".

Dr Jacqueline Montwill , MRCPsych , MB, BCh, BAO; MCRN 16382
Consultant Psychiatrist May 8th 2013

ORAL SUBMISSION TO JOINT OIREACHTAS COMMITTEE ON HEALTH AND CHILDREN PUBLIC HEARINGS ON THE PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013

Dr Seán Ó Domhnaill MB DPM MRCPsych PG Dip. CBT

Consultant Psychiatrist & Psychotherapist

My name is Dr Seán Ó Domhnaill, I am Consultant Psychiatrist in General Adult Psychiatry employed by the Health Service Executive. I have worked exclusively in Psychiatry since 1997, having graduated from the Royal College of Surgeons in Ireland in 1994.

I'd like to thank the Committee for asking me to comment on the heads of the Bill. I, however, share some of the concerns expressed by Deputy Billy Timmins and others who have queried whether this consultation is meaningful if the government does not take the expert evidence into account in regard to abortion and suicidality.

There was complete agreement from all the psychiatric experts who gave evidence in January that abortion - the direct and intentional killing of the unborn child - was not a treatment for suicidality. I find it quite extraordinary then, that this government has seen fit to disregard all the evidence accrued and to cynically propose legalising abortion on suicide grounds.

I would like to draw the Committee's attention to recent votes at the conferences of the Irish Medical Organisation and the Irish College of General Practitioners where motions in support of abortion, even within the limitations envisaged in the "X-case" ruling, were voted

down, and where it clearly emerged that the majority of doctors do not support legalising abortion on suicide grounds. We are a profession which is very much evidence-based in our approach to our work and there is no evidence base for the proposal to allow abortion for suicidality, regardless of any attempts to restrict the scope of the proposal. If there is no case for treatment of suicidal intent using abortion, then there is no point in proceeding with this legislation. We should nail the lie at this point, that Ireland has any obligation imposed by the European Court of human Rights to legislate for abortion. The ECHR has requested that we "clarify" our law, ***not write new law!***

Now to the Bill, which I believe has been misnamed since, while every person wishes to protect women in pregnancy - and I would support **absolute clarity** for those medical practitioners, including myself, caring for pregnant wo6men - the primary purpose of this proposal is not the protection of life during pregnancy, but the deliberate ending of one life, during pregnancy.

It would have been possible to provide further clarity for the protection of women in pregnancy without legalising abortion. This government has chosen instead to include the deliberate destruction of unborn human life.

This is an enormous change for Irish medical practice, and, in my view, a hugely retrograde step.

Abortion has no place in modern medicine; it is a medieval solution to crisis pregnancy. This Bill is not about saving lives - as it allows the killing of a physically healthy baby carried by a physically healthy mother. All of this is despite the evidence which shows that abortion does not reduce mental health risks and may be associated with an increased risk of mental health problems.

There are 5 key points I would like to make briefly about the Bill.

1. How would this proposal operate in practise? It's time for a reality check. I have enormous respect for Irish medical practitioners who are very often working under extremely difficult conditions and in under-resourced hospitals. However, I would like to introduce some reality to the debate around Head 4 of this Bill.

It is a fact that there are some psychiatrists who are ideologically supportive of abortion, and who believe that abortion should be available on request/on demand to Irish women. It stretches the boundaries of credibility to suggest that those psychiatrists would not be more likely to approve abortions if this Bill becomes law. As it is, they are demanding that only Psychiatrists who are in agreement with them be allowed to participate in the panels outlined in the Heads of Bill.

We have seen this play out in practice in many other jurisdictions. I would remind the Committee of the experience of California, where abortion was legalised in 1967 on several grounds, one being to preserve the mental health of the pregnant woman, under supposedly very restrictive conditions. It was required that a hospital committee unanimously agreed that the pregnancy was causing such an extreme mental health risk to the pregnant woman that she would be required to be committed to a psychiatric institution.

Despite this, in 1970 more than 65,000 abortions were approved and almost 63,000 abortions were performed - 98% being for "for reasons of mental health."

Did all 63,000 abortions take place according to the spirit of the law? The notion is ridiculous. **The California Supreme Court questioned the integrity of the process saying that "serious doubt must exist that such a considerable number of pregnant could have been committed to a mental institution."** Evidently some doctors who believed that

women had a right to access abortion used the subjectivity of making a judgment on mental health grounds for abortion in order to make abortion freely available. We all know of the experience in Britain. It mirrored almost exactly that of California and in the same year. We need to be honest, something that has been lacking in this debate so far, and to stop fooling ourselves that things will be any different here in Ireland.

2. My own experience in psychiatry has been that abortion can be harmful to women and that this is largely ignored by those supporting abortion legislation. I find it extraordinary that Women Hurt By Abortion have been excluded from these hearings. This is a broad-based consultative process, not simply a professional forum, because abortion is not primarily about medical emergencies. It is usually about psychosocial stressors and the choices people make in response to these.

We have all read the tragic story of Miss C, forcibly taken abroad for an abortion by the State into whose care she had been placed and which, she says quite categorically, left her suicidal and caused her to attempt to take her own life many times.

The distress is very real, and the loss felt by these women feel is very acute. The harshness and lack of sympathy expressed by abortion supporters towards Women Hurt and towards Miss C is, frankly, breathtaking.

3. I am in full agreement with Dr Sam Coulter Smith who spoke for many of his colleagues when he said that "our psychiatric colleagues tell us that there is currently no available evidence to show that termination of pregnancy is a treatment for suicidal ideation or intent and, as obstetricians, we are required to provide and practice evidence-based treatment. It,

therefore, creates an ethical dilemma for any obstetrician who is requested to perform a termination of pregnancy for the treatment of someone with either suicidal ideation or intent."

It is my opinion that psychiatry cannot support a provision which obliges Obstetricians to deliberately end the life of a child being born to a physically healthy mother, when the evidence that abortion is a treatment for suicidality simply does not exist.

I noted, as did many others, that two Obstetricians from the National Maternity Hospital gave evidence on Friday and I wondered why two obstetricians from the same institution were invited to give their opinions, especially since they are so closely related. I would like to ask if the view of the Master of the Coombe was sought.

4. The reality of abortion is being ignored in these hearings as much as it is in the general discussion around this issue. The heads of the Bill make no reference to how abortion procedures should be carried out. This Bill seeks to turn doctors into abortionists. We know from the website of the British National Health Service that unborn children before 12 weeks gestation will be sucked from the womb by a razor vacuum, while after 15 weeks of pregnancy the doctor will have to cause a fatal heart attack and deliver the baby whole or piece by piece. Do not be fooled: the suicide clause in this Bill is about killing babies, not about early delivery.

5. Finally, the evidence of medical experts has been remarkably consistent during these hearings. You have heard from St Patrick's University Hospital - Ireland's leading psychiatric hospital - who said that there is "no evidence either in literature or from the work of St Patrick's University Hospital that indicates that termination of pregnancy is an effective treatment for any mental health disorder or difficulty".

You have now heard Professor Kevin Malone who has stated in his submission that abortion is not a treatment for mental illness in any textbook of psychiatry and asked how can it suddenly become a recommended psychiatric treatment in this legislation. This is one of the world's leading suicide researchers. He must be listened to.

This Committee, and this Government, has heard this evidence before.

I sincerely hope that you display the integrity expected of you by the People of this nation and that you respond to what you have heard, on this occasion. Mothers and babies deserve better than an ideologically-driven Bill which seeks to end, rather than protect, human life in pregnancy.

Dr Seán Ó Domhnaill, Consultant Psychiatrist.

Mental Health Commission
Presentation to the
Joint Committee on Health and Children
on the Protection of Life during Pregnancy (Heads of) Bill 2013

Mr John Saunders, Chairman, Mental Health Commission.

Chairman and members of the Committee, as you are aware, the Mental Health Commission is an independent statutory body established in April 2002 pursuant to Section 32, Mental Health Act 2001 ("the 2001 Act"). The Commission was established to perform the functions conferred on it by the 2001 Act which was commenced in full in November 2006.

The role of the Commission is to promote encourage and foster high standards and good practices in the delivery of mental health services and to protect the interests of persons detained in approved centres.

The Commission's remit extends across the broad spectrum of mental health services. Mental health services are defined in section 2 of the Mental Health Act 2001 as "*services that provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist*".

The procedures referred to in the Heads of Bill do not fall within the definition of mental health services and by extension are not within the remit of the Commission.

All references to the Mental Health Commission in the Heads of Bill solely relate to the registration of a centre at which the psychiatrists involved must be employed.

There are two references to the Mental Health Act 2001 ("the 2001 Act"), both of which indicate that the 2001 Act provided guidance to assist the drafting of the relevant heads.

The Mental Health Commission notes that the Committee is seeking its views on how the proposed legislation will operate. The Heads of Bill clearly specifies that operational matters will be the responsibility of the Health Service Executive (HSE) and agencies providing health and social care services on behalf of the HSE under section 38 of the Health Act 2004.

It is suggested by the Commission that the HSE and relevant Section 38 agencies are best placed to advise the Committee regarding operational matters.

The regulatory body for an "appropriate location" as defined in Head 1, is the Health Information and Quality Authority (HIQA).

The regulatory authority for the relevant medical practitioners is the Medical Council.

Formal medical review procedures will be the responsibility of the HSE who shall be required to establish a panel of relevant experts populated with nominees from the relevant colleges, including the Irish College of Psychiatry.

Therefore, there is no role for the Commission under any of the Heads in relation to assessment or oversight.

General Comments in relation to the Protection of Life During Pregnancy (Heads of) Bill 2013

The Commission, from its experience in implementing provisions of the Mental Health Act 2001, makes the following general comments in relation to certain matters arising in the Bill that in the view of the Commission may assist the Committee in formulating its report to Government.

Head 1 Interpretation,

- "psychiatrist" means a medical practitioner who is registered in the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007 under psychiatry.

  It is suggested that clarification is required to ensure inclusion of relevant specialities within psychiatry "Self- Destruction" no definition provided.

- " Head 6, subhead (4) refers to the appointment and authorisation by the HSE of one or more of its employees with appropriate qualifications and experience for the purposes of establishing and convening a committee for the purposes of a review. It is unclear as to what constitutes "appropriate qualifications and experience". The Mental Health Act 2001 may provide guidance in this regard, specifically Section 9(8), and the Mental Health Act 2001 (Authorised Officer) Regulations 2006 (S.I. Number 550 of 2006), whereby the grade of person who is authorised to perform the role of an "authorised Officer under the 2001 Act" is prescribed.

Head 4

- Clarification is provided in the explanatory note that the two psychiatrists involved must be employed at an approved centre and one of them must be attached to an institution where the procedure will be carried out.

The Commission advises the Committee that the above criteria may exclude psychiatrists working within specialist community mental health services as they are not always employed at an approved centre, i.e. a centre that is registered by the Mental Health Commission. A requirement that one of the psychiatrists involved must be attached to an institution where the procedure is to be carried out is a further restrictive criterion as there are only three such psychiatrists and they provide services on a part-time basis in the Dublin region only.

- Risk of loss of life from self-destruction.

The explanatory note refers to self destruction as 'suicidal intent', however this term is not specifically stated within Head 4 or in the interpretation section Head 1.

Head 5

- The Commission is of the view that the reasonable opinion of the medical practitioners should be (a) required in writing, following (b) an examination of the woman concerned and (c) the reason(s) for the opinion should be provided.
- The definition of "examination" in Part 2, Mental Health Act 2001 may be of assistance. In relation to certain procedures under the 2001 an examination means "...a personal examination carried out by a registered medical practitioner or a consultant psychiatrist of the process and content of thought, the mood and the behaviour of the person concerned".

Head 8

- The Heads of Bill is silent in relation to a mechanism for appeal of a decision of a Review Committee.

Heads of Bill in relation to a person under the age of 18 yrs.

- The Heads of Bill is silent in relation to a requirement to hear, consider and document the views of a woman who has not yet reached the age of consent.
- A child who has a mental disorder and is receiving care and treatment for their mental disorder in an approved centre is detained under Section 25 of the Mental Health Act 2001. A decision in relation to the administration of electroconvulsive therapy may only be provided by the District Court. The Heads of Bill is silent in relation to children detained under the Mental Health Act 2001.

Congenital Heart Disease in Pregnancy

Dr Kevin Walsh,
Consultant Cardiologist (Adult and Paediatric Congenital Heart Disease)
Mater Misericordiae University Hospital, Eccles Street Dublin 7
Our Lady's Children's Hospital, Crumlin, Dublin 12

BIO:
TCD Graduate 1981
Postgraduate Training in Dublin, London and Liverpool
Consultant Cardiologist , Alder Hey Children's Hospital, Liverpool 1989-99
Consultant Cardiologist in Dublin since 1999 where I work both in Our Lady's, Children's Hospital, Crumlin and at the Mater. The Mater Adult Congenital Heart Clinic provides a National Service for patients with "Gown-up Congenital Heart Disease". We also have a joint service with Dr Peter McKenna from the Rotunda Hospital for Maternal Heart Disease.

Advances in treatments for congenital heart disease over the last 50 years has created a cohort of survivors with heart disease that has been either palliated or repaired, but with significant residual problems requiring ongoing medical supervision and repeat catheter and surgical interventions. In the Republic of Ireland there are approximately 1700 adults alive with complex congenital heart disease and 14,000 adults with simple congenital heart disease. Many women with repaired congenital heart disease wish to have children. There are now more pregnant women with congenital heart disease than acquired heart disease in the developed world.

Pregnancy causes significant changes to cardiovascular physiology with marked increases in blood volume, cardiac output (increased stroke volume and heart rate) and a reduction in systemic vascular resistance (reduced blood pressure). These changes may be tolerated poorly by women with:
1) pulmonary vascular obstructive disease of any cause (usually Eisenmenger syndrome),
2) very poorly functioning systemic ventricles,
3) severe left sided obstructive lesions.

Pregnancy also causes changes in the vascular wall with a risk of aortic dissection in patients with coarctation of the aorta, Marfan syndrome and Ehlers Danlos syndrome.

A pro-thrombotic state exists during pregnancy and women with artificial valves have an increased risk of life threatening valve thrombosis. The oral anticoagulant Warfarin crosses the placenta and can cause embryopathy in the first trimester, haemorrhage and fetal loss throughout pregnancy. Heparin injections are therefore often substituted as it does not cross the placenta but is a less effective anticoagulant; even if meticulously monitored the mother the mother is at risk of potentially valve thrombosis.

Pre-conception counseling is an important part of the care of these women and should start once puberty is underway. Risk assessment and planning of management during pregnancy for these women is conducted through a joint Mater/Rotunda Maternal Heart Disease multidisciplinary team meeting involving obstetrics, cardiology, anesthesia and haematology. This results in 3 to 4 high risk women/year being delivered in the Mater Hospital rather than in the Rotunda so that they can be monitored more closely and go to Intensive Care for post-partum monitoring. With this Mater/Rotunda team approach there have fortunately been no maternal deaths in our group of patients with congenital heart disease over the last 10 years.

In pregnancy with congenital heart disease the elective termination rate was reported as 5% by Drenthen et al (PDF attached). Communications with colleagues from the UK with large Adult Congenital Heart Disease practices report very small numbers of terminations for medical reasons - 1or 2 a year out of a practice of 3000 women with adult congenital heart disease. This lower than reported termination rate is probably because good pre-conception counselling means that most high risk women either don't get pregnant or know the pregnancy will be very high risk before they start. The terminations have been either early with accidental pregnancy or late to save the mother's life - 2 in 13 years. **(Head 2)**

When termination is required to save the life of a woman with critical illness then it would have to be performed in the adult major teaching hospital with access to intensive care and the relevant specialists. This clearly would not be the case in any of the Dublin public obstetric hospitals. The termination would likely be on an urgent planned basis rather than immediate emergency basis. **(Subhead (1) and Head 3)**

Good evening, Mr Buttimer and members of the Committee

I would like to thank you for the invitation to express my opinion as a Medical Oncologist on the proposed Heads of Bill as presented for cancer in pregnancy. I am a Consultant Medical Oncologist in both St Vincent's University Hospital and the Adelaide and Meath Hospital Tallaght.

Cancer is a disease of increasing age so while cancer during pregnancy is encountered; it is rare. International data suggest that it complicates approximately 0.1% of all pregnancies, therefore in the absence of published Irish data we estimate there are approximately 60-70 cases diagnosed in Ireland per year. However, with increasing age of childbearing, it is likely that this number will increase. In pregnancy, a variety of cancers occur but breast cancer, haematologic cancers such as lymphoma or leukaemia, gynaecological and skin cancers are the most frequently encountered. As you have many gynecologists who can comment on surgical cancer treatment on the panel, my focus is the administration of drugs during pregnancy. Agents used in Medical Oncology include traditional cytotoxic chemotherapies, biological therapies and anti-hormonal agents which for convenience I will refer to as "chemotherapy" going forward.

When considering the implications of this bill for cancer in pregnancy. Two main questions arise:

1. **Does the pregnancy confer a worse outcome to the pregnant mother with cancer and if so, will a termination of pregnancy improve her outcome? The literature here is consistent in demonstrating a lack of evidence to suggest that termination will abrogate mortality risk in pregnant women with cancer.**

2. **Does the administration of chemotherapy in the pregnant woman put that woman's life at risk in a way that is not experienced in the non pregnant woman?**

In clinical practice, we in the hematology and medical oncology field not infrequently navigate this challenging scenario. In the vast majority of cases, chemotherapy will be administered to the pregnant woman as curative or life prolonging therapy without significant modification as per international guidelines. We work very closely with our obstetric colleagues to identify the optimum time for delivery of the baby (striving for fetal maturity rather than just fetal viability).

> **There are risks with chemotherapy administration in every trimester for mother and fetus, however available evidence suggests that many of the agents used in the treatment of cancer have a safe profile particularly if initiated after the first trimester thereby minimising risk to the unborn. As doctors, a challenge for us is balancing the risk of fetal abnormalities in the unborn as a result of the administration of chemotherapy during the first trimester or its deferral until a potentially safer time for the fetus but this has implications for the mother when immediate chemotherapeutic intervention is required. Organogenesis occurs during week's five to ten of gestation. The administration of chemotherapy may have unintended complications, requiring intensive care unit management potentially threatening the life of the mother. May a termination be required to save the life of the mother in this circumstance, it is possible but these situations are exceedingly rare.**

In answering these questions, I do acknowledge a dearth of large prospective randomised trials investigating each question here but through retrospective cohort studies, case series and case reports the results achieved reach similar conclusions regardless of what country the study was performed. It is universally recognised that treatment recommendations in pregnant women with cancer will always rely on limited evidence.

My only comment in appraising the Heads of Bill is that should a situation arise where the life of the mother is at significant risk, it would be advisable that two medical practitioners on the Specialist Register with expertise in this area be involved in the certification process with the Consultant Obstetrician e.g. two Consultant Medical Oncologists or Consultant Haematologists as they would have the medical expertise to advise and guide in this difficult area.

Thank you

Dr Janice Walshe

M.B., B.Ch., B.A.O, MRCPI

Joint Committee on Health and Children Public

Hearings on the Protection of Life During Pregnancy (Heads of) Bill 2013

Written Submission

Paul Brady BL

21st May 2013

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(c) Head 4 does not require a procured abortion to be offered only as a "treatment" for a recognised medical condition. 8

(d) Head 4 does not require a procured abortion to be an option of last or ultimate resort. 8

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APPENDIX 14

BIOGRAPHICAL NOTE

I was called to the Bar in 2006 and am a practising barrister. I have a specialist interest in constitutional law, mental health law and medico-legal ethics and am a co-author of the book *Psychiatry and the Law* (2nd edition, Blackhall, Dublin, 2010).

I am currently completing a doctorate in the philosophy of law at Balliol College, Oxford. Prior to that I obtained an LLM from Harvard Law School where my studies included comparative constitutional law, jurisprudence and international law. I have a MA in Legal and Political Theory (Distinction) from University College London. My thesis addressed different conceptions of disability and their relevance for the articulation of disability rights in law. I also wrote a dissertation on the place of moral argument in liberal politics with reference to the work of John Rawls and Ronald Dworkin. I hold a First Class Honours degree in Philosophy from UCD and am a former recipient of the NUI Pierce Malone Award in Philosophy. I studied law in the King's Inns where I was awarded the Antonia O'Callaghan Memorial Prize in Constitutional Law and, on graduation, the Society's Exhibition Prize.

I have given tutorials, seminars and lectures at Griffith College Dublin, Trinity College Dublin and University College Dublin in the fields of constitutional law, jurisprudence and medico- legal ethics respectively.

My other publications include a chapter on the social and political foundations of the 1922 Irish Constitution in a forthcoming edited volume by Cambridge University Press and an article on statutory interpretation in light of the European Convention on Human Rights published in the UK's Statute Law Review.

I am a former Fulbright Scholar and O'Reilly Foundation Scholar. In 2008 I was the recipient of a NUI Travelling Studentship and a doctoral award from the UK's Arts and Humanities Research Council.

WRITTEN SUBMISSION

(1) Introduction

From the public discussion of the Heads of the Protection of Life During Pregnancy Bill 2013 since their publication it appears there is still some confusion as to what is permissible under the proposed legislation with respect to abortion on the grounds of risk from suicide. If an informed and reasoned debate on the merits of this aspect of the Bill is to be possible in the coming weeks or months, a necessary first step is to achieve some level of clarity as regards:

(a) what restrictions on abortion on the grounds of risk of suicide are and are not contained in Head 4 of the Bill; and

(b) what, if any, is the legal requirement to legislate for such abortions.

This submission is addressed to answering (albeit in a condensed manner) these two questions. Section 2 makes a few comments on terminology that is relied upon in what follows. Section 3 considers 6 features of Head 4 which I believe are significant but perhaps not yet sufficiently well understood. In light of the points raised Section 4 goes on to discuss to what extent the Oireachtas is under an obligation to legislate for abortion on the grounds of risk of suicide on foot of the X Case[1] and the *A, B & C v Ireland*[2] case.

(2) Note on terminology

For the sake of clarity it is useful to define and justify one's terminology at the outset. This submission shall use the following terms for the reasons stated:

"unborn child" – Embryo and foetus are specialised medical terms for the unborn which are appropriate in certain contexts, particularly where it is important to be precise about the gestational or anatomical features of the developing human life. Neonate or pre-pubescent are similar specialised terms that may be used to distinguish different stages in physiological development after birth. Legally speaking, however, "unborn child" is a recognised term in Irish statute[3] and case law,[4] as well as European case law,[5] and there is no basis for not using such a term in formal legal discourse.

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[1] *The Attorney General v. X.* [1992] 1 IR 1.

[2] 25579/05, Judgment (Grand Chamber) 16 December 2010.

[3] Section 58 of the Civil Liability Act 1961 states: "For the avoidance of doubt it is hereby declared that the law relating to wrongs shall apply to an unborn child for his protection in like manner as if the child were born, provided the child is subsequently born alive."

[4] See, e.g., *G. v. An Bord Uchtála* [1980] 1 IR 32; *The Attorney General (S.P.U.C.) v. Open Door Counselling Ltd.* [1988] IR 593; *The Attorney General v. X.* [1992] 1 IR 1.

[5] See, e.g., *H v Norway*, 17004/90, Decision (Admissibility), 19 May 1992; *Boso v Italy*, 50490/99, Decision (Admissibility), 5 September 2002; *Vo v France*, 53924/00, Judgment (Grand Chamber), 8 July 2004; *A, B & C v Ireland*, 25579/05, Judgment (Grand Chamber) 16 December 2010; *R.R. v Poland*, 27617/04, Judgment (Fourth Section), 26 May 2011.

"procured abortion" – This term is used to mean the direct and intentional killing of the unborn child. It is used to avoid the ambiguity in the phrase "termination of pregnancy" and to distinguish the procedure from other uses of the term "abortion" in medical discourse, e.g. spontaneous abortion. It is consonant with the following definition of abortion offered by the Supreme Court in *The Attorney General (S.P.U.C.) v Open Door Counselling Ltd*[6]:

> *"The performing of an abortion on a pregnant woman terminates the unborn life which she is carrying. Within the terms of Article 40, s. 3, sub-s. 3 it is a direct destruction of the constitutionally guaranteed right to life of that unborn child."* (emphasis added).

"the X Case test" – This phrase will be used as a short-hand for the binding interpretation of Article 40.3.3 authoritatively decided by the Supreme Court in *The Attorney General v X*[7] (the "X Case), which was summarised by Hamilton J in *In re Article 26 and the Information (Termination of Pregnancies) Bill 1995*[8] as follows:

> *"The Attorney General v. X. ... established that having regard to the true interpretation of the Eighth Amendment, termination of the life of the unborn is permissible if it is established as a matter of probability that there is a real and substantial risk to the life, as distinct from the health, of the mother and that that risk can only be avoided by the termination of her pregnancy."* (emphasis added).

(3) What Head 4 permits as currently drafted and how it may operate in practice

Head 4 is entitled "Risk of loss of life from self-destruction".

It provides as follows:

> *"(1) It is not an offence to carry out a medical procedure, in accordance with this head, in the course of which or as a result of which unborn human life is ended, where–*
>
> > *(a) that procedure is carried out by a registered medical practitioner at an appropriate location,*
> >
> > *(b) one obstetrician/gynaecologist, who must be employed at that location, and two psychiatrists, both of whom shall be employed at a centre which is registered by the Mental Health Commission, and one of whom shall be attached to an institution where such a procedure is carried out, in accordance with this head, jointly certified in good faith that –*
> >
> > > *(i) there is a real and substantial risk of loss of the pregnant woman's life by way of self-destruction, and*

[6] [1988] IR 593 per Finlay CJ at 625.

[7] [1992] 1 IR 1.

[8] [1995] 1 IR 1.

(ii) in their reasonable opinion this risk can be averted only by that medical procedure.

(2) (a) At least one of the three medical practitioners referred to in paragraph (b) of subhead (1) shall consult with the pregnant woman's general practitioner where practicable.

(b) In forming the aforesaid opinion, the medical practitioners should examine the woman.

(3) Where three medical practitioners referred to in this head have jointly certified an opinion referred to in paragraph (b) of subhead (1), the certifying obstetrician/gynaecologist referred to in paragraph (b) shall forward the certificate to a location referred to in paragraph (a) of subhead (1) and shall make arrangements for the carrying out of the procedure at that location.

(4) It will always be a matter for the patient to decide if she wishes to proceed with a termination following a decision that it is permissible under this Act."

The following does not purport to be an exhaustive discussion of the issues raised by Head 4. Rather it is an attempt to explain some of the most significant features of Head 4 and to dispel some of the misunderstanding that surrounds them.

(a) Head 4 permits the direct and intentional killing of the unborn child.

First, we must be clear that Head 4 creates a new and unprecedented statutory basis in Irish law for the direct and intentional termination of an unborn child's life, i.e. for procured abortion. For the first time in Irish law there will be a formal legislative framework for a medical procedure the defining object (or success condition) of which is not merely the relocation but the death of the unborn child. This would appear to represent a significant change in existing medical practice. This existing practice was well articulated by Dr Rhona Mahony (Master of the National Maternity Hospital) at the Joint Committee on Health and Children's hearings in January 2013 when she stated:

> *"In my hospital last year we had three cases in which we had to intervene prior to foetal viability because of our concern that a woman would die. There is a tiny number of cases, 30 or 40 is an overestimate. The figure nationally is more likely to be between ten and 20. We never kill a foetus. That is not our aim. Occasionally it is required that we deliver a pregnancy before the baby is viable or capable of surviving in our neonatal intensive care unit. When there is any possibility at all that we can preserve the life of the baby we will do so. We are able to do so from very low gestations, from 23 weeks on and in those cases Members can be very certain that we will make every effort to preserve life.*
>
> *In other cases, we are required to terminate a pregnancy as part of a treatment of a medical condition because we feel a woman will die. That is not killing the baby.*

That is simply delivering the baby before it is viable. There is a difference. It is always our wish to preserve life and society should be very reassured about that. "[9]

Consider the underlined words. It is clear that they could not be applicable to a "medical procedure" carried out under Head 4, i.e. a procedure which is carried out with the guiding goal of killing an unborn child in order to give effect to a decision that a real and substantial risk to the pregnant woman's life from suicide can only be averted by a procured abortion.

(b) Head 4 permits late-term procured abortion (i.e. after viability).

Second, we must be clear that under Head 4, and depending on the circumstances of the individual case, a procured abortion could lawfully be carried out at any stage in pregnancy. The claims made by some that it would always be illegal to intentionally kill an unborn child after viability are simply not supported by anything in the Bill as it is presently drafted. The point is easily illustrated: If a woman presents to a psychiatrist late in her pregnancy, perhaps as a result of a traumatic experience of some sort, and states that the very thought of having a baby makes her want to kill herself or that she would rather die than have this baby and give it away, on what basis under the current Bill would a psychiatrist necessarily be breach of the law in certifying a late-term procured abortion? After all the psychiatrist is quite free (legally speaking) to form an opinion in good faith that it is the very prospect of the child's future existence which is driving the woman's suicidality. On this analysis, and notwithstanding the need to preserve unborn human life as far as practicable, the psychiatrist might conclude in good faith that the risk of suicide in such a case cannot be averted by an early inducement of labour but can only be averted by a procured abortion, i.e. by a medical procedure "as a result of which unborn human life is ended" (to use the language of the Bill). If she and a colleague of her choice[10] formed such an opinion, and the obstetrician was content to defer to their expertise in the area of suicidality, the terms of Head 4 would permit a late-term abortion to be certified and carried out in such circumstances.

It is quite understandable that some people's initial reaction might be to criticise this analysis as extreme or alarmist. This is quite natural as the scenario is indeed an alarming one and legislates for an extreme position on abortion that most would find morally objectionable whatever their views on early-term abortion. But it is always a mistake to shoot the messenger. And it is even worse to do so when you know that the message is correct but you simply do not like it or do not want others to hear it.

To be clear, it is not suggested here that the fact that Head 4 allows for the possibility of a procured abortion at any stage of pregnancy is the result of any malice or carelessness on the part of the proposers or drafters of this Bill. On the contrary it is submitted that the possibility of late-term abortion is a necessary consequence of the faithful application of what is defined above as the X Case test to a risk other than one caused by the physiological effects of the pregnancy on the woman. In other words, it is not the test of "real and substantial risk to the life" per se that creates the possibility of lawful late-term abortion. This is because in applying that test to risks to the mother's life arising from obstetrical or other physical

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[9] Hearings, 8th January 2013, page 42.

[10] See sub-section (f) below.

conditions there is never a situation where the death of the unborn child is the intended and desired outcome of whatever medical treatment is required to avert the risk in question. The death of the unborn child may be an inevitable consequence of the treatment but it will not be the death *per se* that averts the threat, as distinct, say, from the fact that the child is no longer in the woman's womb. By contrast, if one allows the test of "real and substantial risk" to be applied to situations where it is claimed that the very fact of the present or future existence of the child (or, indeed, the thought of being refused an abortion) is itself the cause of a risk to the pregnant woman's life from suicide, then it is clear that the test could in such cases permit (and so require) a medical procedure the intended and desired outcome of which is the killing of the unborn child.

If this analysis is correct then an obvious question arises: Is the Oireachtas really required to apply the X Case test to the risk of death from suicide and to legislate for procured abortion on grounds of such risk? This will be considered in section (4) below.

(c) Head 4 does not require a procured abortion to be offered only as a "treatment" for a recognised medical condition.

(d) Head 4 does not require a procured abortion to be an option of last or ultimate resort.

These points can be taken together. Whatever one's views on the merits or morality of abortion on grounds of risk of suicide there is a duty to be honest and clear about how Head 4 will actually operate. For example, though many may be under the impression that abortion can only be offered as a last resort or when all other "treatments" for suicidality have been exhausted, there is in fact nothing in the Bill that requires anything like this. The test under Head 4 with respect to the permissibility of certifying a procured abortion for a woman at risk from suicide is whether the risk of self-destruction "can be averted only by that medical procedure".

Non-medics (such as lawyers and legislators) may not appreciate that from the perspective of psychiatry not every instance of suicidal ideation, intention or even behaviour necessarily constitutes or manifests a "mental illness" which can be "treated" by professional psychiatric interventions. A threat of suicide, including a very forceful and credible threat, by a person is, on its own, not a sufficient ground to admit that person as an involuntary psychiatric patient under Irish law.[11] This means that psychiatrists would be free to operate under the Bill as follows: in a case where for example (a) a pregnant woman says that she will kill herself if she is refused an abortion and (b) she is deemed not to be suffering from a recognised mental illness (or indeed from any medical condition), a psychiatrist may form an opinion in good faith that (a) one should always err on the side of believing a woman in such circumstances[12] and (b) there are no psychiatric treatment options which can first be tried for the simple reason that the woman does not have a recognised psychiatric condition. To be clear: psychiatrists will be lawfully entitled in such a case to consider the certification of a procured

[11] For the necessary and sufficient conditions see section 3 of the Mental Health Act 2001.

[12] The author is aware of at least one psychiatrist who has stated that her approach is to believe what a woman tells her.

abortion as the first and only option, not as an ultimate option of only last resort once other "treatments" have been tried and found ineffective.

(e) Head 4 permits a procured abortion to be carried out upon a partially delivered baby.

That the terms of Head 1 when read with Head 4 may, no doubt inadvertently, in principle permit partial-birth abortion is a shocking prospect. While this is an aspect of my analysis in which I hope that I am mistaken, it seems to follow necessarily from the definition given of "unborn" in the Bill. Head 1 defines "unborn" in a somewhat curious manner as follows:

> *"unborn" as it relates to human life means following implantation* *until such time as it has completely proceeded* *in a living state from the body of the woman.*

From the explanatory notes it appears that this definition was at least partly inspired by the suggestion of the Expert Group that there is a lacunae in the provisions of sections 58 and 59 of the Offences Against the Person Act 1861 such that there is no express criminal prohibition on the killing of a baby during delivery.[13] In other words, it appears that this definition was formulated so that a baby in the course of being delivered would, by being deemed an "unborn" for the purposes of the Bill, have the benefit of the criminal offence created at Head 19(1) which states:

> *"It shall be an offence for a person to do any act with the intent to destroy unborn human life."*

Unfortunately it does not appear to have occurred to the drafter(s)[14] that, by being deemed an "unborn", a baby in the course of being delivered does not just gain the benefit of protection under Head 19 but is simultaneously exposed to the risk of being lawfully terminated under Head 4 (for the reasons set out at (a) and (b) above).

(f) The requirement under Head 4 that an abortion can only be certified with the approval of three medical practitioners is not necessarily a robust safeguard in practice.

In practice obstetricians will not be deciding whether there is a real and substantial risk to the life of a pregnant woman from suicide or whether an abortion is the only way to avert that risk. This will fall to the two psychiatrists. In reality, however, the critical decision-maker under Head 4 will be the first psychiatrist who sees a pregnant woman presenting with suicidality of some form. If that psychiatrist is satisfied that the test set out in Head 4 has not been met then there is no point in him even contacting a second psychiatrist in order to examine the woman. Alternatively if the first psychiatrist does believe the woman should be certified for an abortion then he is free to contact a colleague of his own choosing to conduct the second examination. The explanatory memo says the Bill is deliberately silent on this referral process to allow flexibility. However this allows the first psychiatrist to choose only like-minded colleagues. Indeed he may have a colleague whom he virtually always asks in

[13] See "Report of the Expert Group on the Judgment in A, B and C v Ireland" page 51.

[14] I am not asserting for a moment that there is at present any medical practitioner in Ireland who would contemplate performing a partial-birth abortion. Ultimately, that is beside the point. At this stage of legislative drafting one should aim to identify all of the unforeseen and undesirable effects which may in principle follow from a proposal (however unlikely in practice) with a view to revising the drafting and avoiding as many such effects as possible.

this regard. Again, nothing said here is intended to cast aspersions on any current practitioners. One of the purposes of a critical legal analysis of a Bill at this stage is to identify what unintended or unforeseen consequences it may have. That is not the same as saying that these consequences will occur or even that they are likely to occur.

(4) Is the Oireachtas required to legislate for abortion on grounds of risk of suicide because of the X Case?

The Heads of Bill have been proposed on the basis that they legislate in a manner required by the X Case. But this move to legislate for the X Case was itself motivated by the decision in 2010 of the European Court of Human Rights in *A, B & C v Ireland*.[15]

The kernel of Court's ruling in favour of the third applicant, C, is expressed in its conclusion that

> *"the authorities failed to comply with their positive obligation to secure to the third applicant effective respect for her private life by reason of the absence of any implementing legislative or regulatory regime providing an accessible and effective procedure by which the third applicant could have established whether she qualified for a lawful abortion in Ireland in accordance with Article 40.3.3 of the Constitution."*[16]

Regrettably the Expert Group set up by the Government to advise on the implementation of the judgment gave no consideration in its report to the jurisprudence of the ECtHR or the documents of the Committee of Ministers with respect to the implementation of judgments by Contracting States. The starting point of any consideration as to the options available to Ireland in its execution of the *A, B & C v Ireland* judgment should have regard to the following four principles:

(a) It is primarily for the Contracting State to choose the means to be used in its domestic legal order in order to discharge its legal obligation under Article 46 of the Convention.[17]

(b) This "discretion"[18] or freedom[19] with respect to the choice of means is subject to the condition that such means are compatible with the conclusions set out in the Court's judgment.

(c) A central aspect of the obligation under Article 46 is the adoption of general measures that may be deemed effective for preventing the recurrence of a breach of the Convention similar to that found in the Court's judgment.[20]

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[15] 25579/05, Judgment (Grand Chamber) 16 December 2010.

[16] At 267. See further paragraphs 263, 264, 274, 277 and 279.

[17] *Scozzari and Giunta v Italy*, 39221/98 and 41963/98, Judgment, 13 July 2000 at para 249. See also, most recently, *Kurić and Others v Slovenia*, 26828/06, Judgment (Grand Chamber), 26 June 2012 at para 406. See also *Draon v France* 1513/03, Judgment, 6 October 2005 at para 106-108.

[18] *Papamichalopoulos and Others v Greece (Article 50)*, 14556/89, Judgment, 31 October 1995 at para 34.

[19] Ibid.

(d) In addition to the discretion and freedom noted above and with particular reference to the adoption of general measures in respect of positive obligations, a Contracting State enjoys a "wide margin of appreciation"[21] and it is not for the Court to indicate the most appropriate means for a State to adopt.[22]

Practically speaking, the principal test for assessing compliance with a judgment of the ECHR is whether the measures proposed by a State will be effective in preventing a recurrence of the original breach. Contrary to the relative cursory analysis given by the Expert Group to the matter in Chapter 7 of its report, it would be possible for the State to properly comply with what is required under *A, B & C v Ireland* by means of any of the four options identified by the report. Legislation with associated regulations is not the only practically and legally viable option. However, since that is the Government's preferred option and Heads of a Bill have been produced the more pressing question is now this: Is the Oireachtas constitutionally required to legislate for abortion on grounds of risk of suicide because of the X Case? It is submitted here that a careful reading of the X Case establishes that it is a binding authority for no more than what is defined above as the "X Case test". As a matter of Irish law, therefore, the Oireachtas is not under any legal obligation to legislate for abortion on grounds of risk of suicide.

To understand why one must begin by considering what the Supreme Court did and did not decide in the X Case. And before doing that it is necessary to recall that not everything which is said by a Court in the course of a judgment constitutes a binding precedent. One of the basic rules in this regard was stated by O'Dalaigh CJ in *The State (Quinn) v Ryan*[23] as follows:

> *"It requires to be said that a point not argued is a point not decided; and this doctrine goes for constitutional cases (other than Bills referred under Article 26 of the Constitution and then by reason only of a specific provision) as well as for non-constitutional cases."*

The same point was made by a Divisional High Court (Morris P, Carroll and Kelly JJ) in *Maguire v Ardagh*[24] as follows:

> *"The respondents contend that the argument made concerning the lack of an inherent jurisdiction to conduct an inquiry of the type in suit runs counter to the decision of In re Haughey [1971] I.R. 217. Despite the extensive nature of the argument made in that case, it does appear that this point was never argued. A point not argued is a point not decided. It may not have been raised for any number of reasons. One*

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[20] See "Rules of the Committee of Ministers for the supervision of the execution of judgments and of the terms of friendly settlements" (Adopted by the Committee of Ministers on 10 May 2006), Rule 6.2. See also Committee of Ministers Annual Report 2011 (April 2012) at p. 16. See also Interim resolution DH (99) 434 "Action of the security forces in Turkey: measures of a general character" (adopted by the Committee of Ministers on 9 June 1999 at the 672nd meeting of the Ministers' Deputies)

[21] See, e.g., *A, B & C v Ireland* para 233, 240 and 249.

[22] *A, B & C v Ireland* para 260.

[23] [1965] IR 70 at 120.

[24] [2002] 1 IR 385 at 445.

perhaps was that the particular inquiry in that case was being carried out with specific statutory powers pertinent to that inquiry. For whatever reason, the point was not argued or decided and therefore we do not think that the decision In re Haughey can be relied upon as providing judicial authority for the notion of an inherent power to conduct an inquiry of the type involved in this case."

This dictum of the Divisional Court was approved by the Supreme Court.[25]

Thus leaving aside the issues of EU law and the question of the direct enforceability of constitutional rights via the Courts, there were actually only two issues which were in dispute and argued before the Supreme Court in the X Case regarding the interpretation of Article 40.3.3 itself. To understand the first issue, however, one must first recognise what was conceded and thus was not argued. Counsel for the Attorney General formally conceded two points during the hearing of the appeal in the Supreme Court. The first was that "abortion" is lawful under Article 40.3.3 in certain circumstances.[26] That concession had the regrettable effect of excluding from the formal consideration of the Court the distinction between (procured) abortion and necessary life-saving treatment for the mother that animates current obstetrical practice in Ireland (as articulated by Dr Mahony in the passage quoted above). The second concession was that in certain circumstances an abortion could be the only way to avert the death of a woman from suicide and that such an abortion would be lawful under Article 40.3.3.[27] This concession had the equally regrettable effect of excluding from the formal consideration of the Court the evidentiary basis for the contention that abortion is an occasionally necessary means for protecting women from suicide. It also left unargued a range of important issues about the nature of and appropriate therapeutic responses to suicidality and the ethical, political and broader social policy implications of permitting a risk or a threat of suicide by one person to change the legal rights of another. An example of one of the more egregious factual inaccuracies contained in the judgments as a consequence of how the appeal was heard is included as an Appendix.

These concessions were extremely significant and fundamentally shaped the resulting arguments and judgments.[28] Indeed taken together they represent what many commentators and legislators today assume was decided by the Supreme Court in the X case. On the contrary the two issues of interpretation of Article 40.3.3 that were actually argued by counsel for Ms X, in light of the concessions made by counsel for the Attorney General, were:

(1) That Ms X was entitled to a lawful abortion under Article 40.3.3 because there was a real and substantial risk to her life;

[25] [2002] 1 IR 385 per Murray J at 598 and per Geoghegan J at 722. Note also Keane CJ (dissenting) at 517 who did not disagree with the principle as stated by the High Court but did dispute its interpretation of In re Haughey.

[26] *The Attorney General v. X.* [1992] 1 IR 1 at 32.

[27] *The Attorney General v. X.* [1992] 1 IR 1 at 36.

[28] The political context cannot be overlooked. The Government of the day encouraged the Ms X and her parents to appeal against the High Court decision and offered to pay their legal costs.

(2) That even if Ms X was not entitled to an abortion under Article 40.3.3 that her right to travel took precedence over the right to life of the unborn such that it would not be appropriate to injunct her from travelling to England.

As against this counsel for the Attorney General argued:

(1) That the correct test was whether there was an inevitable and imminent risk to the life of the mother;

(2) That a right to travel did not take precedence over the right to life of the unborn.

On point (1) Ms X won by a majority of 4 to 1. Strictly speaking that rendered point (2) obiter. On point (2) the Attorney General won by a majority of 3 to 2. What was never argued however (and therefore never formally decided) was the appropriateness of allowing the test of "real and substantial risk" to be invoked in order to justify a procured abortion on the grounds of a risk of suicide. It appears this aspect of the case was noted a few months after the decision in the X Case in a paper delivered by one of Ireland's most eminent constitutional jurists, Mr Justice Brian Walsh, speaking extra-judicially at University College Galway.[29] He stated that the Eight Amendment (which inserted Article 40.3.3)…

> *"confers no immunity for taking life and its stated objective is the preservation of and respect for life. It is perfectly consonant with the idea of the safeguarding of the mother's life without intentional and direct intervention to terminate the life of the foetus. The claim that it admits of direct termination has never been fully argued. In the X case it was conceded. There was no legitimus contradictor to argue against such a construction and therefore the court's decision can only bind the particular case as it was based on a conceded and unargued construction. It is well established that neither a constitutional provision nor even a statutory provision can be construed on the basis of a concession if it were to be binding in rem."*[30]

In sum, there is a strong case to be made that in legislating for the practical implementation of Article 40.3.3 the Oireachtas is bound by the X Case test (as defined in section (2) above) but is not bound by the application of that test by the majority of the Supreme Court to the circumstances of Ms X. A point not argued is a point not decided. The Court's application of the test was premised on concessions made by the parties which had the practical effect of precluding any airing or consideration of either argument or evidence in respect of the complex and weighty issues which legalising abortion on the grounds of risk of suicide necessarily raises. That these concessions should have determined the fate of such an important court case is perhaps regrettable. That 21 years later they should be determining the fate of our legislature's deliberations is no longer just unfortunate, it is inexcusable.[31]

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[29] "Justice and the Constitution", 11 November 1992.

[30] Quoted in Byrne & Binchy, *Annual Review of Irish Law 1992* at page 175.

[31] With apologies to the late Mr Justice McCarthy (*The Attorney General v. X.* [1992] 1 IR 1 at 82).

APPENDIX

The discrepancies between the expert psychiatric testimony given to the Joint Committee on Health and Children on 8th January 2013 and the assumptions about the nature of and proper treatments for suicidality in pregnancy underlying the judgments of the majority in the Supreme Court in the X Case is well illustrated by comparing the following two passages:

> *"If a physical condition emanating from a pregnancy occurs in a mother, it may be that a decision to terminate the pregnancy in order to save her life can be postponed for a significant period in order to monitor the progress of the physical condition, and that there are diagnostic warning signs which can readily be relied upon during such postponement.*
>
> *In my view, it is common sense that a threat of self-destruction such as is outlined in the evidence in this case, which the psychologist clearly believes to be a very real threat, cannot be monitored in that sense and that it is almost impossible to prevent self-destruction in a young girl in the situation in which this defendant is if she were to decide to carry out her threat of suicide.*
>
> *I am, therefore, satisfied that on the evidence before the learned trial judge, which was in no way contested, and on the findings which he has made, that the defendants have satisfied the test which I have laid down as being appropriate and have established, as a matter of probability, that there is a real and substantial risk to the life of the mother by self-destruction which can only be avoided by termination of her pregnancy."* (*The Attorney General v X* [1992] 1 IR 1 at 55 per Finlay CJ.)

> *"Another aspect that really has not been brought out pertains to when the expert group considered the emergency situation in a medical context. In such a situation as when, for example, a woman has had an epileptic fit and the baby must be delivered very quickly, speed is of the essence. In psychiatry, precisely the opposite is the case. Someone who is intensely suicidal often needs admission to hospital. It is exactly the opposite to the medical intervention and, consequently, even the notion of carrying out an emergency termination is completely obsolete in respect of a person who is extremely suicidal. I reiterate that in our practice, we see people who are profoundly depressed, who feel hopeless, worthless or utterly helpless to deal with situations. In such situations, one can see clearly the intervention usually is to admit such people into hospital, day hospital or home care but the intention is to support and help them through the crisis they are in. It is not to make a decision that is permanent and irrevocable."* (Perinatal psychiatrist Dr John Sheehan, Committee on Health and Children hearings, 8th January 2012)

Written Submissions

of

Dr Simon Mills, Barrister-at-Law

Joint Oireachtas Committee on Health and Children

9 January 2013

Executive Summary

This written submission commences with certain prefatory remarks concerning:

- The nature of the debate on abortion,
- The self-evident corollaries of the *X Case*
- Those aspects of abortion law that seem to arise from Article 40.3.3º of the Constitution, but which were not dealt with in the *X case*.

The submissions go on to set out a draft law, entitled for the purposes of these submissions, the Termination of Pregnancy Bill 2012. The submissions explore, through a process analogous to the Explanatory Memorandum of a Bill, the provisions set out in the draft law, explaining and justifying each section.

The aim of the law is to draft an outline format for a law that espouses the moderate pro-life/moderate pro-choice view that has been articulated in public forums and reflected in opinion polls. The draft Bill seeks, first, to seeks consensus for an abortion law that addresses some of the needs of Irish women and, secondly, to explore that territory in abortion law that seems to the author not to infringe on the area of constitutional protection staked out by Article 40.3.3º.

The broad scheme of the legislation is as follow:

- Section 1 Preliminary
- Section 2 Definitions
- Section 3 Criminalisation of termination of pregnancy
- Sections 4-9 Defences/Exceptions
  - Termination of pregnancy as a consequence of medical treatment
  - Termination of pregnancy where there is a real and substantial risk to the life of a woman (other than the threat of suicide)
  - Termination of pregnancy where there is a real and substantial risk to the life of a woman arising from the threat of suicide
  - Termination of pregnancy in the case of inevitable miscarriage
  - Termination of pregnancy in the case of lethal foetal abnormality
- Section 10 Ministerial Regulations
- Section 11 Offences
- Section 12 Prohibition on termination of viable pregnancy
- Section 13 Provisions allowing for conscientious objection in the performance of termination of pregnancy
- Section 14 Centres where termination of pregnancy may be carried out and associated reporting requirements
- Section 15 Provision of information to pregnant women
- Section 16 Penalties

- Section 17 Role of the High Court
- Section 18 Repeals

In my view, none of the matters canvassed in the draft legislation offends against the spirit or letter of Article 40.3.3º, albeit that it covers ground more extensive than that set out in the *X case*. Furthermore, I believe that the matters set out in the draft legislation are those which will command broad support from those of moderate views on the question of abortion.

Biographical Note - Dr Simon Mills

Qualifications:

MB, BCh, BAO, BA (U Dubl); BCL (NUI), MSc (Lond), MICGP, Barrister-at-Law

Medical Background:

I qualified in medicine from Trinity College Dublin in 1993. I was awarded Honours in that part of my final examination dealing with Medical Jurisprudence (including Medical Law and Ethics). While a student at TCD, I was president of the Irish Medical Students' Association.

I completed a pre-registration intern year in St James' Hospital in 1993-4, including periods in surgery and medicine. I was accepted onto the Dublin Regional Vocational Training Scheme in General Practice (now the TCD Training Scheme in General Practice) in 1994 and commenced a 3-year training rotation in General Practice. During that course I obtained a Diploma in Child Health and a Certificate in Palliative Care. At the conclusion of the course, in 1997, I was successful in the Membership Examination of the Irish College of General Practitioners (MICGP).

From 1997-2011, I practised as a part-time General Practitioner, predominantly in the Stoneybatter area of Dublin 7. During that time, I saw many patients who were considering termination of pregnancy and in particular those who were experiencing crisis pregnancies and those whose pregnancies were affected by lethal foetal abnormalities.

Legal Background:

While practising as a part-time General Practitioner, I attended University College Dublin from 1997-2000, where I studied for the degree of Bachelor in Civil Law. I qualified in the top few of my class and was awarded the Swift McNeill Scholarship and a medal in Constitutional Law.

I completed the Barrister-at-Law degree from the Honorable Society of King's Inns in 2002 and have practised since 2002 as a Junior Counsel at the Law Library, specialising in all aspects of healthcare law. I am the author of *Clinical Practice and the Law* (Bloomsbury Professional, 2nd edn, 2007; 3rd edn in preparation) and lead author of *Disciplinary Proceedings in the Statutory Professions* (Bloomsbury Professional, 2011). I am contributing lecturer and external examiner in Medical Law at the Law Society, Blackhall Place. I was admitted as a Foundation Member of the Faculty of Forensic and Legal Medicine in 2009.

Medical Ethics:

I hold an MSc in Philosophical Medical Ethics from Imperial College London. I was awarded First Class Honours and first place in the Class. I was also awarded First Class Honours for my thesis, which dealt with the subject of abortion and was entitled *Identity, Dependency and Rawls - Notes Towards a Pluralist Abortion Law*. I lectured in Medical Ethics at the Royal College of Surgeons of Ireland from 2004 until 2011, when I declined to provide further lectures.

Interest in this matter:

- I have been invited to attend on the basis of my unusual experience in the three related areas of medicine, law and medical ethics. I have contributed extensively to broadcast and other media on the issue of abortion, including calls for reform of abortion law. I do not share the views of those occupying either of the more extreme ends of the abortion "debate".

A. Introduction

Calling the discourse about abortion a 'debate' may be to do violence to that word. Discussion of abortion can be vituperative, divisive and closed-minded. Nonetheless, the academic literature and some public discussion of the question make clear that informed, reasoned and temperate debate is possible, even if years of debate have failed to produce a final determination of whether abortion is morally right or wrong and even if some of the discussion is indeed vituperative *etc*…

There are certain themes that emerge from discussions in the literature that are of recurring interest, both as moral questions and as practical applications of the answers to moral questions about abortion. In particular, three strands present themselves for repeated consideration:

i. Why should we give an abortion decision any considered moral thought, especially against the backdrop of the adoption of permissive abortion legislation by the majority of western pluralist states?

ii. Are there inherent qualities in the foetus (and indeed in us) that mean we are normatively obliged to give serious weight to the abortion decision?

iii. How should a society that professes itself to be pluralist legislate – if at all – for abortion?

While I believe the first and second strands are interesting and deserving of further debate, I consider mainly the third strand, namely the form that law should take in a pluralist society such as this one.

A three-sided argument

The commonly held view on the abortion debate is that there are only two sides. The divide can be parsed in a number of ways (pro-life *versus* pro-choice; anti-abortion *versus* pro-choice), but the implication remains consistent: you are either for abortion or against it. However, my submission is that there are three "sides" to this dispute. Two of the groupings are assuredly those on the polar opposites of the discussion and who are either (a) opposed to abortion in all circumstances or (b) supportive of an abortion-on-demand regime where the availability of abortion is an unqualified question of reproductive rights and the prerogative of every pregnant woman.

The unfortunate corollary of a debate that is most typically articulated by these two camps is that there is a third, and I believe substantial, group that is either shut out of the discussion or forcibly shoehorned, nuance notwithstanding, into one of the two "conventional" camps. This third group is the camp comprised of those who espouse moderate pro-life and moderate pro-choice positions and who positions frequently overlap, precisely because of their reasonableness in the face of clean-looking principles that refuse to be applied neatly to the rough-hewn surface of real life.

Principled equivocation

What I call "principled equivocation" is watermarked into many people who hold views that are predominantly but not completely within either the pro- or anti-abortion camps. Those from the moderate pro-life point of view will hold that while abortion is *prima facie* wrong, an exception may be made for those who are the victims of rape or who by reason of age or mental capacity could not consent to abortion. Conversely, those who are intuitively or philosophically supportive of abortion may recognise that certain decisions to terminate a pregnancy are less morally clear-cut than others are. So, the philosopher Judith Jarvis Thompson wrote:

> "It would be indecent in the woman to request an abortion and indecent in a doctor to perform it, if she is in her seventh month and wants the abortion just to avoid the nuisance of postponing a trip abroad."[1]

I do not propose to devote any energy to rehearsing each and every abortion argument, but I will sketch out in point form the shared elements of the moderate pro-choice and moderate pro-life positions:

- The status of the embryo is neither absolutely human nor absolutely nugatory.
- Thus, the decision to have a termination of pregnancy is neither morally impermissible nor morally inconsequential.
- Therefore, there are circumstances (although there may be disagreement about what those circumstances are) where termination is morally permissible.
- In such circumstances, the law should not criminalise those who seek a termination of pregnancy on those grounds where persons of a moderate persuasion can agree.

Demography and the abortion debate

Opinion polls seem to consistently reflect that neither the pro-life nor the pro-choice extremes appears to carry the support that their medic presence might tend to suggest and consistent support seems to be shown for liberalisation of abortion laws in the jurisdiction, notwithstanding those who have criticised the wordings of one or more polls. One review of polls (from the Irish Family Planning Association) on the question of the availability of abortion indicated the following outcomes:

- In December 2012, a Sunday Business Post/Red C Poll found that 85% of people surveyed supported legislation for the X case, allowing abortion where a woman's life is threatened, including by suicide.[2]
- In September 2012, a Sunday Times Behaviour & Attitude Poll found that 80% of people said they would support a change in the law to permit abortion in cases where the mother's life is at risk.
- In 2011, study of 500 established GPs and almost 250 GPs in training revealed that 75% of Irish GPs feel that there are situations in which abortion should be available in Ireland with 52% believing that abortion should be available to any woman who chooses it.
- In 2010, an Irish Examiner/Red C Poll found that 60% of people supported legal abortion and three in five people aged 18-35 believed abortion should be legalised.
- Also in 2010, a Marie Stopes/YouGov opinion poll indicated that 79% of those questioned were in favour of liberalisation of Irish abortion laws in certain circumstances.
- In 2007, an Irish Times Behaviour and Attitudes Poll found that 54% of women believe the Government should act to permit abortion.
- A 2004 Crisis Pregnancy Agency study found that 90% of 18-45 year olds support abortion in certain circumstances, with 51% stating that women should always have to right to choose an abortion.

B. Defining terms

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[1] Thompson, J. 'In Defence of Abortion', in *Bioethics*, Harris J (ed.), Oxford University Press (2001), p. 40. This is a position that seems quite close to that of the "virtue ethicist": see Hursthouse R. 'Virtue Theory and Abortion', *Philosophy and Public Affairs*, (1991) 20;3:223-46

[2] This poll also demonstrated 82% support for "a constitutional amendment to extend the right to abortion to all cases **where the health of the mother is seriously threatened and also in cases of rape**."

I would suggest a definition that does not deal with questions of "deliberation" and "intention" and that is, instead simply, factual:

> "Termination of pregnancy" means any artificial process, whether effected by the administration of medication or by the carrying out of any surgical or other procedure, leading to the expulsion of the embryo or foetus from the womb and references to "terminating a pregnancy" are to be construed accordingly,

There has been a tendency, particularly among Catholic commentators on the pro-life side, to characterise the distinction between what is abortion and what is not abortion as being a distinction between those acts that involve a "deliberate and intentional" destruction of the embryo and those that do not. While this may be a useful exercise moral theology, I am not persuaded of the view that it should shape either policy making or legislation and I am further not persuaded that it is a coherent exercise in moral thought. I am not alone in this view (and again, I do not go into it in detail, because the emphasis of this submission is on the law) and I note the recent comments of Desmond M Clarke in the Irish Times of December 27, 2012, critiquing a statement of the Irish Bishops, issued on December 18:

> "The statement of the archbishops appeals to a distinction between "direct and intentional killing" and other kinds of taking life. For most moral philosophers, however, it makes no sense to claim we are not responsible for actions that result in someone's death simply because we do not "intend" it or because the consequences are "indirect".
>
> We are taken to intend all the likely and foreseeable consequences of our actions and we cannot escape responsibility for some specified consequences by some kind of private mental activity in which we disavow some of them. Here again the archbishops seem to wish to enforce their ethical views, no matter how implausible they may be, on others who reject them for good reasons."

C. Scope of legislation

I note that the Committee is asked to "legislate for X". I respectfully submit that such an approach does not go far enough to deal with matters that ought properly to be dealt with at this juncture in Irish legislative affairs. It should be apparent to the Committee and to those who have considered this matter that the decision in *X* is a decision on the facts of *X* and those facts alone. Accordingly, it cannot and should be considered to dispose of all the scenarios in which the termination of pregnancy is lawful under Irish law; rather it simply disposes of the scenario of the suicidal victim of statutory rape.

The Committee might consider two other legal scenarios.

Inevitable miscarriage

While no attempt is made to prejudge the outcome of the inquiry into the death of Savita Halappanavar, the allegations that have been reported can give rise to a fruitful discussion of a particular series of question: first, what if a woman in an Irish hospital were to request a termination, because of a threat to her health posed by an unresolved but irreversible and inevitable miscarriage? What if the hospital were to refuse? What if she were, through her legal representatives, to make an application to the High Court? Could the High Court be said to be constrained by the decision in *X* from finding that here was another ground on which an abortion would be permissible in Irish law? I find it hard to believe that such an application would be unsuccessful, once a threat to the health or life of the mother was established and where that threat was posed by the miscarriage of a foetus that would inevitable die.

Lethal Foetal Abnormality – D case

In the case of *D v Ireland*, the European Court of Human Rights declined to hear the case of an Irish woman who was pregnant with an anencephalic foetus (that is, the foetus was missing a significant part of its brain and could not be expected to live – if at all – for more than 72). The decision not to hear the case was based on the fact that D had not exhausted all her domestic remedies by testing her right to an abortion in the Irish Courts, before appealing to Europe. The Court in *D* observed that:

> The presumption in the X case was that the foetus had a normal life expectancy and there is, in the Court's view, **a feasible argument to be made that the constitutionally enshrined balance between the right to life of the mother and of the foetus could have shifted in favour of the mother when the "unborn" suffered from a abnormality incompatible with life**. The Court also notes the subsequent rejection (in 1992 and 2002) of the proposed amendments to the Constitution to restrict the effect of the judgment in the X case.

The X Case

Turning to the X case, it seems clear that any law must contain the entirety of the elements of the *X case* judgment on the basis (a) that any law regulating the termination of pregnancy in the State must conform with the demands of Article 40.3.3º and (b) that the Article was interpreted by the Supreme Court (on the facts of that case) as affording a right to abortion where there is a real and substantial risk to the life of the pregnant woman (the Supreme Court used the word "mother", but that appears in the circumstances of this debate to be unhelpfully freighted language and so I used the term pregnant woman, which is a statement of uncontroversial fact), including the threat of suicide. Accordingly, a law that excluded the threat of suicide would seem to me to be unconstitutional.

It appears from facets of the debate about legislation for abortion in Ireland that the threat of suicide is a particular stumbling block and it is suggested, in some quarters, that the 1983 referendum should be revisited for a third time to exclude the risk of suicide. I have some difficulty in understanding the logic behind this approach and I believe that the threat of suicide, where it exists, should be entitled to exactly the same consideration as any other (physical) risk to the life of the mother, including being subject to the requirement that the provision of an abortion should be the only possible treatment for the threat of suicide.

If the opponents of the threat suicide as a basis for abortion are correct in their repeated assertion that abortion is never a treatment for suicidal thoughts, then no such abortions will be carried out. Furthermore, safeguards, such as those set out in the attached draft legislation will serve to deter those who might consider by feigning suicidal thoughts.

It may also be observed that those who are critical of suicidal thoughts as the basis for abortion are not infrequently those who, as a facet of their personal beliefs or moral values, are those who view suicide as a moral wrong or failing and it is hard to be certain that such views do not inform their assessment of the role of suicide in this facet of the discussion of termination of pregnancy.

D. Content of Legislation

I turn now to the contents of the draft Bill, set out at Appendix 1. The draft Bill is necessarily an incomplete first attempt at legislating for the present state of Irish law and it will be seen that it goes beyond the scope of X, although not (in my submission) in a fashion that is inconsistent with Article 40.3.3º or with the ostensible consensus on the question of abortion in Ireland. Furthermore, it will be

noted that the Act reflects the preferred approach of the Expert Group in that it provides, first, a legislative backbone and, secondly, scope for regulations dealing with matters such as statutory forms (s. 10), reporting of terminations and the authorisation of centres where terminations may take place (both in s. 14).

I wish to acknowledge the invaluable assistance in drafting this legislation provided by my colleague, Mark Tottenham BL.

The Bill is drafted in such a way that each of the envisaged grounds for lawful abortion is considered separately. As such, in the event that the Bill were (even in heavily amended form) to become law, any challenge to a given ground that might arise (for example, by reference under Article 26), then in the event of a successful challenge to that ground, the balance of the Bill would still stand, capable of enactment without further change.

What is not in the legislation?

I do not deal in the legislation with the question of pregnancy that arises in unlawful circumstances (incest and rape, including statutory rape) although I am firmly of the view that termination should be permissible in such circumstances. However, it seems to me that any attempt to legislate for rape or incest would necessarily fall foul of Article 40.3.3º unless the *X case* criteria were to be fulfilled or unless the attached Bill were to become law and one of the criteria set out therein were satisfied.

In order for rape or incest to be grounds for termination of pregnancy, Article 40.3.3º would have to be revisited and either be removed or recalibrated in such a way that a rape/incest exception was created.

I turn now to deal with the individual sections in the legislation offering an explanation and/or justification for each of the sections contained therein.

Part 1

Section 1 – Preliminary

This section deals with uncontroversial preliminary matters, including the entitlement of the Minister to commence the legislation on dates to be confirmed.

Section 2 – Definitions

This section provides relevant definitions for terms used in the legislation. Other relevant terms are defined in relevant sections and it is possible that certain of these definitions might more appropriately be moved to the sections that are most relevant.

The term "termination of pregnancy" is used to distinguish the act in question from a spontaneous abortion.

The definition of "Viable" is subject to specification by the Minister in accordance with section 12(2). [3]

Part 2

Section 3 - Criminalisation of termination of pregnancy

[3] Defining viability is not without problems. While some foetuses can survive being born at very early ages (for example at 24 weeks), the vast majority of such foetuses do not survive and where a foetus does survive extreme prematurity, severe handicaps are very common.

This section re-states, in more modern language, the prohibition currently contained in sections 58 and 59 of the Offences Against the Person Act 1861. The offences remain unchanged in their nature, however the proposed terms of imprisonment are brought into line with the views expressed by the All-Party Oireachtas Committee on the Constitution, particularly in relation to the life sentence contained in the 1861 Act. Accordingly the maximum sentences for procuring one's own miscarriage or procuring the miscarriage of another are reduced to 12 years (from life) and the maximum sentence for providing materials for use in an unlawful abortion is reduced to 2 years (from 3).

<u>Part 3</u>

Part 3 of the Bill deals with those circumstances in which, notwithstanding the fact that a termination of pregnancy occurs, it will not be unlawful. In each case, save for section 4, the prerequisite for a lawful termination of pregnancy is that two doctors (including in all cases, at least one doctor from the most relevant medical specialty) certify in writing their opinion that the conditions necessary for a lawful termination of pregnancy are extant.

In the case of some of the sections in Part 3, the comments set out hereunder are not necessarily repeated where the sections are similar or identical in wording and therefore the following comments should be read as a whole.

Section 4 - Termination of pregnancy as consequence of other medical treatment

This section is intended simply to codifying the existing, and to my knowledge uncontroversial, position whereby it is accepted that where treatment A, being necessary to save the life of a pregnant woman, has the consequence of causing a termination of pregnancy, then that termination of pregnancy cannot be regarded as unlawful.

Sections 5 and 6 - Termination of pregnancy in cases of risk to life of pregnant woman (not including threat of self-destruction)

These sections deal with the first limb of the *X case* scenario, namely the situation where there is a real and substantial risk to the life of a pregnant woman and where that risk can only be averted by the performance of a termination of pregnancy. In order for such a termination to come within the exception provided for by law, it will be necessary for two doctors (one of whom must be an obstetrician) to certify in writing that there is a risk to the life of the pregnant woman and that the risk in question can only be averted by termination of pregnancy.

On the identity of the certifying doctors, it should be noted that there are cogent reasons for requiring that only one of the doctors is mandated to be a consultant obstetrician: there may be circumstances where the life-threatening condition is not an obstetric one (or, in any event, not purely obstetric) and certification from a non-obstetrician may be appropriate in the circumstances.

Section 6 provides that section 5 does not cover the case of a risk posed by the threat of suicide and the reason for that provision is because the threat of suicide is dealt with separately and with safeguards appropriate for suicide.

Section 7 - Termination of pregnancy in cases of risk to life of pregnant woman arising from threat of suicide

This section differs from section 5 in that the safeguards are both different and more stringent, which measures are intended to both recognise the special nature of suicidality and to ensure that it is less probable that insubstantial claims of suicidality will be advanced. First, one of the examining doctors

must be a Consultant Psychiatrist. Secondly, each of the examining doctors must carry out an assessment on two separate occasions to ensure than any suicidality is consistently present and expressed. It may be that thought might be given to establishing a specific minimum time frame between assessments, but that would be a matter for expert psychiatric evidence.

Section 8 - Termination of pregnancy in cases of inevitable miscarriage of non-viable pregnancy

It seems to me that where a non-viable pregnancy is in the course of miscarrying, then the balance of right must shift decisively and promptly in favour of the pregnant woman. Accordingly, while this section does not in any way preclude allowing an inevitable miscarriage to proceed naturally to conclusion, it is cognizant of the fact that where the foetus cannot survive (and therefore, its right to life cannot, in any meaningful way, be defended or vindicated) then a threat to the health or life of the mother will permit a termination of pregnancy to occur.

While, as previously observed, one does not wish to prejudge the outcome of any ongoing inquiries, were the inquiry into the death of Savita Halappanavar to determine that the duration of her miscarriage was a factor in her death, then legislating solely for the *X case* would not prevent a similar case occurring in the future or, at a minimum, might require the Courts to consider whether inevitable miscarriage is grounds for a termination of pregnancy. If the Courts did so, then further legislation would be necessary.

As with the previous section, the lawfulness of the termination would be dependent on doctors certifying in writing their opinion as to the existence of the requisite conditions.

Section 9 - Termination of pregnancy in cases of lethal foetal abnormality

I have previously referred to the comments of the European Court of Human Rights in *D v Ireland* and it seems to me that where there is a pregnancy with an abnormality that is incompatible with life, then it should not be incumbent on a pregnant woman (and, where relevant, her partner) to bring to term (assuming the pregnancy makes it to term) a pregnancy that is – in effect – born to die. This is not to demean those who say that every life has an intrinsic value, but rather to say that the mother (or parents) of a pregnancy with a lethal foetal abnormality may believe that being born to die is to inflict suffering that is unwarranted and morally unjustifiable in the case of a pregnancy that will never live to apprehend or enjoy a right to life.

In such cases, it appears to me (and seems to have appeared to the European Court of Human Rights in *D v Ireland*) that a necessary recalibration of the rights set out in Article 40.3.3º should occur and that such a recalibration would permit an abortion in the circumstances set out in Section 9.

It may be observed that cases of lethal foetal abnormality are not uncommon and, as well as the case of *D v Ireland*, there was also the unrelated case of *D (A minor)* which came before the High Court and also concerned a lethal foetal abnormality.

Sections 10 and 11 – Regulations and offences under Part 3

This section deals with two matters. The first, uncontroversially, allows the Minister to make regulations for the forms on which doctors' certification of the existence (or otherwise) of grounds for abortion would be recorded.

The second matter, which may be more controversial and is a matter that requires further discussion, confers an immunity from civil liability for a doctor acting in good faith when certifying his or her opinion under the Act. The section also imposed a potential criminal liability on a doctor who does not

act in good faith or who misrepresents facts or circumstances relating to a pregnant woman when certifying his or her opinion.

Section 12 – Prohibitions on termination of viable pregnancy

This section imposes a prohibition on the termination of a pregnancy where that pregnancy involves a foetus that, if not terminated, would be or would be expected to be, capable of surviving outside the womb by reason of its gestational age.

For the further clarification of this section, the Minister may – with the benefit of medical advice and on the condition that such advice is published – make regulations stipulating a time of gestation beyond which a foetus may be deemed to "viable", such that no termination may take place. The requirement for any such decision to be based on transparent medical advice is to ensure that no arbitrary decision is taken to either unreasonably curtail or unreasonably extend the period during which a termination of pregnancy might be permissible.

Part 4

Section 13 – Conscientious objection

The Expert Group called for conscientious objection to be recognised and this section achieves that aim with two recognitions of the right to conscientious objection.

The right to exercise a conscientious objection to participation in termination of pregnancy is extended to all doctors and nurses (save where the termination in question is necessary to save the life of a pregnant woman) and does not include an obligation to refer the woman to a person who will carry out a termination.

Where a request is made for an opinion as to whether a pregnant woman meet the criteria for a lawful termination of pregnancy, then while a registered medical practitioner may, citing a conscientious objection, refuse to provide such an opinion, he or she must refer the patient onto someone else who will furnish such an opinion. It should be noted that the obligation does not oblige any registered medical practitioner to provide a supportive opinion.

Section 14 - Authorised centres and reporting of terminations of pregnancy

Section 14 provides that terminations of pregnancy can only take place in certain centres, either by reason of them offering Health Act services to patients (and the precise wording of that subsection may need some tweaking) or by reason of being approved by the Minister. Where terminations are performed by a centre, then there will be reporting requirements and the Minister is given the power to make regulations specifying how such reporting is to be furnished.

This section is required to allow for accountability and transparency on the question of where terminations might take place, the frequency with which they might take place and the basis on which they might take place.

Section 15 – Provision of information

It may be that this section is not required, but it is to take account of the need to provide information to women relating to the categories of termination that would be lawful in the event that the Bill were enacted. It seems desirable to include this provision to counter the far-reaching and somewhat opaque provisions of the Regulation of Information (Services outside State for Termination of Pregnancies) Act 1995.

Section 16 - Penalties

A single offences is provided for in the Act (relating to the certification of opinions by registered medical practitioners) and it may be that further offences will be created by regulations (for example, relating to reporting of terminations) and this section provides for the imposition of limited penalties in such cases.

Section 17 – Role of the Court

This section allows the High Court to determine any disputes that may arise in relation to the Act and to set out the procedure to be followed in determining those disputes.

Section 18 - Repeals

Having restated the law contained in the 1861 Act, the relevant sections can be repealed. Similarly, the section of the Health (Family Planning) Act 1979 requires to be amended to take account of the provisions of Part 3 of the Bill.

APPENDIX

TEXT OF DRAFT TERMINATION OF PREGNANCY BILL

Draft Termination of Pregnancy Bill 2012

Long Title

An Act to Amend and Clarify the Law relating to Termination of Pregnancy by Registered Medical Practitioners in Defined Circumstances.

Part I – Preliminary and General

Short Title and Commencement

1. (1) This Act may be cited as the Termination of Pregnancy Act 2012

(2) The Minister for Health and Children shall, by order or orders, specify such day or days on which this Act shall come into operation, and different days may be so appointed for different purposes and different provisions.

Definitions

2. In this Act, except where the context otherwise requires–

"Court" means the High Court,

"Minister" means Minister for Health and Children

"Registered Medical Practitioner" means a medical practitioner registered with the Medical Council within the meaning of the Medical Practitioners Act 2007,

"Registered Nurse or Midwife" means a nurse or midwife registered with An Bord Altranais within the meaning of the Nurses and Midwives Act 2012,

"Register of Medical Specialists" means the register of medical specialists maintained by the Medical Council,

"Substance" means any substance, whether for oral, intravenous or vaginal administration, and whether or not containing a pharmacologically active substance, intended to procure the miscarriage of a pregnancy,

'Termination of pregnancy" means any artificial process, whether effected by the administration of medication or by the carrying out of any surgical or other procedure, leading to the expulsion of the embryo or foetus from the womb and references to "terminating a pregnancy" are to be construed accordingly,

"Viable", in relation to a pregnancy, means a foetus or embryo that is, or would be expected to be, capable of surviving outside the womb by reason of its gestational age and the term "non-viable" shall be construed accordingly.

Part II – Criminal offences

Criminalisation of termination of pregnancy

3. (1) It shall be an offence–

(a) for any pregnant woman to administer to herself any substance or to use any instrument or other means upon herself, with the intention of terminating her own pregnancy,

(b) save as provided for in Part 3 of this Act, for any person to administer any substance to a woman (knowing or reasonably believing her to be pregnant) or to use any instrument or other means upon a woman (knowing or reasonably believing her to be pregnant), with the intention of terminating the pregnancy of that woman.

(2) Any person found guilty of an offence under *subsection (1)* shall be liable, upon conviction, to a sentence up to 12 years' imprisonment.

(3) It shall be an offence, save as provided for in Part 3 of this Act, for any person to supply or procure any substance, any instrument or any other thing, knowing that the said substance, instrument or other thing is intended to be used with the intention of procuring the termination of pregnancy of any woman.

(4) Any person fund guilty of an offence under sub*section (3)* shall be liable, upon conviction, to a sentence up to 2 years' imprisonment.

Part III – Defences and related matters

Termination of pregnancy as consequence of other medical treatment

4. It shall not be an offence under Part 2 for a Registered Medical Practitioner to carry out a termination of pregnancy where the termination of pregnancy is a secondary consequence of any medical or surgical treatment necessary to save the life of a pregnant woman.

Termination of pregnancy in cases of risk to life of pregnant woman (not including threat of self-destruction)

5. It shall not be an offence under Part 2 for a Registered Medical Practitioner to carry out a termination of pregnancy where two Registered Medical Practitioners (one of whom must be a Consultant Obstetrician and Gynaecologist on the Register of Medical Specialists) have each independently examined and assessed the woman in question and certified in writing, in good faith in all the circumstances of the woman's case, their opinion that–

    (a) there is a real and substantial risk to the life, as distinct from the health, of a pregnant woman, and

    (b) the real and substantial risk to the life of the woman can only be averted by the termination of her pregnancy.

6. Section 5 shall not apply where the real and substantial risk to the life of a pregnant woman arises from a threat of suicide made by the pregnant woman.

Termination of pregnancy in cases of risk to life of pregnant woman arising from threat of suicide

7. It shall not be an offence under Part 2 for a Registered Medical Practitioner to carry out a termination of pregnancy where two Registered Medical Practitioners (one of whom must be a Consultant Psychiatrist on the Register of Medical Specialists) have each independently examined and assessed the woman in question on no fewer than two separate occasions and have certified in writing, in good faith and in all the circumstances of the woman's case, their opinion that–

    (a) there is a real and substantial risk to the life, as distinct from the health, of a pregnant woman arising from a threat of suicide made by the pregnant woman, and

    (b) the real and substantial risk to the life of the woman can only be averted by the termination of her pregnancy.

Termination of pregnancy in cases of inevitable miscarriage of non-viable pregnancy

8. (1) It shall not be an offence under Part 2 for a Registered Medical Practitioner to carry out a termination of pregnancy where two Registered Medical Practitioners (one of whom must be a Consultant Obstetrician and Gynaecologist on the Register of Medical Specialists) have each independently examined and assessed the woman in question and certified in writing, in good faith and in all the circumstances of the woman's case, their opinion that–

    (a) a pregnant woman is experiencing an inevitable miscarriage, and

(b) the inevitable miscarriage is not amenable to any medical or surgical treatment, and

(c) allowing the natural progression of the inevitable miscarriage poses or is likely to pose a significant risk to the life or health of the woman.

(2) For the purposes of this section, “inevitable miscarriage” means the commencement of an irreversible process whereby a non-viable embryo or foetus is, or is expected to be, expelled from the womb of a pregnant woman,

Termination of pregnancy in cases of lethal foetal abnormality

9. (1) It shall not be an offence under Part 2 for a Registered Medical Practitioner to carry out a termination of pregnancy where two Registered Medical Practitioners (one of whom must be a Consultant Obstetrician and Gynaecologist on the Register of Medical Specialists) have each independently examined and assessed the woman in question and certified in writing, in good faith and in all of the circumstances of the woman’s case, their opinion that–

(a) a woman is pregnant with an embryo or foetus suffering from a lethal foetal abnormality, and

(b) the pregnancy in question is non-viable with the meaning of this Act.

(2) In this section, “lethal foetal abnormality” means an abnormality of an embryo or foetus (whether of genetic, metabolic or other origin) such that the condition of the embryo or foetus is incompatible with life outside the womb.

Regulations and offences under Part 3

10. The Minister may make Regulations pursuant to this Part–

(a) Requiring any certification by a Registered Medical Practitioner referred to in this Part to be certified by the practitioner concerned in such form and at such time as may be prescribed by the Regulations,

(b) Requiring the preservation and disposal of any certificates made for the purposes of the Regulations;

(c) Requiring any Registered Medical Practitioner who terminates a pregnancy to give notice of the termination and such other information relating to the termination as may be so prescribed;

(d) Prohibiting the disclosure, except to such persons or for such purposes as may be so prescribed, of notices given or information furnished pursuant to the regulations.

11. Where a Registered Medical Practitioner offers certifies his or her opinion in writing under this Part–

(1) Any Registered Medical Practitioner who so certifies his or her opinion in good faith and with a reasonable belief in the facts certified under this Part shall be immune from liability in any civil proceedings;

(2) It shall be an offence for a Registered Medical Practitioner to offer an opinion under this Part other than in good faith or in circumstances where he or she knows or ought to know that facts stated in such opinion are misleading or untrue.

Prohibition on termination of viable pregnancy

12. (1) Nothing in Part 3 of this Act shall make it lawful to terminate a viable pregnancy.

(2) The Minister may make regulations prescribing, on the basis of medical expertise for the time being available to the Minister, time limits outside which any foetus is deemed for the purposes of this Act to be viable.

(3) For the purposes of any Regulations made in accordance with *subsection (2)*, the Minister:

(i) Shall have regard to the view of a broad body of obstetric experience, and

(ii) Shall, together with any regulations that may be made, publish the advice upon the basis of which such Regulations have been made.

Part IV – Conscientious Objections and other miscellaneous matters

Conscientious objection

13. (1) Subject to subsection (2) of this section–

(a) no Registered Medical Practitioner or shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in the provision of any opinion required by Part 3 of this Act to which he or she has a conscientious objection and

(b) no Registered Medical Practitioner or Registered Nurse or Midwife shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any termination of pregnancy authorised by this Act to which he or she has a conscientious objection,

provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

(2) Nothing in *subsection (1)* of this section shall affect the duty of any Registered Medical Practitioner or Registered Nurse of Midwife to participate in any treatment which is necessary to save the life of a pregnant woman.

(3) Where a Registered Medical Practitioner refuses, by reason of conscientious objection, to provide an opinion under Part 3 of this Act, he or she shall refer the pregnant woman to another Registered Medical Practitioner who is willing to furnish such an opinion.

Authorised centres and reporting of terminations of pregnancy

14. (1) Any termination of pregnancy carried out in accordance with this Act must be carried out in or under the supervision of–

(a) a hospital providing obstetric and gynaecology services to women and operating under the provisions of the Health Act 1970 (as amended), or

(b) a hospital, clinic or other facility authorised for the purpose of termination of pregnancy by Order of the Minister.

(2) Any hospital or other clinic performing terminations of pregnancy under *paragraph (a)* shall be required to report, in writing, to the Minister on not less than an annual basis, setting out:

(a) The numbers of terminations of pregnancy carried out, if any, and

(b) The section of this Act under which such terminations were carried out.

(3) The Minister may make Regulations for the better operation of this section, including but not limited to regulations providing for:

(a) The recognition of hospitals or other clinics authorised to carry out terminations of pregnancy pursuant to sub-paragraph (a)(ii);

(b) The revocation of any authorisation given to any hospital or other clinic to carry out terminations of pregnancy pursuant to sub-paragraph (a)(ii);

(c) The manner, form and timing of reporting of terminations of pregnancy to the Minister;

(d) The collation, analysis and publication of such reports of terminations of pregnancy

Provision of information

15. It shall not be unlawful for any person to provide information to any person in relation to any termination of pregnancy that would be lawful under Part 3 of this Act.

Penalties

16. Any person who contravenes any provision of this Act or any regulation made hereunder (not being a provision contained in Part 2 of this Act) shall be liable on summary conviction to a fine not exceeding €1,000 or on conviction on indictment to a fine not exceeding €5,000 or to a maximum of one year's imprisonment.

Role of the Court

17. Where any dispute arises to the entitlement of any person to a termination of pregnancy under this Act, such person may make application to the Court and the Court shall make such orders as it sees fit in relation to the hearing and the determination of the dispute.

Repeals

18. (1) Sections 58 and 59 of the Offences Against the Person Act 1861 are hereby repealed.

(2) Section 10 of the Health (Family Planning) Act 1979 is amended by the insertion of the following section:

"Nothing in this Act shall be construed as authorising—

a. the procuring of abortion saved as permitted by Part 3 of the Termination of Pregnancy Act 2012,
b. the doing of any other thing the doing of which is prohibited by Part 2 of the Termination of Pregnancy Act 2012, or
c. save as may be required for the operation of the Termination of Pregnancy Act 2012, the sale, importation into the State, and manufacture of abortifacients,
d. the advertising or display of abortifacients."

INTRODUCTION OF TONY O'CONNOR ON 21 MAY 2013

I have had the benefit of reading the views of Professor Kieran Murphy on behalf of the Irish Medical Council given to this Committee last Friday 17 May 2013. At the time of preparing my outline written submission which had to be delivered early on that Friday morning, I was not aware of those views. For the sake of full disclosure I should say that I have attended in my professional capacity, meetings at which Professor Murphy presided or was in attendance. However I have had no discussion with Professor Murphy or the Medical Council about its submission prior to my appearance before this Committee Hearing today.

In brief I agree with the statement of facts which Professor Murphy succinctly set out. I also fully endorse the view of the Medical Council and other doctors who have attended hearings of this Committee that it is in the public interest that doctors have legal clarity when making clinical decisions. Such clarity as can be introduced through legislation will assist patients undoubtedly.

More particularly and in light of my summary of the current law relating to a patient's capacity to consent or refuse treatment in my outline written submission, I agree with the Medical Council's view that the draft heads do not make it clear how a decision about a procedure which may cause the ending of an unborn human life will be enabled where the pregnant woman's capacity to consent or refuse may be impaired. I note that that the work of the joint Committee on Justice Defence and Equality last year, lead to useful work by the Centre for Disability Law and Amnesty and I sincerely hope that the Assisted Decision Making Capacity Bill will be published and enacted soon. I suggest the following amended wording for Head 2 (5) for consideration:

"Following certification in writing by the two registered medical practitioners in accordance with Head 2 (1) (b) including certification that regard has been had to the right to life of the unborn, a decision by or on behalf of the Patient must be made and communicated in accordance with law before the medical procedure is undertaken by a registered medical practitioner".

Even if the Assisted Decision Making Capacity Bill is not enacted soon, I respectfully express the hope that this type of wording assists the difficult situations relating to capacity which have been mentioned or alluded to by Professor Murphy, Senator Burke and others last Friday. Furthermore it helps to fulfil the duty of the State by its laws to defend and vindicate the rights under Article 40.3.3.

I noted the repeated requests by contributors last Friday for the merging of Headings 2 and 4. Once a decision is made about the number of practitioners who should be involved in any treatment consideration, it is principally a matter for the drafters. However I do indeed see merit in attempting to out rule possible different applications of the same principles due to the use of two sections when one section could cover the regime for procedures which may lead to the termination of the life of an unborn human life.

Lastly I fully endorse the opinion of the Medical Council that the monitoring system to be provided under Heads 11 and 14 should incorporate appropriate requirements to preserve the confidentiality of the patient and certifying practitioners. I suggest that the statistical or monitoring purpose for the making of regulations be included under Head 14 which will guide the Minister on the making of the regulations envisaged.

I refrain from making suggestions for the definition section as I know that the Office of the Attorney General will pick up on issues which the Committee will mention in its report. Having expressed that confidence, I still urge this Committee and the Oireachtas to scrutinise each and every definition in order to exclude interpretations, which could lead to unnecessary adversarial contests in the Courts about the rights of anyone other than the rights of the gestational mother and the unborn human life in this legislation. The Courts with their adversarial processes should be avoided as much as possible and particularly given the limited time that usually arises in this area of medicine. In conclusion, I believe that the High Court should be a forum of extreme last resort to determine any issue relating to decisions arising from the extent of risk, proposed medical procedures and measures for the protection of life.

Protection of Life during Pregnancy Bill 2013

CAROLINE SIMONS

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INTRODUCTION

Caroline Simons B.C.L., Dip E.L., Solicitor

Caroline Simons is a solicitor by profession. She takes a particular interest in biotechnology, biomedicine and bioethics. She is currently a full time Masters candidate in Medical Law. As a newly qualified solicitor she was the first in house lawyer at the Employment Equality Agency, working on secondment from one of Ireland's leading law firms. She worked for many years as a commercial litigator, and tutored in Litigation, Intellectual Property Law, European Law and Employment Law on the professional courses at The Law Society from 1983-2007. She has been a legal consultant to the Pro Life Campaign since 1992. She is a governor of the National Maternity Hospital. She makes this submission in a personal capacity at the invitation of the Committee.

Preface

I would like to thank the Chairman, Deputy Buttimer, and the members of the Committee for the invitation to contribute to the Committee's deliberations on the heads of the Protection of Life During Pregnancy Bill 2013 (the Bill).

This submission is a brief consideration of certain questions regarding the heads of Bill, as follows –

1. What action is required by the decision of the European Court of Human Rights (ECHR) in *A, B and C v Ireland*[1] (ABC)?
2. What is the test laid down by the Supreme Court in *The Attorney General v. X*[2] case(the X case) and how will it operate with Head 4 of the heads of Bill?
3. The proposal that psychiatrists will participate in a certification process to permit termination of pregnancy under Head 4.
4. Head 12 - Conscientious Objection.

At the outset of this analysis, it is noted that the Bill proposes the direct and intentional termination of the lives of the unborn (denominated as 'it' in the definitions) (abortion) as a 'medical procedure' to treat cases of threatened suicide throughout nine months of pregnancy. It must also be noted that this proposition has no scientific or medical basis. It contradicts the evidence given by every obstetrician and psychiatrist to this Committee in January 2013 (which was to the effect that abortion has never been shown to be an appropriate treatment and is never prescribed for complications of pregnancy in which they have expertise). In fact, the expert psychiatrists advised that abortion has been shown to be harmful to a significant number of women.

It should also be noted that the wording of the Bill regarding what is being permitted is inconsistent throughout.

Head 1 refers to a 'medical procedure that will end unborn human life'.

Heads 2, 3 and 4 refer to a 'medical procedure…in the course of which or as a result of which unborn human life is ended'.

Head 12 refers to 'termination of pregnancy'.

These wordings have very different meanings. They are not equivalent. Reference will be made to this again under Head 12 on Conscientious Objection.

[1] 25579/05, Judgment (Grand Chamber) 16 December 2010.
[2] The Attorney General v. X. [1992] 1 IR 1.

Summary

1. As a matter of law, the Bill and the X case test permit the direct and intentional termination of the lives of the unborn as a medical treatment for threatened suicide, at any time up to birth.
2. The ABC case does not require Ireland to legislate for the X case.
3. There is no evidence that abortion is efficacious in the clinical care of suicidal women in pregnancy. There is evidence of increased risk of suicidality in some women following abortion.
4. This Bill proposes an untested and experimental treatment. Where there is a proposal to use an untested and experimental treatment, certain criteria apply – conventional treatment, if any, must have proved unsuccessful; there must be reason to anticipate potential patient benefit which justifies the potential risks of the experimental treatment; and, the treatment will not increase the suffering of the patient. It appears that the treatment proposed to address suicide by the proposed Bill does not satisfy any of these criteria.
5. There are very serious concerns about Head 12, the Conscience clause.

A., B., and C. v. Ireland (ABC) – ECHR requirements

The European Court of Human Rights (ECHR) found that

'…*the authorities failed to comply with their positive obligation to secure to the third applicant respect for her private life by reason of the absence of any implementing legislative or regulatory regime providing an accessible and effective procedure by which C could have established whether she qualified for a lawful abortion in Ireland in accordance with Article 40.3.3 of the Constitution.*'[3]

The ECHR also pointed to certain difficulties as to the effectiveness of existing procedures.[4] That decision does not require Ireland to maintain its substantive law on when abortion is or is not available. The judgment requires Ireland to establish 'accessible and effective procedures'. Ireland has complete freedom to choose the means it deems necessary to ensure and implement the rights. The ECHR cannot stipulate what measures a State should adopt in order to prevent similar violations of the Convention in the future.

Equally, the Council of Ministers of the Council of Europe, which supervises the implementation of the ECHR judgment, cannot stipulate what measures the State should adopt in order to comply with the judgment. It can only decide whether the measures taken were satisfactory.

The Council of Ministers is a governmental body comprising the Ministers of Foreign Affairs of the member states. It is a political, not a judicial body. Therefore it can only apply diplomatic or political pressure to secure the implementation of ECHR decisions. It can and does assist the implementation process through suggestions and recommendations in decisions and interim resolutions. Infringement proceedings may be brought in exceptional circumstances, but there has never been any such proceeding. The Committee of Ministers can also refer a case to the ECHR if a State refuses to implement a judgment, but it has never done so. Because it is a political body, there have been cases where a State has refused to implement ECHR decisions, with the backing of other States. Eventually the Council of Ministers adopts final resolutions, when it considers the measures taken by the offending State are sufficient to prevent future violations. [5] Ireland's record before the Council of Europe is outstanding, in marked contrast to other member states. For example, of Italy's 2583 pending cases, 2486 of them pre-date ABC. Of Germany's 103 pending cases, 59 pre-date ABC . This has led academics such as Dr Maria Cahill of University College Cork to question the disproportionately acute political pressure on Ireland to implement ABC by invoking a widespread desire to see the Convention honoured in all 49 member states of the Council of Europe.

[3] A, B and C v Ireland at paragraph 267

[4] ibid. paragraphs 252-264

[5] For further consideration, see Puppinck, G. *The European Convention on Human Rights and States' obligations towards life, health and privacy: considering the A., B., and C. v Ireland judgment and its execution*.' Submitted at Fourth Annual Conference of the Irish Society of Comparative Law, 2-3 March 2012, Faculty of Law, University College Cork, Ireland. Publication pending in *Irish Journal of Legal Studies.*

Implementation of ECHR decisions – national obligations

The European Convention on Human Rights Act 2003 incorporates the Convention into Irish law at 'sub-constitutional'[6] level. In fact, as national legislation takes precedence over the Convention as interpreted by the ECHR, the Convention has, in effect, been incorporated into Irish law sub-legislatively. Murray C.J. put this very clearly in the Supreme Court decision of *McD v L*[7]

'*at national level national law always takes precedence over international law*.'

Chief Justice Murray continued

'*The obligations undertaken by a government which has ratified the Convention arise under international law and not national law. Accordingly those obligations reside at international level and in principle the State is not answerable before the national courts for a breach of Conventions obligations unless provision is duly made in national law for such liability. Thus contracting states may in principle, so far as the effect of the Convention at national level is concerned, ignore the decisions of the Court.'*

While this submission does not advocate ignoring ECHR decisions, it is clear that while Ireland does change national laws in order to be more Convention-compliant, there is no obligation in national law to do so.

Constitutional Requirements

Article 40.3.3 of the Constitution provides

'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 Expert Group reported in November 2012[8] and recommended that the Government legislate to regulate access to lawful termination of pregnancy in accordance with the X case. It is important

[6] Byrne, R., McCutcheon, P. 2009. Byrne and McCutcheon on the Irish Legal System. Dublin: Bloomsbury Professional at p. 812, O' Connell, D., Cummiskey, S., Meenaghan, E., O'Connell. P. 2006. ECHR Act 2003: A Preliminary Assessment of Impact. Dublin: Law Society of Ireland, at 10ff.
[7] J. McD. V P.L.and B.M. [2010] 2 IR 199
[8] http://www.dohc.ie/publications/pdf/Judgment_ABC.pdf

legislators and the medical profession appreciate the very real implications of activating the X case formula in the proposed legislation.

Legislators are not obliged to legislate for every Supreme Court decision which enumerates constitutional rights. They ought not do so where it is clear that the basic premise of a decision is ill-founded, and where it is not legally or medically required. There are many examples of unenumerated rights found by the Supreme Court which have no statutory expression, e.g., the right to bodily integrity[9], the right to privacy[10]and parental conscience rights.[11]

There is an alternative. Kenny, J. in *The People v Shaw*[12] said

'*The word 'laws' in Article 40, s.3 is not confined to laws which have been enacted by the Oireachtas but comprehends the laws made by judges and by Ministers of State when they make statutory instruments or regulations'*

This was cited with approval by Egan, J. *in A.G. v X and Others*[13]. Professor William Binchy and pro life groups have recommended that the Government implement ABC by introducing Guidelines from a Government department which would target the most important areas of maternal care and safety, including those areas that were at issue for Ms C, the third applicant in ABC, and for Ms. Halappanavar. This submission concurs with their view that this is the only way to avoid creating a formalised regime which would permit abortion throughout nine months of pregnancy on the ground of threatened suicide. This has been extensively covered in previous submissions to this Committee by the Pro Life Campaign.

Activating the X case test

The Expert Group argued[14] that the Supreme Court, in speaking of terminating the pregnancy rather than the life of the child, did not authorize the termination of the life of a viable child. Professor Binchy[15] has said that

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[9] Ryan v. The Attorney General [1965] 1 IR 294
[10] Kennedy v. Ireland [1987] IR 1
[11] North Western Health Board v. W(H) [2001] 3 IR 622,635
[12] [1982] I.R. at p. 62
[13] [1992]I.R.1 at paragraph 176
[14] Report of the Expert Group on the Judgment in A, B and C v Ireland, November 2012, p,28
[15] 'It's time we had some plain speaking on abortion Bill' Irish Times , 9 May 2013
http://www.irishtimes.com/news/social-affairs/it-s-time-we-had-some-plain-speaking-on-abortion-bill-1.1386476

'*…that interpretation is not easy to reconcile with a fair reading of paragraphs 37 to 38 of Finlay C.J.'s judgment and is inconsistent with the normative basis of the Supreme Court X judgment, which is that suicidal ideation is a basis for the intentional taking of the life of the unborn child. Arguments about practicability [of saving the child] were not strong enough to prevail against that fundamental norm.'*

Professor Binchy's is an entirely logical reading of the X case judgments. Indeed, it is clear from the preceding paragraph, numbered 36, that this was the intention of the Chief Justice -

'I am satisfied that the test proposed on behalf of the Attorney General that the life of the unborn could only be terminated if it were established that an inevitable or immediate risk to the life of the mother existed, for the avoidance of which a termination of pregnancy was necessary, insufficiently vindicates the mother's right to life.'(emphasis added).

It is clear that the test which the Chief Justice then formulated would add to, not detract from, that proposed by the Attorney General. Lest there might be any doubt, Hamilton J reiterated the X case test in *In re Article 26 and the Information (Termination of Pregnancies) Bill 1995* [16] as follows

'*The Attorney General v. X….established that having regard to the true interpretation of the Eighth Amendment, termination of the life of the unborn is permissible if it is established as a matter of probability that there is a real and substantial risk to the life, as distinct from the health, of the mother and that that risk can only be avoided by the termination of her pregnancy'* (emphasis added).

In the case of a suicide threat, it may be the very existence of the unborn that is the cause of the woman's suicidality, not the physiological changes occasioned by pregnancy. The X case and the heads of this Bill permit direct and intentional killing of the unborn in these circumstances. Once the X case test is activated, in the words of the explanatory notes in the heads of Bill, the requirement to sustain life after delivery '*does not go so far as to oblige a medical practitioner to disregard a real and substantial risk to the life of the woman on the basis that it will result in the death of the unborn*.'

It was fanciful of Minister Reilly to suggest on an RTE radio show recently that where a baby was not wanted by the mother, and perhaps had sustained injury by reason of the deliberate early termination of pregnancy, that the Government would take such children into care. Does he believe that women who avail of this procedure on the basis of suicidality will want the procedure to result in a live birth? One study of women electing for late second trimester abortions in the UK indicates a 91% preference for a dead baby[17].

[16] [1995] 1 IR 1.

[17] Jackson RA, Teplin VL, Drey EA, Thomas LJ, Darney PD. Digoxin to facilitate late second-trimester abortion: a randomized, masked, placebo-controlled trial. *Obstet Gynecol* 2001;97:471–6.

Many experts in obstetrics and their representative bodies believe that the proposed Bill will not permit late term abortions. With the greatest of respect, this may indeed be the case where there are medical or obstetric complications and the object of the intervention is not to terminate the life of the unborn baby, but to deliver the baby early to save the mother's life. We know that current obstetric and neonatal practice is to do everything practicable to save the baby. However, where a termination is sought on the basis of suicidal ideation, it is an entirely different matter. It would be permissible under the X case and the heads of this Bill to lawfully terminate the life of an unborn at any stage during pregnancy where the psychiatrists/obstetrician determine that the continued existence of the unborn child is the basis for the suicidal intention which is the real and substantial risk to the mother's life. Legislators who approve this legislation must appreciate that, and psychiatrists, obstetricians and hospitals will be required to be in a position to certify and provide these procedures. This is not scaremongering. It is simply pointing out what may be required by the law if this Bill is passed.

The Medical Reality

There is no scientific or empirical evidence that abortion prevents suicide. This is so whether the woman is suicidal because of the pregnancy or where she is suicidal because of mental illness. There is no evidence available on whether abortion reduces the risk of suicidality in women with unwanted pregnancy and suicidal ideation. There is no evidence to suggest that following abortion, women have better mental health outcomes than women who keep their babies. There is some evidence to suggest that the risks may be higher in women having abortions. Abortion or termination of pregnancy has never been prescribed as a treatment for risk to life by suicide.

The heads of Bill, if passed, would fundamentally change the practice of psychiatric and obstetric medicine in Ireland. Psychiatrists would be asked to prescribe a procedure which is not a treatment for psychiatric patients, which has not been shown to have any efficacy in preventing suicide in pregnancy, and which has been shown to increase suicidality in some women. Obstetricians could be asked to perform abortions on physically healthy women with no medical complications of their pregnancy, including late term abortions.

The Supreme Court in the X case prescribed an entirely experimental procedure for suicidality. Now the Government proposes to legislate for it. There is no evidence of what the effect of these procedures will be. It is unethical to prescribe an untested treatment where there is no reason to hope that it might be beneficent and there is reason to believe that it may increase the risk of harm.

Experimental Treatments

The *Dunne* case[18] cannot govern experimental treatment because, as the procedure is experimental, it is unlikely therefore that there will be a responsible body of medical opinion to support its use. It would appear from the case law that where the patient's condition is very serious and the standard treatment is ineffective, a doctor will be justified in taking greater risks in an attempt to provide some effective treatment.

It is unclear what an experimental procedure is and terms such as "research", "experiment", "Treatment", "procedure, "therapy" and the adjectives "new", "innovative" or "experimental" are used interchangeably.[19] The Department of Health in the UK has defined an "interventional procedure" as "*one used for diagnosis or treatment that involves incision, puncture, entry into a body cavity, electromagnetic or acoustic energy*" and "[a]n interventional procedure should be considered new if a doctor no longer in a training post is using it for the first time in his or her NHS clinical practice". A new interventional procedure has elsewhere been described as experimental. For instance, in New Zealand "innovative practice" involves "*the provision of a clinical intervention (diagnostic, therapeutic or prophylactic) be it a therapeutic drug, medical devise or clinical procedure, that is untested, unproven or not in common use and therefore poses its own unique set of characteristics and issues."*[20]

Sara Fovargue in 'The (Ab)use of Those with No Other Hope?' defines "experimental procedure" as follows –

"*I use "experimental procedure" to mean "novel and unvalidated...an 'experiment' is a procedure adopted on the chance of its succeeding. It consists in the performance of a new or non-standard intervention as all or part of a therapeutic activity and not as part of a formal research project. I employ this term to highlight the fact that using it is an experiment (a test), as it has not previously been clinically used, and it is not known what will happen when it is used in or performed on a human. It cannot yet be called "treatment" or "therapy" because both of these terms suggest that is has proven benefit, and this is not so where the relevant activity has not been clinically tried."*

Patients may be offered experimental procedures because there are no other alternatives for them and they may accept because of the change of benefit, even though it is more likely that the results will

[18] Dunne v. National Maternity Hospital [1989] IR 91, followed in Kearney v. McQuillan [2010]IESC 20.
[19] Fovargue, S. 2013. "The (Ab)use of Those with No Other Hope?" *Cambridge Quarterly of Healthcare Ethics* (2013), 22, pp.121-141
[20] Ministry of Health. Operational Standard for Ethics Committees. Wellington: MH; 2006 at para 116.

benefit others. They may indeed wish to try an experimental procedure when there is no alternative. Some patients with no other hope enrol in clinical trials because there is no standard treatment for them. The law on clinical trials is highly regulated and any medical practitioner managing a clinical trial must ensure that the patient engaging in the clinical trial has given informed consent and is fully aware of the potential risks.

The Declaration of Helsinki, the Council for International Organisations of Medical Sciences and the World Health Organisation guidelines[21] provide ethical guidance on medical research. If these guidelines were also to apply to experimental procedures, the experimental procedure would require a protocol that is ethically reviewed and approved before the procedure would be performed. It would also be necessary to include a risk-benefit analysis in which the latter outweighs the former.[22] The Declaration of Helsinki would appear to deal more fully with experimental procedures which provides as follows –

"*In the treatment of a patient, where proven interventions do not exist or have been ineffective, the physician, after seeking expert advice, with informed consent from the patient or a legally authorized representative, may use an unproven intervention if the physician's judgement it offers hope of saving life, re-establishing health or alleviating suffering. Where possible, this intervention should be made the object of research, designed to evaluate its safety and efficacy*."[23]

In the UK, an experimental procedure is not statutorily defined but if it falls within the category of a new interventional procedure, this area is regulated by Health Circular HSC 2003/011. Where a practitioner wishes to perform a new interventional procedure in the UK he/she is required to seek approval from his or her NHS trust's clinical governance committee and notify the Interventional Procedures Programme at the NICE if the procedure is not already listed by the NICE. If it is not listed, then once the NICE is notified of a new interventional procedure, a brief overview of the evidence of its safety and efficacy will be prepared, specialist advisers will be consulted, a NICE advisory committee will decide whether to issue guidance on it or to ask for more information and the public will be consulted on the guidance. There is some debate about the binding nature of health service circular but it establishes that where a treatment is experimental, it needs to be strictly monitored.

In New Zealand every innovative practice must be prospectively reviewed and approved by an ethics committee demonstrating that it is justifiable in terms of this potential contribution to medical knowledge and that it has the potential to be of direct benefit to individuals based on pre-clinical

[21] World Medical Association (WMA), Declaration of Helsinki, Ethical Principles for Medical Research Involving Human Subject, adopted by the 18thWMA, Helsinki, Finland, June 1964 as amended in 2008; Council for International Organisations of Medical Sciences and World Health Organisation. International Ethical Guidelines for Biomedical Research Involving Human Subjects. Geneva: CIOMS; 2002.

[22] See Note 38, WMA 2008, at B12, B14-15, B18, B21; note 39, CIOMS and WHO 2002, at Guidelines 1,2,8 and Appendix 2.

[23] Declaration of Helsinki, Ethical Principles for Medical Research Involving Human Subjects, adopted by the 18th WMA, Finland, June 1964, as amended in 2008, paragraph 35.

examination, clinical evidence and that it does not expose participants to undue harm. Requirements of consent and justice must also be considered prior to its initiation.

Cases

Ormrod J. in *Corbett v. Corbett*[24] said of experimental or innovative treatment that *"if they are undertaken for genuine therapeutic reasons, it is a matter for the decision of the patients and the doctors concerned in the case."* Where a patient is injured as a consequence of an experimental procedure, any deviation from standard practice requires justification which will principally centre on the views of peers and the supporting scientific evidence. In *Hunter v. Hanley*[25] , Lord Clyde said that a negligent procedure departing from accepted practice is one which "*no professional man of ordinary skill would have taken if he had been acting with ordinary care*".

There have been some interesting judicial dicta on the provision of experimental treatment and the circumstances in which it will be authorised. In *Simms v. Simms*[26], in two separate cases, an 18 years old male and a 16 year old female were suffering from probable variant Creutzfeldt-Jakob disease ("vCJD"), a rare neurodegenerative disorder. No recognised effective treatment or cure had yet been found, but overseas medical research had identified a treatment which inhibited the formation of abnormal protein prion in mice. The parents of the patients wished them to receive that treatment, which had not been tested on humans. They sought declarations that it was lawful as being in their best interests for them to receive the proposed treatment. The medical evidence given was to the effect that there was no cure for the illnesses, and no effective drugs to prolong life or arrest the continuing deterioration and accordingly, the patients were bound to die.

Dame Elizabeth Butler-Sloss P, stated as follows at paragraph 51 –

"*I am satisfied, consistent with the philosophy that underpins the Bolam test that there is a responsible body of relevant professional opinion which supports this innovative treatment. That is, in my view, subject to the seriousness of the risks involved and the degree of benefit that might be achieved".*

"[W]here there is no alternative treatment available and the disease is progressive and fatal, it seems to me to be reasonable to consider experimental treatment with unknown benefits and risks, but

[24] [1971] 2 All ER 33.
[25] [1955] SLT 213
[26] [2002] EWHC 2734

without significant risks of increased suffering to the patient, in cases where there is some chance of benefit to the patient."[27]

She continues at paragraph 61 –

"*I am satisfied from all the evidence that both JS and JA have a life that is worth preserving and that any treatment that might be beneficial would be of value to them. It has to be recognised that the treatment proposed for these two patients would not lead to recovery. None the less, on the totality of the medical evidence, I find that there are possible benefits both to JS and JA from this pioneering treatment.*"

1. Accordingly, it would appear from this decision
    a. that the prospect of clinical benefit was a necessary threshold for legitimacy.
    b. at the time there were no recognised effective drugs to halt the neurological deterioration or prolong life.
    c. There was a responsible body of professional opinion which supported the treatment;
    d. Without significant risks of increased suffering.

2. In *Estrada v. Jacques*, the North Carolina Court of Appeals stated that "*the health care provider has a duty in exercising reasonable care under the circumstances to inform the patient of the experimental nature of the proposed procedure*".[28] Accordingly, there are substantial disclosure requirements as the procedures carry an especially high level of inherent risk due to their novelty. Patients therefore involved in experimental treatment are entitled to detailed information regarding the extent of existing knowledge relating to the procedure, the currently approved treatments available and the foreseeable risks attaching to it.

3. The European Court of Human Rights in *Hristozov v. Bulgaria*[29] had cause to consider this issue recently. In this case the authorities in Bulgaria refused the applicants authorisation to use an experimental medicinal product. The applicants were in the final stages of terminal cancer and were asking for the authorities to authorise the use of an experimental anticancer product which a number of other Contracting States had authorised for "compassionate use". The applicants argued that the authorities had breached their Convention rights under Article 2 (right to life), Article 3 (treatment amount to inhuman and degrading treatment) and Article 8 (right to privacy and right to family life). In considering the case put before it, the Court considered the legal position in other Contracting States and noted that 22 Contracting States, including Ireland, have in place rules (both primary and delegated legislation) allowing access to unauthorised medicinal products outside clinical trials for certain patients, notably those who are terminally ill.

[27] Para 57
[28] 321 SE 2d 240 (N.C.Ct.App. 1984); See also Zimmer v. Ringrose, (1981) 124 DLR (3d) 215
[29] 47039/11 and 358/12 http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-114492

4. The Court also noted that in the United States pursuant to regulations which issued in May 1987 conditions were laid down setting out the rules concerning the provision of promising new drugs which had not yet been licensed which could be made available to persons with serious and life threatening illnesses for whom no comparable or satisfactory alternative drug or therapy was available. The regulations are currently contained in the Code of Federal Regulations, Title 21, Part 312, Subpart 1 (Expanded Access to Investigational Drugs for Treatment Use) 312.300-320 and make provision for an "expanded access" programme under which the Food and Drug Adminstration may under certain conditions authorise the use of an "investigational new drug" in respect of patients suffering from "a serious or immediately life-threatening disease or condition, [when] there is no comparable or satisfactory alternative therapy to diagnose, monitor or treat the disease or condition (21 CFR 312.305(a)(1)). The general criteria governing the FDA's decision are whether "[*t]he potential patient benefit justifies the potential risks of the treatment use and those potential risks are not unreasonable in the context of the disease or condition to be treated.*"

5. The ECHR also referred to the decision of *United States v. Rutherford* 442 U.S 544 (1979) where the United States Supreme Court unanimously dismissed a request by terminally ill cancer patients to enjoin the authorities from interfering with the distribution of an unlicensed drug. In its view for such patients, as for anyone else, a drug was unsafe if its potential for inflicting death or physical injury was not offset by the possibility of therapeutic benefit. In *Abigail Alliance for Better Access Developmental Drugs v. Von Eschenbach* (2 May 2006, 445 F. 3d 470 and 7 August 2007, 495 F.3d 685) the Court held that the legislature was entitled to prohibit the sale of unlicensed drugs. In giving judgment it stated that the legislature and the executive had "*continually responded to new risks presented by an evolving technology*" and because the legislature had a "*well established power to regulate in response to scientific, mathematical and medical advances*." The court went on to say that self-defence, the tort of interference with rescue and the United State Supreme Court's "*life or health of the mother*" abortion case provided no support for a right to seek investigational drugs because those doctrines protected only "*necessary*" life-saving measures, whereas the claimants sought "*access to drugs that [were] experimental and [had] not been shown to be safe, let alone effective at (or 'necessary' for) prolonging life*".

6. In considering the submissions of the parties the Court held in relation to Article 2 as follows –

   "*the first sentence of Article 2 enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction. The Court has previously said that it cannot be excluded that acts and omissions of the authorities in the field of healthcare policy may in some circumstances engage the State's responsibility under Article 2....*
   In the present case, it is not being argued that the applicants have been denied health care which is otherwise generally available in Bulgaria. Nor are the applicants suggesting that the State should pay for a particular form of conventional form of treatment because they are unable to meet its costs. The applicants' claim is rather that, because conventional treatments did not work in their cases, domestic law should be framed in such a way as to entitle them, exceptionally to have access to an experimental and yet untested product... in the Court's view Article 2 of the Convention cannot be interpreted as requiring that access to unauthorised medicinal products for the terminally ill be regulated in a particular way."

   The Court proceeded to state at paragraphs 120-121 as follows –

> "*When it comes to experimental medicinal products, it is in the nature of things that their quality, efficacy and safety are open to doubt. The applicants do not deny this. They rather seek to argue that because of the dire prognosis attaching to their medical condition, they should have been allowed to assume the risks attendant on potentially life-saving experimental product... The Court nonetheless accepts that in view of their medical condition and the prognosis for its development, the applicants had a stronger interest than other patients to obtain access to experimental treatment whose quality, safety and efficacy have not yet been subjected to comprehensive testing*."

7. Where there is a departure from conventional treatment, a medical practitioner would require a very good reason for so doing. However, where the treatment is "untested" and in essence experimental, entirely different considerations pertain and could only apply in the following situations –

   a. Where conventional treatment has proved unsuccessful;
   b. The potential patient benefit justifies the potential risks of the treatment – this would appear to rule out treatment where there is no evidence that it will improve the patient's situation.
   c. A responsible body of medical professionals support the experimental treatment;
   d. The treatment will not increase the suffering of the patient.

It does not appear that there is any medical or psychiatric justification for the procedure proposed by the Bill, not even on an experimental basis.

Conscientious Objection

Accommodation of conscientious objection in the health care context represents 'a recognition that the legal permissibility of certain (morally contentious) medical practices and their availability within health care institutions does not eliminate the reality of moral disagreement at the level of practice.'[30] Conscientious objection to participation in medical intervention or treatment does not arise where that medical intervention or treatment is necessary to save life in a medical emergency. In the case of proposed legislation of abortion to address suicide, however, it is important that this head is robust. European and International Law recognise unambiguously that the starting point of any discussion on the matter is the right to life for all human beings. The right to life is universally and ethically recognised, legally recognised, and in Ireland, also explicitly recognised constitutionally for the unborn. The right to conscientious objection is therefore a fundamental human right grounded in an objectively and universally recognised ethical, religious and moral human standard.

[30] Campbell, M. "Conscientious Objection, Health Care and Article 9 of the European Convention on Human Rights." (2011) *Med Law International* 11 (4) pp. 284-304.

The right to conscientious objection is explicitly recognised in EU, ECHR and International Law (including case-law).

The problems with the current wording in Head 12 (and other related Heads):

a. Scope of conscientious objective far too narrow: there is widely available evidence that many States extend it to *any person* likely to be asked to participate formally or materially in an abortion in the course of their profession or occupation.
b. The *arbitrary exclusion of hospitals, organisations and third parties* from the scope of the right: it is illogical, irrational and not grounded in law.
c. Freedom of conscience is expressed in absolute terms in Article 9.

Article 9 of the ECHR provides for freedom of thought, conscience and religion.[31]

The Parliamentary Assembly of the Council of Europe (PACE) acknowledged in a 2010 resolution the 'right to conscientious objection within the framework of legal medical care'.[32] The ECHR has declared that 'freedom of conscience has in the past all too often been paid for in acts of heroism'.[33] The law guarantees freedom of conscience today, so that this price is not exacted.

Stated simply, conscientious objection is the refusal by any person or institution to participate in acts that they consider in their conscience to be unjust, even if the acts are permitted by law. A conscientious objection clause in a legislation means that the State recognises a legal right to persons and institutions to not participate in acts that they consider to be unjust. In the context of abortion, some persons or institutions consider that the act is contrary to basic human morality, and will refuse to participate to it, even if it is legalised.

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[31] Article 9 ECHR '(1) Everyone has the right to freedom of thought, conscience and religion: this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.
(2) Freedom to manifest ones religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.'

[32] In this resolution, PACE declared that 'no hospital, establishment or person may be subjected to pressure, be held responsible or suffer discrimination of any kind for refusing to carry out, accommodate or assist an abortion, an induced miscarriage or an act of euthanasia, or to submit to such procedures, nor for refusing to carry out any intervention aiming to cause the death of a foetus or human embryo, for whatever reason'. http://assembly.coe.int/ASP/APFeaturesManager/defaultArtSiteView.asp?ID=950

[33] Decision of ECHR at fn 3; para 3 of joint partly dissenting opinion of JJ. Vučinić and de Gaetano.

The right to conscientious objection to the practice of abortion is widely recognised and accepted in international and European Law. It is the hallmark of a democratic and tolerant society. It means that States recognise that its citizens have the right to live according to their moral principles, including when those conflict with legislation. Citizens who consider abortion as gravely unjust and want to conduct their lives without participating formally or materially to it must be able to do so without breaching the law, and without fear of being victimised because of their religious or ethical beliefs. It is therefore necessary that the *Protection of Life During Pregnancy Bill* 2013 includes an adequately drafted clause on conscientious objection.

Besides clear cut situations of directly performing abortions, there are many other related situations to which citizens will object. People will find themselves in these situations because of their occupation or profession, and will seek to refuse to participate to certain acts, because these acts will be related to abortion. For example, an anaesthetist will refuse to administer drugs to a patient whom he knows is coming to theatre to undergo an abortion. A nurse will refuse to prepare a patient for theatre if he/she knows the patient will undergo an abortion. A hospital pharmacist or pharmacy technician will refuse to deliver certain abortion drugs to a ward, or even stock these drugs in the hospital pharmacy. Cleaning personnel will refuse to service certain operation theatres if they know they are used for abortions. The list can go on. None of those categories of people are being asked to directly perform the abortion. But their acts are necessary to carry out the abortion, and as such, basic human morality will command them to refuse to do those acts.

It is the responsibility of Government, TDs and Senators to ensure that the right to conscientious objection is guaranteed in its most noble form. Not doing so would give the hallmark of a totalitarian regime to the *Protection of Life During Pregnancy Bill* 2013, as it would end up forcing some citizens to participate in abortion, in order to avoid the consequences of discrimination or of breaking the law.

There is very little precedent for the right to conscientious objection in Irish law. However, looking at the issue from an international and European perspective, one will understand quickly that it is widely developed elsewhere. Those who object in conscience to abortion have the law on their side.

The right to conscientious objection and to freedom of religion are guaranteed in the following instruments:

- The Charter of Fundamental Rights of the European Union in article 10(2) states that ‘The right to conscientious objection is recognised, in accordance with the national laws governing the exercise of this right’.
- The European Convention on Human Rights in Article 9 guarantees the fundamental freedoms of thought, conscience and religion. Article 14 prohibits any form of discrimination on ground of religious belief or practice. These two provisions provide broad protection to healthcare personnel who refuse to take part in an abortion.
- The International Covenant on Civil and Political Rights protects ‘freedom of thought, conscience and religion’ in article 18. The Human Rights Committee General Comment on

article 18 states: ‘The Covenant does not explicitly refer to conscientious objection, but the Committee believes that such a right can be derived from article 18, inasmuch as the obligation to use lethal force may seriously conflict with the freedom of conscience and the right to manifest one’s religion or belief.’ This comment was aimed at conscientious objection to military service, but it is clear that it also provides an authoritative interpretation of article 18 in the context of abortion: for those who object to it, abortion is the ‘use of lethal force’ against another human being, and does conflict with their right to freedom of conscience and religious belief.

- EU Council Directive 2000/78/EC establishes a general framework for equal treatment in employment and occupation prohibits discrimination on the grounds of religious beliefs, and as such, protects people in the workplace against discrimination in relation to their position on abortion.

These instruments are legally binding in Ireland: they are applicable law in this country, and they impose obligations on the Irish State to protect the right to conscientious objection of all.

As though to emphasise this point, the Parliamentary Assembly of the Council of Europe (PACE) adopted in 2010 a resolution on the “The Right to Conscientious Objection in Lawful Medical Care”.[34] The opening paragraph of this resolution unambiguously states:

“No person, hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion, the performance of a human miscarriage, or euthanasia or any act which could cause the death of a human foetus, for any reason.”

While this resolution is not a legally binding document, it indicates how seriously the Council of Europe takes the right to conscientious objection in the context of medical care and abortion. It is true that the law in the vast majority of member states of the Council of Europe permits abortion, but it is equally clear that these laws raise very significant and objective moral issues for many citizens in those States. That is why the right to conscientious objection is so important, and protected by law. It is also clear that not only physical persons can exercise their right to conscientious objection, but also legal persons, such as hospitals and institutions. Note also that the PACE resolution does not restrict the right to conscientious objection to just doctors: by using the word “person”, it indicates that anyone who may be involved in the act of performance of an abortion has the right to conscientious objection. That includes nurses, midwives, pharmacists, pharmacy technicians, trainee doctors, etc.

The right to conscientious objection in ECHR case-law

There are three significant cases decided by the ECtHR that provide some clarification about the implications of the right to conscientious objection in the ECHR.

[34] PACE Resolution 1763 (2010), 7 October 2010.

In 2007 in *Tysiac v. Poland*[35], the plaintiff alleged that Polish law violated her right because it permitted a gynaecologist to refuse to perform an abortion on grounds of conscience, and that "a patient could not bring a doctor to justice for refusing to perform an abortion". The Court refused to narrow the scope of the right to conscientious objection that is guaranteed under Polish law and upheld its conformity with the Convention.

In the case of *Rommelfange v. The Federal Republic of Germany*[36], the Court held that a hospital was entitled to dismiss the plaintiff because he took ethical positions contrary to those of his employer. This case confirms that a hospital is capable in law of holding ethical positions, and therefore should be entitled to the right to conscientious objection.

This case was confirmed in *Lombardi Vallauri v. Italy*[37], in which it was held that a Catholic institution can limit the rights and freedoms of other people in order to protect its ethos.

In two other cases, the Court clarified what could not come within the scope of the right to conscientious objection. In *Knudesn v. Norway*[38], it was ruled that a priest could not protest against the legalisation of abortion in Norway by way of refusing to perform marriages. The Court held that link between the performance of abortion and the personal obligation of the priest was too weak.

In *Jean Bouessel du Bourg v. France*[39], the Court held that a taxpayer could not rely on his right to conscientious objection to refuse to pay his taxes. The plaintiff had refused his taxes as they were used to fund abortions in France. The Court held that the link between the performance of abortion and the personal obligation of the taxpayer to pay his taxes is too weak.

The scope and limits of the right to conscientious objection

The freedoms set out in Article 9 (1) ECHR are absolute and unqualified. Freedom to *manifest* ones religion or beliefs is not absolute, and may be limited as prescribed by law and as necessary in a democratic society in pursuit of one or more of the aims listed in Article 9 (2). Article 9(2) provides that the freedom to manifest ones religion or beliefs may be circumscribed. Implicitly, then, the right to freedom of conscience must not be susceptible to limitation. Conscientious objection is not the same as objection based on one's subjective beliefs or adherence to the tenets of any religion. It is an objective objection, a product of reasoning which needs no basis in religious belief. Religious objections, on the other hand,

[35] Case 5410/03 http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-79812
[36] Case 12242/86 http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-1010
[37] Case 39128/05 http://www.camera.it/application/xmanager/projects/leg17/attachments/sentenza/testo_integrale_sentenzas/000/000/313/LOMBARDI_VALLAURI.pdf
[38] Case 11045/84 http://hudoc.echr.coe.int/sites/eng/pages/search.asp
[39] Case 20471/92 [1993] 16 EHRR CD 49.

are the product of prescriptions of a particular religion. Judges Vučinić and de Gaetano accepted this argument in their minority dissenting opinion in the Eweida[40] decision (Eweida) last January. They said that the state's margin of appreciation does not enter into the equation in matters of individual moral conscience which attain 'a level of cogency, seriousness, cohesion and importance worthy of protection'[41]. In such cases 'the State is obliged to respect the individual's freedom of conscience both positively (by taking reasonable and appropriate measures to protect the rights of the conscientious objector and negatively (by refraining from actions which punish the objector or discriminate against him or her).'[42]

The ECHR regarded the appeals in Eweida as pertaining to restrictions on freedom of religion. It reiterated that member states enjoy a margin of appreciation in deciding whether and to what extent interference is necessary. The ECHR's role is to determine if the interference is justified in principle and proportionate, having regard always to the fair balance to be struck between the competing interests. Relying on the state's margin of appreciation, the ECHR found against three of the four appellants, and held that it was proportionate to dismiss these employees for refusing remove a small crucifix while working, for refusing to undertake the new duty to perform same sex civil partnership ceremonies and for sharing doubts about a personal ability to counsel same sex couples.

The ECHR Eweida decision endorses actions by employers to force employees to act against their consciences for fear of losing their jobs, 'something which, even assuming that the limitations of Article 9(2) apply to prescriptions of conscience, cannot be deemed necessary in a democratic society'.[43] Instead of employing the model of reasonable accommodation, the court, like the employer, allowed 'obsessive political correctness'[44] to trump individual conscience and religious belief. As Trigg observes, 'once freedom of religion is not thought to be of absolutely fundamental importance in a society, but can give way to current social priorities, freedom of conscience also is challenged.[45]

In the context of abortion, the exercise of conscientious objection in relation to which is not limited to the scope of religious freedom, several considerations operate to define the right of persons or institutions: the right to life of all human beings, the health and life of the mother, and her freedom to choose a termination, and the right to freedom of conscience and religion of all human beings.

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[40] Eweida and Others v. The United Kingdom, nos. 48420/10, 59842/10, 51671/10 and 36516/10 decision of 15 January 2013.

[41] Ibid. para 5 of JJ. Vucčinić and de Gaetano.

[42] Ibid. para 3 of JJ. Vucčinić and de Gaetano.

[43] Ibid. para 7 of JJ. Vucčinić and de Gaetano

[44] Ibid. para 7 of JJ. Vucčinić and de Gaetano

[45] Trigg, R. 2013. "Canary in the Coal Mine: Mounting Religious Restrictions in Europe". Religious Freedom Project. *Berkley Center for Religion, Peace and World Affairs, Georgetown University*. http://berkleycenter.georgetown.edu/rfp/essays/canary-in-the-coal-mine-mounting-religious-restrictions-in-europe

By refusing to perform, provide or participate to an abortion on grounds of conscientious objection, persons and institutions exercise their right to freedom of conscience and religion to prioritise these considerations by order of importance: they place the right to life of both the mother and her unborn child above the mother's freedom to choose a termination. They consider that the law that allows for abortions is morally and ethically unjust, and they claim their right not to follow it.

The current wording of Head 12 'Conscientious Objection' inadequately protects the right to conscientious objection of all citizens likely to be involved in abortions. First, it narrowly restricts it to any 'medical practitioner, nurse or midwife', leaving out all other occupations or professions that are necessary to the administration of a service of abortion. Second, it excludes any 'institution, organisation or third party'. Finally, in relation to medical practitioners, there is a very worrying ambiguity in relation to those likely to be involved in providing a 'reasonable opinion' under Heads 2 (Risk of loss of life from physical illness, not being a risk of self-destruction), 3 (Risk of loss of life from physical illness in a medical emergency) and 4 (Risk of loss of life from self-destruction).

1. Who can exercise their right to conscientious objection

People who exercise a profession or occupation and who may be in a situation where they are asked to collaborate (see below point 2. to explain how the collaboration is characterised) to an abortion should all be entitled to exercise their right to conscientious objection:

- Doctors
- Trainee doctors
- Midwives
- Nurses
- Pharmacists
- Pharmacy technicians
- Hospital managers
- Teachers
- Social workers
- Clerical staff in hospitals, institutions, GP practices
- Hospitals
- Institutions

The provision of an abortion service will not depend solely on the willingness of an obstetrician or midwife to practice it. It will require the collaboration from all the usual professions and occupations involved in the ordinary provision of health services, from clerical staff to cleaners. It is therefore wholly inadequate to restrict the right to conscientious objection to medical practitioners, midwives and nurses. These professions are indispensible to the carrying out of an abortion, but they cannot act alone. The cleaner who ensures that the operation theatre is sanitised is as necessary to the abortion as the nurse who prepares the patient for it, or the clerical staff who records her details. It is a blatant discrimination to exclude certain occupations or professions from the right to conscientious objection.

It is noted that the Heads of Bill does not extend the right of conscientious objection to pharmacists, although pharmacists are mentioned in the explanatory notes.

In the recent Doogan[46] decision, two Glasgow midwives have succeeded in their appeal against a decision which would have imposed supervisory duties over nurses engaged in the provision of abortion. Lady Dorrian observed that "Even in a supervisory role, the labour ward co-ordinators were part of a team responsible for the overall treatment and care of the patient and would thus 'participate in treatment authorised by the [Abortion] Act.'

- In Europe, only a limited number of States extend the right to conscientious objection to persons other than medical personnel (Austria and Belgium).

Austria: No physician is obliged to perform an abortion or to take part in it, except where it is necessary without delay to save the life of the pregnant woman from an immediate threatening danger which cannot otherwise be averted. This applies also to persons in *para-medical, medico-technical, or auxiliary health employment.* (article 97(2)(3) of the Penal Code). No one may be discriminated against for either performing an abortion, or refusing to participate in an abortion (article 97(3) of the Penal Code).

Belgium: No medical doctor, nor any nurse *or aid to the doctor* will be obliged to take part in an abortion (article 348, al. 2, 6e of the Belgian Penal Code).

Two important considerations must be borne in mind.

First, the Parliamentary Assembly of the Council of Europe 2010 Declaration on conscientious objection is itself broad and encompasses "any person, hospital or institution", and the ECHR provisions (articles 9 and 14) on the matter have never been restricted to just medical personnel. Just as with the legalisation of abortion, it is therefore necessary to understand that under the ECHR, the principle is the broad applicability of the right to conscientious objection. Second, besides the UK and Malta, all other States members to the Council of Europe operate under a civil law system. Ireland operates under a Common Law system. Caution must therefore be exercised when comparing legislations on the matter. The approach adopted in those civil law jurisdictions may not be transferable wholesale, *mutatis mutandis*, to Ireland. In this respect, the example of the United State is far more relevant to Ireland, as it is another Common Law jurisdiction. The following points show that indeed, in the US, there is a near unanimous approach to a broad scope to conscientious objection, both at Federal and State levels.

[46] Doogan & Another, Re Judicial Review [2012] CSOH 32
http://www.bailii.org/scot/cases/ScotCS/2013/2013CSIH36.html

- In the United States, at the Federal level (words in italics emphasise who has the right to conscientious objection):

42 USC § 300a-7: Sterilisation or Abortion

(b) Prohibition of public official and public authorities from imposition of certain requirements contrary to religious beliefs or moral convictions

The receipt of any grant, contract, loan, or loan guarantee under the Public Health Service Act (42 USC 201 et seq], the Community Mental Health Centers Act [42 USC 2689 et seq], or the Developmental Disabilities Service and Facilities Construction Act [42 USC 6000 et seq] *by any individual or entity* does not authorize any court or any public official or other public authority to require-

(1) Such *individual* to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions; or
(2) Such *entity* to –
  (A) Make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or
  (B) Provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the performance or assistance in the performance of such procedures or abortion by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.

(...)

(d) Individual rights respecting certain requirements contrary to religious beliefs or moral convictions

No *individual* shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such programs or activity would be contrary to his religious beliefs or moral convictions.

- In the United States, virtually all States have similarly broadly worded provisions that guarantee the right to conscientious objection to *any individual or institution*. The list is long but deserves to be fully referenced below to show how ridiculously inadequate the current wording of Head 12 is (relevant words are emphasised in the extracts from legislation below):

Alaska: "Nothing in this section requires *a hospital or person* to participate in an abortion, nor is a hospital or person liable for refusing to participate in an abortion..." (Alaska Stat. § 18.16.010(b) (2009))

Arizona: "*A physician or any other person who is a member of or associated with the staff of a hospital, or any employee of a hospital, doctor, clinic or other medical or surgical facility*...shall not be required to participate in the...abortion (Ariz. Rev. Stat. § 36-2151 (LexisNexis2008)).

Arkansas: "No *person* shall be required to perform of participate in medical procedures which result in the termination of pregnancy" (Ark. Code Ann. § 20-16-601(a) (2009)).

California: "No such *employee or person with staff privileges in a hospital facility, or clinic* shall be subject to any penalty or discipline by reason of his or her refusal to participate in an abortion." (Cal. Health & Safety Code § 123420(a) (deering 2008)).

COLORADO "[T]he refusal of *any such person* to participate [in an abortion] does not form the basis for any disciplinary or other recriminatory action against the person." (COLO. REV. STAT. § 18-6-104 (2008))

CONNECTICUT "No *person* shall be required to participate in any phase of an abortion that violates his or her judgment, philosophical, moral or religious beliefs." REGS. CONN. STATE AGENCIES § 19-13-D54(f) (2009)

DELAWARE "No *person* shall be required to perform or participate in medical procedures which result in the termination of pregnancy . . . ." (DEL. CODE ANN. tit. 24, § 1791(a) (2008))

FLORIDA "Nothing in this section shall require any *hospital or any person* to participate in the termination of a pregnancy, nor shall any hospital or any person be liable for such refusal." (FLA. STAT. ANN. § 390.0111(8) (LexisNexis 2009))

GEORGIA "[A]ny *person* who states in writing an objection to any abortion . . . shall not be required to participate in procedures which will result in such abortion; and the refusal of the person to participate therein shall not form the basis of any claim for damages . . . or for any disciplinary or recriminatory action against the person." (GA. CODE. ANN. § 16-12-142(a) (2009))

HAWAII "Nothing in this section shall require *any hospital or any person* to participate in an abortion nor shall any hospital or any person be liable for a refusal." (HAW. REV. STAT. ANN. § 453-16(e) (LexisNexis 2009))

IDAHO "Neither shall *any physician* be required to perform or assist in any abortion, nor shall any *nurse, technician or other employee of any physician or hospital* be required by law . . . to assist or participate in the performance or provision of any abortion . . . ." (IDAHO CODE ANN. § 18-612 (2009))

ILLINOIS "No *physician, hospital, ambulatory surgical center, nor employee thereof*, shall be required . . . to perform, permit, or participate in any abortion . . . ." (720 ILL. COMP. STAT. ANN. 510/13 (LexisNexis 2009))

INDIANA "No *physician or employee or member of the staff of a hospital or other facility in which an abortion* may be performed shall be required to perform an abortion . . . ." (IND. CODE ANN. § 16-34-1-4 (LexisNexis 2009))

IOWA "A person shall not discriminate against any *individual* in any way . . . because of the individual's participation in or refusal to participate in recommending, performing, or assisting in an abortion procedure." (IOWA CODE § 146.1 (2008))

KANSAS "No *person* shall be required to perform or participate in medical procedures which result in the termination of a pregnancy . . . ." (KAS. STAT. ANN. § 65-443 (2008))

KENTUCKY "No *physician, nurse staff member or employee of a public or private hospital or employee of a public or private health care facility* . . . [shall] be required to, or held liable for refusal to, perform, participate in, or cooperate in such abortion." (KY. REV. STAT. ANN. § 311.800(4) (LexisNexis 2009))

LOUISIANA "No *physician, nurse, student, or other person or corporation* shall be . . . in any way prejudiced or damaged because of his refusal for any reason to recommend, counsel, perform, assist with or accommodate an abortion." (LA. REV. STAT. ANN. § 40:1299.31(A) (2009))

MAINE "No *physician, nurse, or other person*, who refuses to perform or assist in the performance of an abortion, shall, because of that refusal, be dismissed, suspended, demoted, or otherwise prejudiced or damaged . . . ." (ME. REV. STAT. ANN. tit. 22, § 1591 (2009))

MARYLAND "A *person* may not be required to perform or participate in . . . any medical procedure that results in . . . termination of pregnancy." (MD. CODE ANN. HEALTH-GEN. § 20-214 (LexisNexis 2009))

MASSACHUSETTS "A *physician or any other person who is a member of or associated with the medical staff of a hospital or other health facility* . . . shall not be required to participate in the medical procedures which result in such abortion . . . ." (MASS. ANN. LAWS. ch. 112, § 12I (LexisNexis 2009))

MICHIGAN "[A] *physician, member, or associate of the staff, or other person connected therewith,* may refuse to perform, participate in, or allow to be performed on its premises an abortion." (MICH. COMP. LAWS SERV. § 333.20181 (LexisNexis 2009))

MINNESOTA "No *person and no hospital* or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion . . . ." (MINN. STAT. § 145.414(a) (2008))

MISSISSIPPI "It shall be unlawful for any person, health care provider, health care institution, public or private institution, public official, or any board which certifies competency in medical specialties to discriminate against *any health care provider* in any manner based on his or her declining to participate in a health care service that violates his or her conscience." (MISS. CODE ANN. § 41-107-5(3) (2009))

MISSOURI "It shall be unlawful for an employer . . . to discriminate against *any individual* . . . because of such individual's refusal to participate in abortion . . . ." (MO. REV. STAT. § 188.105.1(1)(a) (2009))

MONTANA "*All persons* shall have the right to refuse to advise concerning, perform, assist, or participate in abortion . . . ." (MONT. CODE ANN. § 50-20-111(2) (2009))

NEBRASKA "No *person* shall be required to perform or participate in any abortion . . . ." (NEB. REV. STAT. ANN. § 28-338 (LexisNexis 2009))

NEVADA "An employer shall not require a *registered nurse* . . . *or any other person employed* to . . . participate directly in the induction or performance of an abortion . . . ." (NEV. REV. STAT. ANN. § 632.475.1 (LexisNexis 2009))

NEW JERSEY "*No person* shall be required to perform or assist in the performance of an abortion . . . ." (N.J. STAT. ANN. § 2A:65A-1 (West 2009))

NEW MEXICO "*A person who is a member of, or associated with, the staff of a hospital, or any employee of a hospital* . . . shall not be required to participate in medical procedures which will result in the termination of pregnancy . . . ." (N.M. STAT. ANN. § 30-5-2 (LexisNexis 2009))

NEW YORK *"[A]ny person* . . . may refuse to perform or assist in such abortion . . . ." (N.Y. CIV. RIGHTS LAW § 79-i(1) (Consol. 2009))

NORTH CAROLINA "Nothing in this section shall require a physician . . . or any nurse . . . to perform or participate in medical procedures which result in an abortion." (N.C. GEN. STAT. § 14-45.1(e) (2009))

NORTH DAKOTA "[N]or may such *hospital or person* in any circumstances be required to participate in the performance of an abortion . . . ." (N.D. CENT. CODE § 23-16-14 (2009))

OHIO "No *person* is required to perform or participate in medical procedures which result in abortion . . . ." (OHIO REV. CODE ANN. § 4731.91(D) (LexisNexis (2009))

OKLAHOMA "No *person* may be required to perform, induce, or participate in medical procedures which result in an abortion . . . ." (OKLA. STAT. ANN. tit. 63, § 1-741 (LexisNexis 2009))

OREGON "No *hospital employee or member of the hospital medical staff* is required to participate in any termination of a pregnancy . . . ." (OR. REV. STAT. § 435.485(2) (2007))

PENNSYLVANIA "[N]o *medical personnel or medical facility, nor any employee, agent or student* thereof shall be required . . . to aid, abet, or facilitate performance of an abortion or dispensing of an abortifacient . . . ." (18 PA. CONS. STAT. § 3213(d) (2009))

RHODE ISLAND "A *physician or any other person* . . . shall not be required to participate in the medical procedures which result in the abortion . . . ." (R.I. GEN. LAWS § 23-17-11 (2009))

SOUTH CAROLINA "No *physician, nurse, technician or other employee of a hospital, clinic, or physician* shall be required to recommend, perform or assist in the performance of an abortion . . . ." (S.C. CODE ANN. § 44-41-50(a) (2008))

SOUTH DAKOTA "No *physician, nurse, or other person* who refuses to perform or assist in the performance of an abortion shall be liable to any person . . . ." (S.D. Codified Laws § 34-23A-12 (2009))

TENNESSEE "No *physician* shall be required to perform an abortion and *no person* shall be required to participate in the performance of an abortion." (TENN. CODE ANN. § 39-15-204 (2009))

TEXAS "A *physician, nurse, staff member, or employee of a hospital or other health care facility* who objects to directly or indirectly performing or participating in an abortion procedure may not be required to directly or indirectly perform or participate in the procedure." (TEX. OCC. CODE ANN. § 103.001 (2007))

UTAH "A *physician or any other person* . . . shall not be required to participate in the medical procedures which will result in the abortion . . . ." (UTAH CODE ANN. § 76-7-306(1) (2009))

VIRGINIA *"[A]ny person* who shall state in writing an objection to any abortion . . . shall not be required to participate in procedures which will result in such abortion . . . ." (VA. CODE ANN. § 18.2-75 (2009))

WASHINGTON "No *person or private medical facility* may be required by law or contract in any circumstances to participate in the performance of an abortion . . . ." (WASH. REV. CODE ANN. § 9.02.150 (LexisNexis 2009))

WEST VIRGINIA "Nothing in this article, nor in any order issued pursuant thereto, shall require that a *physician* perform an abortion or that *any person* be required to assist in the performance of an abortion if such physician or person, for any reason, medical or otherwise, does not wish to perform or assist in such abortion." W. VA. CODE § 16-2F-7 (2009)

WISCONSIN "No hospital, school, or employer may discriminate against any *person* . . . on the ground that the person refuses to recommend, aid or perform procedures for . . . the removal of a human embryo or fetus . . . ." (WIS. STAT. ANN. § 253.09(3) (LexisNexis (2009))

WYOMING "No *person* shall, in any way, be required to perform or participate in any abortion . . . ." (WYO. STAT. ANN. § 35-6-106 (2009))

GUAM "No employer or other person shall require a *physician, a registered nurse, a licensed vocational nurse, or any person employed or with staff privileges at a hospital, facility or clinic* to directly participate in the induction or performance of an abortion . . . ." (GUAM CODE ANN. tit. 9, § 31.22(a) (2008))

VIRGIN ISLANDS "Except in case of emergency, no *physician, nurse or any other hospital personnel* shall be required to perform, assist or in any other way associate himself with the performance of an abortion . . . ." (V.I. CODE ANN. tit. 14, § 154 (2009))

These examples show that in a country with a comparable legal system to that of Ireland, where abortion is widely available, but also where fundamental freedoms and rights have historically been part of the foundation of the country, the right to conscientious objection is treated with the utmost respect. It is afforded to all persons likely to come in contact with abortion, and not just to medical practitioners, midwives and nurses. In addition, in many States it is also available to hospitals and institutions.

2. The arbitrary exclusion of 'any hospital, organisation or third party' from the scope of application of the right to conscientious objection.

Subhead (3) of Head 12 of the Bill arbitrarily excludes institutions, organisations or third parties from the scope of conscientious objection. The reason for this exclusion is given in the explanatory note: it is "a human right as such applies only to individuals and not institutions".

This rationale is flawed at four levels.

First, as stated above, it is very clear that in the legislation of many States in the US, the right to conscientious objection applies to hospitals and institutions, as well as persons. There is therefore no obstacle on principle to state that hospitals and institutions can hold this right.

Second, it is common knowledge that incorporated companies, hospitals and institutions have a legal obligation to respect their employees' fundamental human rights (for example in their employment conditions and contracts, with regard to non-discrimination and equality). Why, if they have the obligation to respect human rights, wouldn't they also have the right to exercise those rights?

Third, The ECHR itself has held on several occasions that institutions and hospitals have the right to uphold their ethos, and as a consequence to dismiss members of their staff who propagate ideas contrary to this ethos. As stated previously, a German doctor's dismissal was upheld by the Court because his actions violated the pro-life Catholic ethos of the hospital that employed him. Under ECHR law therefore, which is applicable in Ireland, hospitals and institutions are the holders of the right to conscientious objection.

Fourth, under Irish Constitutional law, certain institutions, including State institutions (schools in particular), have the right to uphold their ethos, and conduct their employment and students' recruitment policies accordingly, within the limits of the law on non-discrimination and equality. If Irish law accepts that a school may recruit its pupils according to its ethos, there is no reasonable ground to refuse a hospital the right not to provide abortion services on ground of conscientious objection.

In addition to these four problems, there is a further inconsistency relating to the point dealt with above in 1. The explanatory note recognises that the right to conscientious objection is a *human* right. The beholders of such right should be any person, and cannot be arbitrarily restricted to only medical practitioner, nurse of midwife.

3. The misconceived and misunderstood called "right to conscientious objection" in the Bill

Besides these two obvious issues relating to the quality of the holders of the right to conscientious objection, there are deeper and more fundamental problems with the way this right is presented in the Bill.

As highlighted at the outset of this analysis, the wording of the Bill is inconsistent throughout: in Head 1 it talks about 'medical procedure that will end unborn human life', in Heads 2, 3 and 4, the wording is 'medical procedure...in the course of which or as a result of which unborn human life is ended' and in Head 12 the wording is 'termination of pregnancy'. It is clear that there are differences between these three wordings. They are not equivalent, and in relation to the right to conscientious objection, it is not clear to what 'termination of pregnancy' actually relates.

This language inconsistency brings a first set of problems in relation to Subhead 1, which supposedly gives the right to conscientious objection to medical practitioners, nurses and midwives. The approach taken here is in violation with the nature of the right to conscientious objection. Subhead 1 gives the impression that doctors, nurses and midwives somehow have a right to object to terminating a pregnancy even when the life of the mother is at risk. The explanatory note states that this right is not absolute, and must be balanced against other competing rights, such as the right to life of the mother.

However, it must be clearly understood that when the life of a mother is objectively at risk, the right to conscientious objection does not exist, and doctors, midwives and nurses have the obligation in law to preserve her right to life, including by performing a ‘medical procedure...in the course of which or as a result of which unborn human life is ended’ (following the wording of Head 2). These cases occur extremely rarely, and when they do, all medical staff must protect the life of the mother. Some mothers choose to not accept treatment because they want to protect the life of their unborn baby, but this choice can by no means be imposed on them by law, let alone by the choice of another person (doctor, nurse of midwife). It is inaccurate to say that in this case the ‘right to conscientious objection must be balanced against someone else’s competing rights, for example the right to life in the case of a medical emergency’. In such a case, the right to conscientious objection does not exist.

Subhead 2 continues with the fraught rationale started in subhead 1. Before analysing the problems with Head 4, it should be noted that read together, subheads 1 and 2 could be interpreted as meaning that the right to conscientious objection is inapplicable only in the case of threatened suicide. As explained above, this interpretation would be erroneous, and the current wording of these two subheads is misleading.

There is, however, another fundamental aspect to conscientious objection, which is directly relevant to Head 4 and the right to conscientious objection in Head 12, and which is at the heart of medical practice, and how it is regulated by the law. In making a decision that an abortion is permissible or even recommended, some doctors presumably decide on a course of action that they deem best for their patient. Beside the fact that many doctors consider that an abortion can never be the best treatment for their patient, the question is when abortion can be medically considered as acceptable, or even preferable, to another form of treatment. The question is the degree of freedom of medical practitioners in determining whether the best medical treatment for such condition can include an abortion. The X case established a legal rather than a medical test for abortion in cases of suicidal ideation, and there is therefore a direct issue of conscientious objection for doctors who consider the legal test contrary to best medical practice. The hearings of the Health Parliamentary Committee have unambiguously exposed that there is no evidence whatever in holding that abortion can be a treatment for the suicidal ideation of a pregnant woman. In such cases therefore, doctors will find themselves in a dilemma: best medical practice will recommend a course of action, and the law will demand an abortion. The right to conscientious objection that they have should therefore in this case actually be embedded in Head 4: it is the right to exercise medicine according to best medical practice.

The point is further compounded when considering that the explanatory note states that the obligation to preserve the life of the unborn ‘governs the actual medical procedure – the termination of pregnancy only and not whether there is a real and substantial risk to the life of the mother.’ Doctors are obliged by law to protect the life of a pregnant woman from risks of suicide. They are also obliged to preserve the life of the unborn as far as practicable. Irish doctors operate a two patient model. Up to this point, they have acted to protect both lives. This legislation, by forcing them to separate both obligations, puts doctors at risk of breaching their constitutional obligation to protect the right to life of the unborn as far as practicable.

It is extremely serious that in addition to excluding the right to conscientious objection in cases of threatened suicide in Head 12(2), Head 4 also restricts the right of doctors to treat suicidal pregnant women according to best medical practice.

Submission by William Binchy

Biographical background:

I am a practising barrister. Formerly I was Special Legal Adviser on family law reform to the Department of Justice (1974-1976), Research Counsellor to the Law Reform Commission (1976-1992), Regius Professor of Laws at Trinity College Dublin (1992-2012) and Commissioner of the Irish Human Rights Commission (2001-2011). I was a Visiting Fellow at Corpus Christi College, Cambridge (Michaelmas term, 2002) and a Visiting Fellow at the Institute of European and Comparative Law, Oxford (June 2011). I am on the board of the Irish Centre for European Law.

I represented Ireland at the Hague Conference on Private International Law in the formulation of its Conventions on marriage (1976) and international adoption (1992). I participated as representative of the Irish Human Rights Commission in the formulation of the United Nations Convention on the Rights of Persons with Disabilities (2003-2006). I have been an invited expert on private international law at the European Parliament. I have lectured in Medicine and the Law at postgraduate level at Trinity and was invited to give the Ver Hayden De Lancey Lecture on Law and Medicine at the University of Cambridge University in May 2001. I am legal adviser to the Pro Life Campaign.

Executive Summary

The submission argues that the basic premise on which the General Scheme of the Bill is founded, is mistaken and unjust, violative of human rights and conducive to a deterioration of medical practice standards in Ireland. The particular focus of the submission is on Head 4.

The Full Submission

This submission addresses the General Scheme of the Bill. The request for submissions indicates that they should be on a head-by-head basis. No doubt, this approach may yield some good focused analysis, but it does so at a significant price if it seeks, implicitly, to direct those who make submissions to engage in commentary on the details rather than to consider the principle on which the Bill is founded. The objective of the Bill must, as a preliminary matter, be addressed. If that objective is unacceptable, it must follow that discussion of the details becomes otiose.

The government is proposing, for the first time since Ireland became independent, that the Oireachtas pass a law prescribing the death of innocent human beings. It does so in the face of the evidence of psychiatrists to the Joint Committee last January, as well as the overwhelming evidence of international research. It falsely claims that it is bound to take this step by the

judgment of the European Court of Human Rights whereas in fact the judgment merely requires clarity in our law.

The Bill provides no extra clarity as to medical treatment. Instead, it sets up a procedure for decisionmaking and decisionmakers, with no specific guidance as to the content of any decision to be made.

Although the Taoiseach has claimed that the Bill does not change the position, this disguises the fact that the Bill changes the position in practice in a profound way. The Supreme Court decision of *Attorney General v X* [1992] 1 IR 1 is the basis of the Bill's provisions. That decision, which heard no evidence from any psychiatrist, authorised abortion for suicidal ideation at all stages of pregnancy. The Bill would require hospitals which respect the equality and dignity of everyone to introduce facilities for the termination by obstetricians of the lives of babies of physically healthy mothers where suicidal ideation is established in accordance with the criteria for abortion set out in the Supreme Court decision . If the Bill becomes law, far from there being "no change", there will be a profound change in practice.

Short title to the Bill

As the Bill is proposing for the first time to authorise the intentional direct termination of a human life, the title is inappropriate. In cases falling within Head 4, the intention is to terminate, not protect, the life of the unborn child. An argument that this is really about protection because the aim is to protect the life of the mother cannot credibly be advanced. Head 4 incorporates bad medicine, with the breach of a foundational norm of our society, which is that it is a violation of human rights to take the life of an innocent human being.

Head 1

The bill defines "unborn as it relates to human life" as meaning "following implantation until such time as it has completely proceeded in a living state from the body of the woman". The explanatory memorandum justifies this definition on the basis that it "protects the foetus from implantation until birth, including a foetus in the course of being born, thereby closing off a potential legal irregularity in legislation identified by the Expert Group in its report...." Yet, the definition has the potential effect of affording legal protection to interventions at the end of pregnancy when the unborn has not completely proceeded in a living state from his or her mother's body. If late abortions are authorised under the Bill (and it will be argued that they are under Head 4), then these abortions receive protection by reason of this definition of "unborn".

Head 4

Head 4 gives rise to serious concern. It introduces into Irish medical practice the obligation on the obstetric profession to carry out abortions where there is no requirement of medical necessity. The fact that Head 4 is premised on the assumption that there can be a necessity to carry out a "medical procedure", ie abortion, gives it no greater force than if the Head were to state exactly what it at present states save only the the existence of a born rather than an unborn child is the stated cause of suicidal ideation creating a risk to the mother's life which "can be averted only" a "medical procedure" terminating the life of the child. In the case of abortion for suicidal ideation, where that ideation need not necessarily be attributable to a mental illness, there is nothing

medical about the decision to authorise the abortion. What is involved is the determination that it is appropriate intentionally to terminate the life of the child. The medical dimension relates to the means to give effect to that prior determination.

The Minister for Health has claimed that the Bill will not involve abortion of viable children in any circumstances. Where medical treatment of mothers is concerned, doctors' obligation to have regard to the need to preserve unborn human life as far as practicable should ensure that the lives of viable children in the latter stages of pregnancy will be preserved and nurtured. But what of the position in relation to the ground of suicidal ideation? The bill contains no time limits. Here we are in an entirely different situation. In medical situations where the location of the child within its mother's womb is causing danger to the mother, doctors will remove the child and zealously strive to keep it alive. In cases of suicidal ideation, however, the problem is deeper than one of the geographical location of the child. In some cases the very existence of the child may be the basis of the suicidal ideation. As long as the child lives, the problem remains. Merely to end the pregnancy and keep the child alive will not solve those cases. On the premise that abortion is a legitimate option in those cases, the goal must be to terminate the life of the child.

The expert group argued that the Supreme Court, in speaking of terminating the pregnancy rather than the life of the child, did not authorise the termination of the life of a viable child. The expert group appeared to think that this distinction applied in cases of suicidal ideation. But that interpretation is not easy to reconcile with a fair reading of paragraphs 36 to 37 of Finlay CJ's judgment in *Attorney General v X* and is inconsistent with the normative basis of the Supreme Court judgment, which is that suicidal ideation is a basis for the intentional taking of the life of the unborn child. Arguments about the practicability of saving the child were not strong enough to prevail against that fundamental norm.

The Minister for Health has sought to say that viable children will not be aborted, but, even on that assertion, hard questions would remain. Is it intended that a mother of a child of 26 weeks' gestational age who indicates that she will choose to terminate her life if her baby continues to live is to be subjected to a nonconsensual medical intervention designed to remove the baby and keep it alive, though possibly severely disabled? What should be done at 21 weeks? What happens if an abortion is carried out which results in a live baby? These, and similar, questions would arise on the premise that the Bill does not authorise the termination of the lives of viable children. But the Supreme Court gave no clear indication that its judgment should be read in that way.

Concluding observations

The Bill seeks to implement the Supreme Court decision. In taking this course, it transforms the practice of Irish medicine, rendering it incompatible with the core values of human rights, which respect and protect the equal dignity and worth of every human being. The Bill is not required by the decision of the European Court of Human Rights in *A, B and C v Ireland,* which only requires clarity in our law and a review procedure. This clarity can be provided through detailed codes of practice and a transparent review procedure. In due course, after further review of the national and international evidence on abortion and suicide, the People should be given the opportunity to vote on the question by way of referendum. If the Constitution is the book which guides politicians, the People as authors of that book are entitled to write a further chapter on this issue of deep importance in the protection of human rights.

Dr. Maria Cahill

Faculty of Law
University College Cork

I thank the Joint Committee on Health and Children for its invitation to be a witness before you today. My interest in the legislation is as a constitutional lawyer who works on institutional structures and separation of powers, as well as the relationship between national and international/supranational law, and who is keen to ensure, as we all are, that the fundamental rights guaranteed in Bunreacht na hÉireann are upheld as fundamental. All of us come to this question from different angles; with different professional expertise to offer, as well as different personal experiences, which make for varying entry-points into the conversation. As a constitutional lawyer, in a panel with other constitutional experts, speaking to you as legislators, our Constitution is our common ground, and our starting-point for our conversation today.

It is a Constitution that is uncompromising in its defence of human life. According to Articles 40.3.1, 40.3.2, 40.3.3, 15.5.2, and 28.3.3, the direct and intentional taking of a life is prohibited. Each human life is valued for its intrinsic worth, as a fundamental right of the human person. This is evidenced by the fact that the Constitution prohibits the direct and intentional taking of not only innocent life, but also even of guilty life, by forbidding the introduction of the death penalty in the strongest possible constitutional terms.

If we were to assess the compatibility of the legislation with the Constitution, with the rights guaranteed under the Constitution, it would be very difficult not to conclude that Head 4 is simply unconstitutional. It targets a specific subset of those who are guaranteed a right to life under the Constitution and makes the direct and intentional targeting of their lives lawful in certain circumstances. That is simply incompatible with the strict terms of the fundamental rights guaranteed by the Constitution. Applying a proportionality analysis, which would examine the legitimacy of the infringement on the fundamental right in question in the light of the rationality of the means chosen to pursue a constitutionally-legitimate purpose, Head 4 would fail parts 2, 3, and 4 of the test for choosing a means that is not rationally connected to the ends sought, for failing to impair the right as little as possible, and for being disproportionate to the ends.

Of course, the genesis of the approach taken in Head 4 is not to be found here in Leinster House, but rather in the Four Courts, in the decision of the Supreme Court in the X case, where, without any term limits, the Court ruled that abortion was permissible where the existence of the unborn life was determined to have inspired suicidality in the pregnant woman, to such an extent that there was a real and substantial risk to her life.

In seeking to uphold the Supreme Court decision, Head 4 succeeds in replicating the conditions of that permission: where there is a real and substantial risk to the life of the woman which can only be averted by that medical procedure, the unborn life can be ended "at any time following implantation until such time as it has completely proceeded in a living state from the body of the woman". Under the rules of statutory interpretation, it is difficult to see how this legislation could be interpreted so as to prohibit late-

term, full-term, or even partial birth abortion. Indeed, if it did, of course, it would not be a faithful interpretation of the decision in the X case which imposed no such temporal limitations.

Thus, in its detail, the legislation is faithful to the detail of the test laid down by the X case. It appears not to be cognisant, however, of the development of the X case test in later cases that deal with suicidality. One example is the 2006 case of *Cosma v. Minister for Justice*, in which a woman sought that her deportation order be quashed on the grounds that if she were to be deported, she would commit suicide.

In this case, applying the legal test laid down in the X case of 'real and substantial risk to life that could only be averted, in this case, by quashing the deportation order, the High Court, in a decision that was not overturned by the Supreme Court, held (1) that the absence of a treatment plan for a presenting psychiatric condition and that the fact that a person was not undergoing therapy or counselling were relevant factors in determining how real and substantial the risk to life was; (2) that the fact that the claimant has not even considered removing the risk to life by treatment or by some other means is relevant to considering whether the risk can really only be averted by the course of action she prefers; (3) that the Minister was entitled to take into consideration arguments of public policy, as he had argued very vigorously in submissions that he should be, making the point that "to permit the threat of suicide to act as a stop on the execution of administrative decisions, such as deportation, would be to open a Pandora's box of potential abuse with possible effects of paralysing administrative activity in any given area of government".

On the *Cosma* reading of the *X* case test, Head 4 would fail to meet the necessary standards because it does not require evidence of a treatment plan, or consideration of other means of avoiding the risk to life, and because it does not take into account, as the Minister insisted we should, the public policy arguments that are relevant in assessing claims of suicidality.

When we turn from the detail of the test to the principle behind the test; it is clear that Head 4 is premised on the principle that abortion is legally permissible in cases of a threat to life by suicidality.

At this point in the debate, I'm sure that not one of you is unaware that the judges in the X case did not hear psychiatric evidence; the evidence heard was given by one clinical psychologist with 6 years experience in child psychology who met the young woman once and who had – according to his own testimony – never dealt with a case like this before. He gave evidence on the basis of a single encounter with the young woman and on the basis of what he heard about her from her parents and the guards. When he was asked in Question 78: "Is it your professional view that she would destroy herself if matters continue as they are?" he said: "I would not have taken it on myself to leave that girl alone" and later: "my recommendation would be she was not safe unless under supervision". The majority judges nonetheless decided that such supervision would be impossible, and therefore that it was, in the words of Mr Justice Finlay, "common sense" that she should be permitted to have an abortion.

The psychologist did not argue in his evidence that abortion was the appropriate treatment for suicidality; indeed as far as we know from the case report, he didn't even suggest that it might be. The Court did not hear any medical evidence from a psychiatrist to that effect. Furthermore, and more importantly from the point of view of the doctrine of precedent, the Court did not hear any legal arguments on the issue of whether suicidal ideation could validly satisfy the test determined by the Court. Counsel for the Attorney General conceded the point, and therefore all the medical, legal, and public policy arguments that one could make for or against this proposition were not given consideration by the Court.

The doctrine of precedent is certainly central to our legal system and to the furtherance of the rule of law in general. It is right and just that when the Court, in particular the highest court, makes a determination on an issue of law raised in one case, that determination should be taken to apply to similar issues raised

c/o Paul Kelly
Principal Clerk
Joint Committee on Health & Children
Houses of the Oireachtas
Leinster House
Dublin 2.

Invited Submission to Joint Oireachtas Committee on Health and Children

Dr. Maria Cahill
Faculty of Law
University College Cork

8th May 2012

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Brief Introduction

Dr. Maria Cahill is a Constitutional Law lecturer in UCC and an expert on the institutional aspects of Constitutional Law, in particular the relationship between national and international law, having published both nationally and internationally on this topic.

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Factual Information that the Committee might find useful

During the course of the submission I will refer at several points to the decision of *Cosma v. Minister for Justice* which the Committee may not be fully apprised of, because this case represents a development of law from the decision laid down by in the *X* case. The case reports are [2004] IEHC 345; [2006] IEHC 36; [2006] 7 JIC 1001 and a short summary of the case and judgment, including a comparison of the *Cosma* case and *X* case is presented below in Appendix 1.

Executive Summary

This legislation is constitutionally vulnerable in a number of respects, which the head-by-head analysis outlines in some detail. In summary, these are:

1. That the definition of 'reasonable opinion' means that doctors and psychiatrists will be charged with responsibility for interpreting Article 40.3.3 of the Constitution despite the fact that they do not have a constitutional mandate for doing so. Their determinations will be vulnerable to legal challenge, on the basis of the decisions taken by the courts in *X* and *Cosma*. **See Points 1.1, 2.1, 4.1, 4.4**

2. There is no mention, in the legislation, of the right to life of the unborn, nor of the procedural rights of the unborn to advocacy, nor of the duty of care that is owed to the unborn. There is mention in the Explanatory Notes that doctors "must" make all efforts to save the life of the baby after birth, but there is nothing in the legislation that supports that statement, and it would be unconstitutional if the legislation were to impose time limits on abortion given the decision in the *X* case. **See Points 1.2, 2.2, 4.7**

3. Regarding Head 4, the test of whether "as a matter of probability there is real and substantial risk to the life ... of the mother which can only be avoided by the termination of her pregnancy" has been codified, but there are some legal requirements that have been overlooked. First, the Court held in *Cosma* that one of factors relevant for determining 'real and substantial risk' is a medical treatment plan for psychiatric illness. Second, the 'only' criterion needs to be established to a degree that satisfies the legal tests. Third, the treatment must actually treat the condition in the patient presenting. Fourth, the need to preserve the integrity of law must be taken into consideration. This legislation is weak on all four of these aspects. **See Points 4.2, 4.3, 4.4, 4.5**

4. The right to equality of woman who are treated under Head 4 is jeopardised, since under Head 4 a woman is officially certified as being suicidal and then offered no psychiatric treatment whatsoever for her life-threatening condition, whereas woman who are treated under Head 2 are treated for their presenting medical condition and women who are treated under the Mental Health Act are treated for their presenting psychiatric condition. This discrimination against women on the basis of psychiatric illness is in violation of Article 40.1. **See Points 4.8, 4.9**

5. Whereas the Irish Constitution is uncompromising in its protection of the right to life and the prohibition on the taking of innocent life, in Articles 15.5.2, 28.3.3, 40.3.1, 40.3.2 and 40.3.3, Head 4 operates outwith those constitutional protections. The justification proposed for the inclusion of Head 4 – that Ireland is obliged to implement the decision of the ECHR and the X case – is based on arguments that are unsound and can be rebutted. **See Point 4.11**

6. Regarding Head 12, the exclusion of institutions and organisations and third parties from the right to conscientious objection is contrary to the Constitution, the European Convention on Human Rights and the caselaw of the European Court of Human Rights and a 2010 Resolution of the PACE. **See Point 12.2**

Head 1: Interpretation

Head 1: Interpretation

"reasonable opinion" means an opinion formed in good faith which has regard to the need to preserve unborn human life as far as practicable;

Explanatory notes

"Reasonable opinion"
The definition of "reasonable opinion" requires that this opinion must be formed in good faith and must have regard to protect and preserve unborn human life where practicable. The registered medical practitioner(s) will be obliged to record this opinion in writing if certifying a procedure that will end unborn human life. This definition is intended to place a duty on certifying medical practitioners to preserve the life of the unborn as far as practicable, and is influenced by the Twenty-fifth Amendment of the Constitution (Protection of Human Life in Pregnancy) Bill 2001 (section 1).

1.1 'reasonable opinion'

This definition of reasonable opinion effectively puts the entire responsibility for interpreting Article 40.3.3 of the Constitution on the shoulders of the doctors and psychiatrists. Yet, there is no constitutional mandate which allows them to make such an interpretation of the constitutional provisions.

In the *X* case, the test laid down by the Supreme Court was, in the words of Finlay CJ: "I, therefore, conclude that the proper test to be applied is that if it is established as a matter of probability that there is a real and substantial risk to the life, as distinct from the health, of the mother, which can only be avoided by the termination of her pregnancy, such termination is permissible, having regard to the true interpretation of Article 40, s. 3, sub-s. 3 of the Constitution."[1]

No medical evidence was used in order to apply this test in the case of *X*; no medical evidence was deemed necessary for the application of the test. However, it was necessary that the judges should determine that this test was satisfied because it is a legal test which determines when a constitutionally-guaranteed right has been properly vindicated.

Moreover, the Supreme Court in the *X* case disagreed with the assessment of the psychologist. When the psychologist was asked Question 78: "Is it your professional view that she would destroy herself if matters continue as they are?", he answered: "I would not have taken it on myself to leave that girl alone in the state I saw her", and later stated: "[m]y recommendation would be she was not safe unless under supervision. I would have thought, given the state I found her in, that in-patient treatment would be essential. I don't think the parents can offer 24-hour supervision."[2] Whereas the psychologist did not determine that an abortion was a necessary treatment, the Supreme Court determined that it was. The legal application of the test and the application by the psychologist were at odds with each other.

In the 2006 case of *Cosma v. Minister for Justice*, the court received testimony of a psychiatrist which identified "a strong possibility" that Cosma would commit suicide if deported but found, despite that evidence that there was no real and substantial risk to her life. The legal application of the test and the application by the psychiatrist were at odds with each other.

In sum, (1) the test laid down in the *X* case is a legal test, to be determined at law (2) the Supreme Court considered that medical/psychiatric evidence was irrelevant to their decision in *X* and reached a conclusion that was at odds with the psychologist's testimony in *X* and reached a decision that was at

[1] *Attorney General v. X* [1992] 1 IR 1, at 53-54.
[2] *Attorney General v. X* [1992] 1 IR 1, at 69.

odds with the psychiatrist's testimony in *Cosma*. Therefore, psychiatrists, in particular, would be in an extremely vulnerable position, constitutionally speaking, if they were to purport to form such a 'reasonable opinion' as outlined in Head 1.

Moreover, the inclusion of 'good faith' means that challenges under this head will go to the integrity of the professional rather than the soundness of the medical decision. Moreover, this is out of line with requirements that medical decisions should be taken "in accordance with general and approved practice" from the seminal case of *Dunne v. Natural Maternity Hospital & anor.*[3]

Head 1: Interpretation

"unborn" as it relates to human life means following implantation until such time as it has completely proceeded in a living state from the body of the woman.

Explanatory notes

'**Unborn**' The definition suggested above is based on the Supreme Court judgment in *Roche v Roche & Others*[4] which deemed that embryos acquire legal protection under Article 40.3.3 of the Constitution only from the moment of implantation. This definition of 'unborn' protects the foetus from implantation until birth, including a foetus in the course of being born, thereby closing off a potential legal irregularity in legislation identified by the Expert Group in its report on the *A,B,C v Ireland* Judgement.

1.2 'unborn'

The use of this word is very sparse throughout the text of the proposed legislation, and there are many omissions.

1. No mention is made of the right to life of the unborn, which is the fundamental constitutional principle which governs this area of law, and cannot be ignored by the legislation.
2. No mention is made of the procedural rights of the unborn to advocacy, which is a constitutional right recognised in the *SPUC* line of caselaw and in the *Re Article 26 and the Regulation of Information (Termination of Pregnancies) Bill* and which cannot be ignored by the legislation.
3. No mention is made of the duty of care to the unborn, which is recognised in legislation and caselaw and which cannot be ignored by the legislation.

[3] [1989] IR 91.
[4] [2012] IRRM 411.

Head 2: Risk of loss of life from physical illness, not being a risk of self destruction

Head 2: Risk of loss of life from physical illness, not being a risk of self-destruction

(1) It is not an offence to carry out a medical procedure, in accordance with this head, in the course of which or as a result of which unborn human life is ended, where –

(a) that procedure is carried out by a registered medical practitioner at an appropriate location, and
(b) two medical practitioners, have, in accordance with this head, jointly certified in good faith that –

(i) there is a real and substantial risk of loss of the pregnant woman's life other than by way of self-destruction, and

(ii) in their reasonable opinion this risk can be averted only by that medical procedure.

Explanatory Notes

Subhead (1)(b)(ii) refers to a 'reasonable opinion'. This is defined in the Interpretation to mean an opinion formed in good faith, which has regard to the need to preserve unborn life where practicable. Again, as outlined earlier, this definition is intended to place a duty on certifying medical practitioners to preserve the life of the unborn as far as practicable, and is influenced by the Twenty-fifth Amendment of the Constitution (Protection of Human Life in Pregnancy) Bill 2001 (section 1). This emphasis on preserving unborn human life as far as practicable governs the actual medical procedure – the termination of pregnancy only and not whether there is a real and substantial risk to the life of the mother.

In circumstances where the unborn may be potentially viable outside the womb, doctors must make all efforts to sustain its life after delivery. However, that requirement does not go so far as to oblige a medical practitioner to disregard a real and substantial risk to the life of the woman on the basis that it will result in the death of the unborn.

Essentially the decision to be reached is not so much a balancing of the competing rights- rather, it is a clinical assessment as to whether the mother's life, as opposed to her health, is threatened by a real and substantial risk that can only be averted by a termination of pregnancy.

2.1 'reasonable opinion'

See point 1.1. for the problems with 'reasonable opinion'.

The explanatory notes confirm the analysis of this in 1.1, since they recognise that the reasonable opinion being formed is "a clinical assessment" and not a legal balancing of the rights, which could only be done by the courts. In fact, the explanatory notes affirm that it is impossible for the medical professionals to do what the definition of 'reasonable opinion' in 1.1 requires of them.

2.2 'viability'

The Explanatory Notes state that: "In circumstances where the unborn may be potentially viable outside the womb, doctors must make all efforts to sustain its life after delivery." There is nothing in the legislation that supports this statement and, to the contrary, it appears to be legally inaccurate based on the legislation and on the *X* case, where there are no time limits. Indeed, based on the *X* case, if the proposed legislation did impose a time limit, that would be very constitutionally vulnerable given the existing state of constitutional law.

Head 3: Risk of Loss of Life from Physical Illness in an Emergency Situation

Head 3: Risk of Loss of Life from Physical Illness in an Emergency Situation

(1) It is not an offence to carry out a medical procedure, in accordance with this head, in the course of which or as a result of which unborn human life is ended, where –

(a) that procedure is carried out by a medical practitioner,

(b) he or she in good faith believes that there is an immediate risk of loss of the pregnant woman's life other than by way of self-destruction, and

(c) the medical procedure is, in his or her reasonable opinion, immediately necessary to save the life of the woman.

(2) The opinion referred to in *subhead (1)* shall be certified by the registered medical practitioner referred to in *subhead (1)* in the form and manner prescribed by the Minister.

3.1 'believes in good faith'

This is an entirely subjective test, which is out of line with the usual legal requirements for medical malpractice.

3.2 no right to be part of the decision-making process?

Here the woman is given no statutory right to be heard in the decision-making process regarding the medical procedure.

Head 4: Risk of Loss of Life from Self-Destruction

Head 4: Risk of Loss of Life from Self-Destruction

(1) It is not an offence to carry out a medical procedure, in accordance with this head, in the course of which or as a result of which unborn human life is ended, where –

(a) that procedure is carried out by a registered medical practitioner at an appropriate location,

(b) one obstetrician/gynaecologist, who must be employed at that location, and two psychiatrists, both of whom shall be employed at a centre which is registered by the Mental Health Commission, and one of whom shall be attached to an institution where such a procedure is carried out, in accordance with this head, jointly certified in good faith that –

(i) there is a real and substantial risk of loss of the pregnant woman's life by way of self-destruction, and
(ii) in their reasonable opinion this risk can be averted only by that medical procedure.

Explanatory Notes

Head 4 is concerned with risk of loss of life from self destruction. The criteria are again based on the judgment in the *X* case, this time focusing on cases where a termination of pregnancy is permissible if it is established as a matter of probability that:

1) there is a real and substantial risk to the life of the mother arising from suicide intent; and
2) this risk can only be averted by the termination of her pregnancy.

...

Subhead (1)(b)(ii) refers to a 'reasonable opinion'. This is defined in the Interpretation to mean an opinion formed in good faith, which has regard to the need preserve unborn life where practicable. Again, as outlined earlier, this definition is intended to place a duty on certifying medical practitioners to preserve the life of the unborn as far as practicable, and is influenced by the Twenty-fifth Amendment of the Constitution (Protection of Human Life in Pregnancy) Bill 2001 (section 1). This emphasis on preserving unborn human life as far as practicable governs the actual medical procedure – the termination of pregnancy only and not whether there is a real and substantial risk to the life of the mother.

In circumstances where the unborn may be potentially viable outside the womb, doctors must make all efforts to sustain its life after delivery. However, that requirement does not go so far as to oblige a medical practitioner to disregard a real and substantial risk to the life of the woman on the basis that it will result in the death of the unborn.

Essentially the decision to be reached is not so much a balancing of the competing rights- rather, it is a clinical assessment as to whether the mother's life, as opposed to her health, is threatened by a real and substantial risk that can only be averted by a termination of pregnancy.

4.1 'real and substantial' as a legal test

See 1.1 and 2.1 on 'reasonable opinion'. Psychiatrists are in a particularly vulnerable position if they are to make this interpretation of the rights of the unborn and the mother in the absence of a constitutional mandate.

The test in the X case is a legal test and it cannot be applied only by medical practitioners. In *X*, no psychiatric evidence was relevant to the legal determination 'as a matter of probability' of a 'real and substantial risk' to the life of the woman. The fact that the psychologist explicitly did not determine that an abortion was necessary to save her life did not stop the court from determining that it was. In *Cosma*,

the psychiatrist determined that there was a strong possibility that the woman would commit suicide if deported and the court determined that this did not constitute a 'real and substantial risk'. The courts have determined, therefore, that a medical opinion on the existence of a real and substantial risk is not the same as a legal determination of that criterion, and that they are free to depart from the opinion of a medical expert.

4.2 'real and substantial risk' requires evidence of treatment plan

Moreover, in *Cosma*, the court held that the absence of a treatment plan for the psychiatric condition is a relevant factor in determining 'real and substantial risk'. The judge held that it was significant, in this case, that the applicant "did not address the issue of therapy or counselling or treatment of whatsoever nature". In this legislation does not address the issue of therapy of counselling or treatment of whatsoever nature. There is no requirement that the psychiatric patient should have received a diagnosis and be undergoing treatment for her psychiatric illness, and this again means that the psychiatric determination of real and substantial risk is vulnerable to being constitutionally unsafe.

4.3 'can <u>only</u> be averted' is a legal test

The test in the *X* case clearly established a two-part test, as outlined in the legislation and in the explanatory notes. The first test is the first part is real and substantial risk. The second part is whether that risk can only be averted by the means that the applicant suggests.

In the *Cosma* case, in the application of the second part of this test, the court held that the 'only' part of the test should be rigorously interrogated – by the courts – and that the burden is on the claimant that the course of action chosen is the only way to avoid the threatened suicide. Here, evidence that the applicant had not even considered other courses of action helped the court to conclude that the applicant had not established that this was the only way her suicidality could be assuaged.

In the legislation, there is no requirement that attempts be made to examine other treatment options and this puts the legislation at odds with the *Cosma* interpretation of the *X* case.

4.4 can it be 'a reasonable opinion' that the risk 'can ... be averted' by abortion?

Leaving aside the 'only' criterion, the other essential problem with the test proposed in Head 4 is that it is not in conformity with the principles of best practice and evidence-based medical treatment. There is an enormous amount of scientific evidence and expert testimony which is available in the public domain and which states that abortion does not avert a risk of suicide at all.

It is unconscionable of the legislature to require a psychiatrist to certify in writing to the Minister for something that is known to be in defiance of the principles of best practice and evidence-based medicine. The psychiatrist, the Minister, and the state will be vulnerable to litigation on the basis that they are certifying a procedure that is not medically indicated.

Moreover, there is scientific evidence in the public domain which establishes that the risk of a woman committing suicide is increased after an abortion, and particularly so if she has suffered suicidal ideation prior to birth.

4.5 upholding the integrity of law

In the *Cosma* case, the Minister for Justice, as defendant, refused to overturn a deportation order even after psychiatric evidence had been submitted "in the interests of upholding the integrity of the immigration and asylum laws". He explicitly stated that: "It is a matter of serious concern that a person should threaten self harm if the law is applied to her but it cannot reasonably be held that the law should not apply in such a circumstance." In court, the Minister's position was that "to permit the threat of suicide to act as a stop on the execution of administrative decisions, such as deportation, would be to

open a Pandora's box of potential abuse with the possible effects of paralysing administrative activity in any given area of government" i.e. a floodgates argument.

In a gloss on the *X* case test, the judge in *Cosma* actually accepted that one of the things to be taken into account in cases where suicidal ideation is asserted as a justification for a departure from legal principle is the public policy at stake. Hanna J stated that the Minister was "entitled not just to look at cases in total isolation, although each case must be dealt with on its own merits. He can and indeed should apply his mind to matters of public policy."

In a later case, Macken J in the case of *Minister for Justice v. Johnson* expressly referred to the fact that suicidal ideation may be "feigned" in order to avoid the application of the law.

The law to be upheld in this context is the right to life of the unborn, which is protected by the Constitution and of a higher value, legally speaking, than immigration policy. This proposed legislation does not refer at all to the public policy reasons for needing to uphold this fundamental constitutional principle, rather than allowing it to be held to ransom by threats of suicidal ideation, despite the fact that the Minister for Justice is clearly well aware of the need to uphold the integrity of law in other fields.

4.6 'it is not an offence'

This legislation only proposes to decriminalise the taking of unborn life in the case of suicidal ideation. It does not prevent the psychiatrist being held accountable in tort or for breach of a constitutional right.

4.7 viability

The Explanatory Notes state that: "In circumstances where the unborn may be potentially viable outside the womb, doctors must make all efforts to sustain its life after delivery." There is nothing in the legislation that supports this statement and, to the contrary, it appears to be legally inaccurate based on the legislation and on the *X* case, where there are no time limits. Indeed, based on the *X* case, if the proposed legislation did impose a time limit, that would be very constitutionally vulnerable given the existing state of constitutional law.

Head 4: Risk of Loss of Life from Self-Destruction

(2) (a) At least one of the three medical practitioners referred to in paragraph (b) of subhead (1) shall consult with the pregnant woman's general practitioner where practicable.

(b) In forming the aforesaid opinion, the medical practitioners should examine the woman.

(3) Where three medical practitioners referred to in this head have jointly certified an opinion referred to in *paragraph (b)* of *subhead (1)*, the certifying obstetrician/gynaecologist referred to in paragraph (b) shall forward the certificate to a location referred to in *paragraph (a)* of *subhead (1)* and shall make arrangements for the carrying out of the procedure at that location.

Explanatory notes
This head provides that three doctors are required to form an opinion and jointly certify that a termination is required to avert a real and substantial risk to the life of the mother. This provision arises from the recognised clinical challenges in accurately assessing suicidal intent, and the absence of objective clinical markers. In these cases the Bill provides that the opinion will be jointly certified by an obstetrician/gynaecologist and two psychiatrists. Both of these psychiatrists must be employed in a hospital or other in-patient facility for the care and treatment of persons suffering from mental Illness or mental disorder registered by the Mental Health Commission under the Mental Health Act 2001. Also, one of these shall be attached to the institution where such a procedure is carried out.

Explanatory notes from Head 2
Looking to other areas of medical practice, the case of involuntary detention under the Mental Health Act 2001 provides guidance in that, given the serious consequence arising from the medical assessment, the opinion of more than one doctor is required. In light of the fundamental constitutional rights involved in this clinical decision-making process, i.e. the right to life of the pregnant woman and of the unborn, subhead (1) provides that two doctors will be required to form an opinion and jointly certify that a termination of pregnancy is required to avert a real and substantial risk to the life of the mother. Subhead (2) provides that one doctor must be an obstetrician/gynaecologist, while the other medical practitioner must be of a specialty relevant to the clinical assessment of the woman. One of these medical practitioners must be employed at the location where the termination is due to take place.

4.8 Lack of Equality between women who are treated under Head 2 and women who are treated under Head 4

Despite the similarities in the formal terms laid down in Head 2 and Head 4, there is a substantive inequality which fails to guarantee to women in Head 4 their right to equality under Article 40.1.

It arises because women who are treated under Head 2 (and indeed Head 3) are actually treated with the purpose of alleviating the medical condition they are suffering from. The desired outcome of treatment carried out under Head 2 (and Head 3) is that the woman's physical illness is successfully treated and her physical health is restored.

In contrast, women who are treated under Head 4 are not treated with the purpose of alleviating their psychiatric condition. This desired outcome of treatment carried out under Head 4 is not the psychiatric illness is treated and her psychiatric health is restored. To the contrary, a woman under Head 4 is being treated in a way that is out of line with best practice and evidence-based medicine. To the contrary, medical research shows that the abortion that she is offered will not alleviate her psychiatric illness and may well exacerbate her condition.

Under Head 4 a woman is officially certified as being suicidal and then offered no psychiatric treatment whatsoever for that life-threatening state she is found to be in, which is, arguably, arbitrary discrimination between her and a woman treated under Head 2, in violation of her right to equality under Article 40.1.

4.9 Lack of Equality between women who are treated under Head 4 and women who come under the terms of the Mental Health Act 2001

Discrimination against women who are treated under Head 4 also arises when her position is compared with the position of women and men who are found to be within the terms of the Mental Health Act 2001.

Under Section 3 of the Mental Health Act 2001, where "there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons", the person comes within the terms of 'mental disorder' as defined by the Act. Decisions about their treatment must then, under the terms of Section 4 of the Act, be made according to the best interest principle: "In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made."

In contrast, women who are treated under Head 4 are not treated according to the requirements of the best interest principle with due regard for the interests of other persons who may be at risk of serious harm. Under Head 4 a woman is officially certified as being suicidal and then offered no psychiatric treatment whatsoever for that life-threatening state she is found to be in, which is, arguably, arbitrary discrimination between her and a woman treated the Mental Health Act, therefore in violation of her right to equality under Article 40.1.

Head 4: Risk of Loss of Life from Self-Destruction

(4) It will always be a matter for the patient to decide if she wishes to proceed with a termination following a decision that it is permissible under this Act.

4.10 Full decision-making capacity

This statutory affirmation of the full capacity of the woman to make a decision to terminate the life of her unborn child after having been officially certified as being suicidal is out of line with the law on capacity in the context of psychiatric illness.

4.11 Principled Objection to Head 4

The right to life of unborn children is not mentioned in Head 4, but it is a fundamental constitutional right and a basic constitutional principle and it cannot simply be ignored by the legislation. One of the reasons that rights are enshrined as fundamental in our Constitution is because of the dangerous manner in which the Legislature under the 1922 Constitution eroded the protections for the right to fair trial and right to life by adopting the infamous Article 2A. The right to life and the principled prohibition on the taking of innocent life are centrally enshrined in our Constitution under Articles 15.5.2, 28.3.3, 40.3.1, 40.3.2 and 40.3.3. The prohibition on taking innocent life is so important in the Irish Constitution that it cannot be lifted even in a time of war or armed rebellion. This prohibition on taking innocent life is being lifted by this legislation and that is contrary to the fundamental nature of the right to life in the Irish constitutional order.

The justification given for Head 4 is **(A)** that Ireland is obliged to implement the decision of the European Court of Human Rights in *ABC v. Ireland* and **(B)** that the way to do that is to legislate for the *X* case. These arguments are unsound for the following reasons:

1. Article 46 of the European Convention states that the Member States "undertake to abide by the final judgment of the Court in any case to which they are parties".[5] This is a provision in an international agreement which is not internally binding on Ireland. Once a judgment has been handed down the European Court of Human Rights, supervision of its execution in the state is entrusted to the Committee of Ministers (comprising the Foreign Affairs Ministers of each of the Member States, or their diplomatic representatives). The Committee of Ministers exists as a supervisory body, and, as reiterated in the 6th Annual Report of the Committee of Ministers, published on 10th April 2013, "as regards the nature and the scope of ... execution measures ... the judgments are generally silent. As stressed by the Court on a numerous occasions, it belongs in principle to the respondent State to identify these measures under the Committee of Ministers' supervision. ... This situation can be explained by the principle of subsidiarity, according to which respondent States are, in principle, free to choose the means to be put in place in order to meet their obligations under the Convention".[6]
2. The actual position of the Irish Constitution in relation to the decisions of the European Court of Human Rights is given by the Supreme Court judgment in December 2009 in the case of *McD v. L*, where Chief Justice Murray held that the relationship between the Irish Constitution and international law is "imbued with the notion of dualism" meaning that "at national level national law always takes precedence over international law".[7] With regard to the European Convention on Human Rights, Murray CJ noted that "[c]onceptually, the Convention requires what most international instruments require, namely that the contracting parties take steps to introduce at national level measures giving effect to the obligations which they have undertaken".[8] There is no mechanism by which States can be

[5] European Convention on Human Rights. Available at : http://www.echr.coe.int/NR/rdonlyres/D5CC24A7-DC13-4318-B457-5C9014916D7A/0/ Convention_ENG.pdf
[6] 6th Annual Report of the Committee of Ministers, p.24. Available at: http://www.coe.int/t/dghl/monitoring/execution/Source/Publications/CM_annreport2012_en.pdf
[7] *J. McD. v. P. L. and B. M* [2010] 2 IR 199.
[8] *J. McD. v. P. L. and B. M* [2010] 2 IR 199.

forced to comply with the Convention; rather there is only the ultimate sanction for non-compliance which is expulsion from the Council of Europe. This conclusion he puts somewhat bluntly: "The obligations undertaken by a government which has ratified the Convention arise under international law and not national law. Accordingly those obligations reside at international level and in principle the State is not answerable before the national courts for a breach of Conventions obligations unless provision is duly made in national law for such liability." And again, and even more starkly: "Thus contracting states may in principle, so far as the effect of the Convention at national level is concerned, *ignore* the decisions of the Court."[9]

3. In the case of *ABC v. Ireland*, the Court heard no medical evidence of the condition of Applicant C. The only diagnosis that the Court is made aware of is the Applicant's own self-diagnosis by running an internet search, after which she went to England for an abortion. In these circumstances, it is therefore legally impossible to conclude that she would not have received all possible medical care for her actual condition by medical professionals in Ireland. The Court nonetheless concluded that the procedure by which she could have known that she was entitled to an abortion was not clear enough and that greater clarity was required. It is arguable then that the outcome of the case is a false negative. No health system could reach the standard of providing clarity in relation to treatment plans for patients who do not present themselves for diagnosis before a competent medical professional.
4. The expert evidence showing that the suppositions of the Supreme Court in the *X* case – that abortion would treat the suicidal ideation of the young woman in question and that there was no other way of treating her condition – are medically inaccurate is overwhelming. The expert psychiatrists tell us, to the contrary, that abortion is not, in fact, a treatment for suicide and that there are, in fact, other ways of treating mental health problems that arise during pregnancy.
5. The outcome in the *X* case could not be supported if the courts were to engage in a proportionality test. This test would inquire, as a *first step*, whether the objective would be "of sufficient importance to warrant overriding a constitutionally protected right". Here the objective was the preservation of the life of the mother, and the constitutionally protected right which is being infringed is the right to life of the unborn under Article 40.3.3. The law does allow that in certain circumstances the protection of the right to life of one person may justify the denial of the right to life of another person, most obviously in situations of self-defence, and therefore this first step concerning the objective is passed. The *second step* is to analyse the means used to achieve this objective in order to check whether they are "rationally connected to the objective" as opposed to "arbitrary, unfair, or based on irrational considerations". Is there a rational connection between abortion and preservation of the life of the mother from risk of death by suicide? All of the testimony presented to the Oireachtas Hearings from expert psychiatrists explain to us that abortion is never medically indicated in theory in the treatment of suicidal ideation in pregnant women and therefore it is not recorded in any medical textbooks or academic journals, and also that they have never in practice come across a case in which they would have wanted to advise abortion as a treatment ("we have not had the experience of seeing any women who were suicidal where the appropriate treatment for their suicidal feelings would have been a termination of pregnancy"[10]). If abortion is not actually a treatment for suicidality, then there can be no rational connection between achieving the objective of preservation of the woman's life and the termination of her pregnancy. The *third step* in the test is to check whether the means chosen (abortion) to achieve the objective (preservation of the life of the pregnant woman) impair the right which is being infringed (the right to life of the unborn) "as little as possible". At the Oireachtas Hearings the consensus opinion was that the treatment for suicidality is to treat the suicidality, rather than to terminate the life of the unborn. In relation to the *fourth step*, if it were the case that abortion was a treatment for suicide and if it were the case that abortion would not heighten the risk of suicide, then it could be said that the effects on the rights (i.e. the destruction of the life of the unborn) were proportionate to the objective of saving the woman's life. However, since, to the contrary, abortion will not prevent suicide and may in fact increase its risk, it cannot be said that the effects on the rights are proportionate to their object.

[9] *J. McD. v. P. L. and B. M* [2010] 2 IR 199. Emphasis added.
[10] Volume 1, Appendix 2, at 54.

Head 12: Conscientious Objection

Head 12 : Conscientious Objection

(1) Nothing in this Bill shall be construed as obliging any medical practitioner, nurse or midwife to carry out, or to assist in carrying out, a lawful termination of pregnancy.

(2) Nothing in subhead (1) shall affect any duty to participate in treatment under Head 4.

(3) No institution, organisation or third party shall refuse to provide a lawful termination of pregnancy to a woman on grounds of conscientious objection.

(4) In the event of a doctor or other health professional having a difficulty in undertaking a required medical procedure, he or she will have a duty to ensure that another colleague takes over the care of the patient as per current medical ethics.

Explanatory Notes

Article 9(1) of the European Convention on Human Rights states that: "everyone has the right to freedom of thought, conscience and religion…'. An individual's right to conscientious objection is provided for in most ethical guidelines and has existed with good reason for many centuries. The Medical Council *Ethical Guidelines* state:

'10.2 *If you have a conscientious objection to a course of action, you should explain this to the patient and make the names of other doctors available to them.*

10.3 *Conscientious objection does not absolve you from responsibility to a patient in emergency circumstances.'*[11]

Similarly, the *Code of Conduct for each Nurse and Midwife* makes reference to an entitlement to conscientious objection that may be relevant to professional practice[12].

Subhead (3) refers to the fact that the right to conscientious objection is a human right and, as such, applies only to individuals and not institutions.

12.1 Effect of subhead (2) on subhead (1) in relation to Head 4

The effect of subhead (2) is ambiguous and appears potentially to remove the right of conscientious objection to a person with a 'duty to participate' in abortion certified as a medical treatment under Head 4. As such it is unconstitutional.

12.2 Conscientious Objection for Institutions

The purported prohibition on institutions or organisations from conscientious objection to abortion is most likely also unconstitutional and it is certainly contrary to the European Convention on Human Rights as interpreted by the European Court of Human Rights which has repeatedly affirmed in caselaw that institutions, such as hospitals, hold a legitimate interest in being consistent with their moral or ethical ethos, and may for example forbid their staff not only to practice but also to promote abortion. It is also contrary to the Parliamentary Assembly of the Council of Europe Resolution 1763/2010 on the Right to Conscientious Objection in Lawful Medical Care. This provision would not withstand a challenge before the European Court of Human Rights.

[11] Medical Council: 2009, pg. 16.
[12] An Bord Altranais, 2000.

Appendix 1

Cosma v. Minister for Justice [2004] IEHC 345; [2006] IEHC 36; [2006] 7 JIC 1001

In 1999 Lidia Cosma arrived to Ireland. She applied for asylum on the grounds of religious persecution and was refused both by the Refugee Applications Commissioner (June 2001) and the Refugee Appeals Tribunal (August 2001). In July 2003, she was notified of the Minister's decision to make a deportation order. She sought to challenge that order, and obtained a report by a consultant psychiatrist which referred to an incident that happened in her home country before she left where her niece died while in her care. The psychiatrist concluded his report stating that there was "a strong possibility that she will end her life if she is sent back to a country where she still feels as if she were looked upon as a criminal". In September 2003, her solicitors submitted two psychiatric reports on her behalf and sought reconsideration of her deportation on grounds arising from an alleged threat of suicide.

The Minister again refused, in a letter signed by Principal Officer Noel Dowling, for the following reasons:

(1) Cosma no longer has any right to remain in the State since her application for refugee status was rejected.
(2) Having considered the medical evidence, the Minister decided to confirm his decision, proceeding with the deportation "in the interests of upholding the integrity of the immigration and asylum laws"
(3) Mental illness should be dealt with as mental illness and not as a means to avoid the law: "It is a matter of serious concern that a person should threaten self harm if the law is applied to her but it cannot reasonably be held that the law should not apply in such a circumstance."

Before the High Court, Cosma asked for an order quashing the decision to deport. Her lawyers, among other cases, cited the X case in support. The government's defence was (1) that the psychiatric reports were inadequate to establish a real and substantial risk to life; (2) that "the risk of suicide was and is a medical matter to be dealt with both in [Ireland and Romania] ... and "there is no case made nor evidence presented that either jurisdiction had less than adequate medical facilities to deal with this" (3) that "to permit the threat of suicide to act as a stop on the execution of administrative decisions, such as deportation, would be to open a Pandora's box of potential abuse with the possible effects of paralysing administrative activity in any given area of government"

The High Court (Hanna J) commented that the psychiatrist's report: "comprises almost entirely a narrative by the applicant offering reasons as to why she was threatening to commit suicide ... there is no diagnosis made of any actual mental illness nor any suggested modality of treatment for same".

He held that the burden of proof was on Cosma to establish, on the balance of probabilities, that there was a real and substantial threat to her life by suicide at the time of the refusal to rescind the deportation order and that her threatened act of suicide "could only be forestalled by .. acceding to the applicant's request and stopping the process of deportation and not by any other means such as medical intervention".

Having reviewed the evidence, Hanna J. concluded that

1. Cosma did not establish "a real and substantial risk that she would kill herself. There was undoubtedly a threat to do so. ... More weight was attached to the medical reports... than I would consider appropriate ... they do not evidence whether or not the doctor ever treated or had any intention of treating the applicant. It is reasonable to infer that they were brought into existence at the behest of the applicant's solicitors rather than as a result of any interface between Ms. Cosma and the medical services. By any yardstick the reports fell well short of what one would expect in terms of actual analysis of the applicant's condition, an objective diagnosis and, most significantly, no attempt to address the issue of treatment even in the event of deportation going ahead".
2. Cosma "has not established that revoking the deportation order alone would avert her threatened suicide. No consideration has been given to removing the alleged danger by treatment either here

> or in Romania. Indeed the question of whether some other means of dealing with the situation that exists was not even addressed"

He stated also that the Minister was "entitled not just to look at cases in total isolation, although each case must be dealt with on its own merits. He can and indeed should apply his mind to matters of public policy." And added that it was significant that Cosma "did not address the issue of therapy or counselling of treatment of whatsoever nature"

The Supreme Court refused to hear the appeal on the grounds that the High Court was the proper reviewing authority for this kind of case: "it has been held by the High Court that the deportation order is valid, and that finding cannot be challenged before this Court"

Comparison between *X* and *Cosma* cases (where *X* was entitled to do something that was otherwise illegal because of suicidal ideation and *Cosma* was denied the possibility of having a deportation order revoked because of suicidal ideation)

- In *X*, there was no psychiatrist report; in *Cosma*, there are two.
- In *X*, the psychologist's report was based on one meeting with the young woman, which was arranged by the solicitors and outside of a medical relationship; in *Cosma* the psychiatrist's report was dismissed in part for that reason
- In *X*, there was no diagnosis, and no treatment plan, and no effort to treat the mental illness as a mental illness. In *Cosma* these are all reasons to show that the test of 'real and substantial risk' was not fulfilled.
- In *X*, the test laid down by the Supreme Court was that the risk to her life could only be solved by abortion, but the Court did not consider that there might be other ways of treating her that would save her life so that once they accept that there is a 'real and substantial risk' they conclude that abortion is the only possibility. In *Cosma* this 'only' step is presented as a separate stage in the analysis: the applicant should show that her suicidal ideation can only be solved by the manner she wishes to pursue.
- In *X*, the Court did not consider the public policy reasons for not allowing an individual to have an abortion despite the prohibition on abortion and the constitutionally-recognised right to life of the unborn; in *Cosma* the Court takes on board the floodgates argument and says that the Minister is entitled to have regard to this and to apply the general rule, even in hard cases.

Oireachtas Joint Committee on Health & Children

Public Hearings on the Protection of Life during pregnancy (Heads of) Bill 2013

Submission of Frank Callanan

Chairman and members of the Committee, I am grateful for the invitation of Jerry Buttimer TD, the Chairman of the Joint Committee on Health & Children to make this submission.

THE CONSTITUTIONAL SETTING

It is twenty one years since *Attorney General v X* was decided. The first defendant who was fourteen and a half years old was raped in December 1991, and became pregnant. She and her parents, the second and third defendants were already in England making arrangements to have her pregnancy terminated when they were informed of the granting of an *ex parte* injunction by the High Court in Dublin at the suit of the Attorney General restraining the first defendant and the other defendants from leaving the country, or from arranging or carrying out a termination of the pregnancy of the first defendant. They returned to Ireland. After an application for interlocutory injunction which was treated as the hearing of the action, Costello J delivered a reserved judgement on 17 February 1992, making various orders restraining the first defendant from leaving the jurisdiction for a period of nine months, or from procuring or arranging a termination of pregnancy or abortion, either within or without the jurisdiction.

On the day of her return from London after the making of the *ex parte* order in the High Court, the parents of the girl brought her to what the clinical psychologist who was described as very experienced. He submitted a report and gave oral evidence in the High Court. He stated that when

he had interviewed her, he wanted to have a continuing discussion with her parents. He did not have anyone available to sit with her in the waiting room. His, view on his past experience, of the risk of her committing suicide was so real, that however inappropriate it might have been, he asked her to remain in the room while he discussed the problem with her parents.

The core of the judgement of Chief Justice Finlay is contained in a single plain unadorned but forceful paragraph in which he addressed, as a judge must, the actual circumstances of the case which he or she is called upon to adjudicate. In doing so, he invoked the preamble of the constitution where it is stated, that we the people of Ireland “seeking to promote the common good with due observance of Prudence, Justice and Charity, so that the dignity and freedom of the individual may be assured” and, “true social order attained”, do hereby adopt, enact and give to ourselves this constitution.

Having stated that he accepted the submission made on behalf of the Attorney General as to what the doctrine of the harmonious interpretation of the constitution involved Chief Justice Finlay stated:

> Such a harmonious interpretation of the Constitution carried out in accordance with concepts of prudence, justice and charity, as they have been explained in the judgment of Walsh J in *McGee v The Attorney General* [1974] IR 284 leads me to the conclusion that in vindicating and defending as far as practicable the right of the unborn to life but at the same time giving due regard to the right of the mother to life, the Court must, amongst the matters to be so regarded, concern itself with the position of the mother within a family group, with persons on whom she is dependent, with, in other instances, persons who are dependent upon her and her interaction with other citizens and members of society in the areas in which her activities occur. Having regard to that conclusion, I am satisfied that the test proposed on behalf of the Attorney General that the life of the unborn could only be terminated if it were established that an inevitable or immediate risk to the life of the mother existed, for the avoidance of which a termination of the pregnancy was necessary, insufficiently vindicates the mother‘s right to life.

This is how Chief Justice dealt with what he characterized as “the intimate human problem of the right of the unborn to life and its relationship to the right of the mother of an unborn child to her life”

Some pro-life advocates have strenuously denied that *Attorney General v X* was correctly decided, particularly in extending the principle of a real and substantial risk to the life of the mother to suicide. That is of course an argument which they are perfectly entitled to make. However, I do not believe that a lawyer who believes that *Attorney General v X* was wrongly decided can credibly or responsibly approach the question of the constitutional position in Ireland in relation to abortion on the basis of a denial that the decision of the Supreme Court in *Attorney General v X* represents at the present time, until such time as it is departed from by the Supreme Court, or there is a further amendment by referendum of the Constitution an authoritative statement of the constitutional position. This might seem a fine distinction, but it is clear. One is perfectly entitled to disagree with a judgement of the Supreme Court, but that does not entitle a lawyer to deny that the law in Ireland is as expounded by the Supreme Court in *Attorney General v X,* that is to say that the termination of the pregnancy is constitutionally permissible where it was established as a matter of probability that there was a real and substantial risk to the life of the mother, if the termination was not effected. The obligation to accept that that is at the present time the constitutional position is something that arises from the sovereign independent and democratic nature of the state.

The decision of the Supreme Court in *Attorney General v X* in 1992 was affirmed in the clearest terms three years later, in the reference to the Supreme Court under Article 26 of the Regulation of Information (Services outside the State for Termination of Pregnancies) Bill 1995, the bill that sought to prescribe the conditions under which information relating to services lawfully available in another state could be provided as contemplated by the 14th amendment. In the single judgement of the Supreme Court given by Chief Justice Hamilton, the judgements of the Supreme Court in *Attorney General v X,* particularly that of Chief Justice Finlay, are relied on throughout.

Moreover, it was actually contended by counsel for the unborn that *Attorney General v X* was wrongly decided, because no argument had been addressed to the court in the question of natural law, and that there was no medical evidence adduced with regard to the question of the medical necessity for an abortion (the evidence of the suicidal potential of the first defendant in *X* was that

of a psychologist rather than a psychiatrist). Significantly, this was part of a general argument that the natural law was superior to the constitution. The Supreme Court held: “Having regard to the judgment and decision of this court, which recognizes and emphasizes the supremacy of the Constitution, this Court is satisfied that in the consideration of the issues raised in that case and the conflicting constitutional rights involved, the proper principles were applied to the interpretation of the relevant provisions of the Constitution and in the determination of the issues raised therein and rejects this submission”. The court had earlier considered and rejected the argument that what was described as “the natural law” was the fundamental law of the state, and on such antecedent and superior to all positive law including the Constitution.

It is not merely that the judgement of the Supreme Court in *X* was confirmed in the reference of the Information Bill to the Supreme Court. There has never been the slightest judicial suggestion that *X* was wrongly decided. Moreover, the state has itself elected to rely on *X* in resisting challenges brought against it under the European Convention before the European Court of Human Rights. This is particularly true in relation to the argument successfully advanced by the state in *D v Ireland* that the applicant had failed to exhaust her domestic remedies. This entailed the state arguing based on the opinion of counsel that there was at least a tenable argument that a foetus suffering from a fatal abnormality was not an “unborn” for the purposes of Article 40.3.3, or that even if it was an “unborn” its right to life was not actually engaged, as it had no prospect of life outside the womb [paragraph 69 of the judgement].

Of course it goes further than this. Constitutional amendments that sought to exclude suicide were rejected by the people in 1992 and in 2002. In 1992, in rejecting the exclusion of a risk of suicide, the people adopted the 13th Amendment, which provided that Article 40.3.3 did not limit freedom to travel, and the 14th Amendment which provided that it did not limit freedom to obtain or make available, information relating to services lawfully available in another state. The 13th and 14th Amendments can be seen as responses by the people to the facts of the *X* case and to the judgements of the Supreme Court. The judgement of the Supreme Court in *X* is to this extent woven into the fabric of modern Irish politics.

The reason that this is a point of importance that it is necessary to emphasise that there is a concern that behind the argument, which I struggle to comprehend, that legislation of the character

contemplated in the heads of bill are not necessary lies a mute refusal to accept that the position in Irish law is as enunciated by the Supreme Court in *Attorney General v X,* that *X* is part of the Irish constitutional *acquis.*

THE NEED FOR THE BILL

The requirement for legislation and the purpose of this Bill is to close over the fissure that exists between the enunciation of constitutional rights by the Supreme Court and the giving of legislative effect to those rights.

In the case law there are two striking passages that deal with that fissure.

In *A & B* **v** *Eastern Health Board* [1998] 1 IR 465 Mr Justice Geoghegan stated (at pages 477-478):

> Furthermore, I think it highly undesirable for the court to develop a jurisprudence under which questions of disputed rights to have termination of pregnancy can only be determined by plenary action in the High Court. The High Court undoubtedly has a function in granting injunctions to prevent unlawful terminations taking place, and it may in certain circumstances properly entertain an action brought for declarations and consequential orders if somebody is being psychically prevented without just cause from having a termination. But it would be wrong to turn the High Court into some kind of licencing authority for abortions, and indeed it was for this reason that I have rejected a suggestion made by counsel for C in this case that I should effectively convert the judicial review proceedings into an independent application invoking the inherent jurisdiction of the High Court, and grant leave for such a termination to take place. I took the view that the case should continue in the form of a judicial review and nothing more. The Child Care Act 1991 is a perfectly appropriate umbrella under which these questions can be determined.

These observations anticipated the findings of the European Court of Human Rights in *A B C v Ireland* that the option of litigation relied upon by the Irish State did not offer effective and accessible procedures which would have allowed *C* to establish her right to a lawful abortion in Ireland: The ECtHR stated:

> 285. The court does not consider that the Constitutional Courts are the appropriate *fora* for the primary determination as to whether a woman qualifies for an abortion which is lawfully in a State. In particular this process would amount to requiring the Constitutional Courts to set down on a case by case basis the legal criteria by which the relevant risk to a woman's life would be measured and, further, to resolve through evidence, largely of a medical nature, whether a woman had established that qualifying risk. However, the Constitutional Courts themselves have underlined that this should not be their role…..
>
> 259. In addition, it would be equally inappropriate to require women to take on such complex constitutional proceedings when their underlying constitutional right to an abortion in the case of a qualifying risk to life was not disputable (The Green Paper 1999, paragraph 68 above).

THE PRINCIPLE OF STATUTORY INTERPRETATION IN CONFORMITY WITH THE CONSTITUTION

In assessing the Heads of Bill, it is important to bear in mind the overriding principle that any legislation is to be interpreted and given effect to in conformity with the Constitution. That principle, which of course is of general application, has a particular salience in the case of heads of bill which are so closely headed to, and derivative of the jurisprudence of the Supreme Court.

It is worthwhile also emphasizing the weight given by the Supreme Court in the reference of the Regulation of Information Services Bill of 1995 to the presumption that official acts authorized by Act

of the Oireachtas will be performed in a constitutional manner [for the application of the "double construction rule" to official acts see G W Hogan and G F Whyte, J M Kelly: *The Irish Constitution* 4th edition, paras. 6.2.232-237]. The immediate context was in relation to an argument advanced on behalf of the unborn that the Bill infringed the right of the parents of a minor, or of a husband by failing to require that the parents or husband be notified of the fact that the minor, or the wife has sought and obtained information in relation to abortion services. The Supreme Court held (at page 51):

> In the consideration of the Bill and any particular provision thereof, the court should apply to such consideration the principals laid down by it in *East Donegal Co-Operative v The Attorney General* [1970] IR 317 which are summarized in the decision of this court in *The Adoption* (2) Bill, 1987 [1989] IR 656 at p.661 of the report as follows:
>
> > That it must be presumed that all proceedings procedures discretions and adjudications permitted or prescribed by the Bill are intended to be conducted in accordance with the principles of constitutional justice".
>
> The Oireachtas was also entitled to make that presumption.

The effect is that it is to be presumed that procedures under the act in question will comply with the principles of constitutional and natural justice. This seems preferable to an excessively prescriptive and over-rigid legislative scheme which seeks to anticipate every possible eventuality or combination of circumstances which would risk defeating the purpose of the legislation.

THE HEADS OF BILL

The scheme of the Bill arising from its purpose is conceptually conservative from its purpose. It seeks to translate into legislation the principles enunciated in *Attorney General v X,* rather than seeking either to widen or to add to category of cases in which a termination of pregnancy is permissible.

There is a good deal to be said in favour of this approach. In seeking to craft an act of the Oireachtas that conforms to the principles in *X,* it mitigates the risk that the Act would be held to fall foul of Article 40.3.3. The Bill is a vessel negotiating a narrow strait. It could run aground on Article 40.3.3 by doing more than *X,* or it could come to grief under the European Convention on Human Rights (or indeed under the Constitution) by not doing enough, if it failed to put in place a legislative scheme that gave practical effect to the principles upheld in *Attorney General v X.*

There is a difference being restrictive as these heads of bill are and being unworkable. If provisions of the Bill transpire to be unworkable, the purpose of the Bill is to that extent defeated and we risk finding ourselves back in an *A B C v Ireland* situation, or indeed in a *Tysiac v Poland* situation.

The necessity to ensure that the provisions of the perspective legislation are clear and practicable arise, not merely under the judgement of the Court of Human Rights in *A B C v Ireland,* but from the obligation to ensure respect for the right to life of pregnant women who for one reason or another do not have the option of leaving the jurisdiction for a termination, so that their rights to equality of treatment under Article 40.1 of the Constitution and under Article 14 of the European Convention on Human Rights are not denied them.

The heads of bill in my opinion remains squarely within the parameters of *Attorney General v X.* The scheme of the Bill commends itself as restrained and measured. It appears to me to strike the right balance in remaining firmly within the parameters of *Attorney General v X,* while ensuring that the procedures it prescribes are not impractical as the Constitution itself as well as the Convention on Human Rights requires.

Given the nature of the Bill, as one whose purpose is to give legislative effect to a constitutional right, it seems to me that the Heads of Bill correctly avoid being overly prescriptive. The expert group sensibly observed (at page 30 of its report) of the test in *Attorney General v X*

> Although the medical decisions may be difficult in particular cases, the complexities will not arise from the words of the test but from diagnostic and treatment issues. Implementing the decision does not, therefore, require another definition of the test. Neither is it necessary or desirable to seek to explain it with synonymous terms.

The inclusion of suicide is effectively mandated by *Attorney General v X*. The provision of somewhat different procedures between the risk of life from physical illness in Head 2, and the risk of loss of life from suicide in Head 4 seems reasonable and proportionate arising from what the Minister has referred to as the more subjective nature of the diagnosis of a suicide risk due to the absence of objective clinical markers.

The argument that the heads of bill are deficient in failing to prescribe a time limit after which it would be impermissible for a termination to be carried out is, in my opinion, misconceived. It derives from the abhorrence widely and deeply felt in Ireland, of legislative regimes in other jurisdictions which are believed to permit abortion "on demand". The committee has already heard abundant medical evidence on this subject. When a foetus is viable, or on the cusp of a viability, then it is constitutionally mandatory that every effort must be made to protect the life of the unborn. That absolute constitutional requirement corresponds with and affirms clinical practice. The matter is addressed in the report of the expert group on page 28: "Where a woman has a pregnancy that places her life at risk and her foetus is or may be viable, she may have a right to have the pregnancy brought to an end but not a right to insist that the life of her foetus be deliberately ended. The imposition of time limits is foreign to the scheme of the bill and to its constitutional setting. The inclusion of prescriptive time limits also opens the unwelcome prospect of a constitutional challenge on the grounds that the legislation infringed the equal right to life of the mother, as construed by the Supreme Court in *Attorney General v X* .

I am aware that the Committee has already received many principal comments and suggestions. A number of comments of a technical character occur, many of which have already been canvassed.

In relation to Head 1(1) there does seem to be merit in the proposal that "appropriate location" should extend to all public general hospitals, particularly in the circumstances that as Dr Peter

Boylan has pointed out that the three Dublin maternity hospitals do not have intensive care units. This has also been advocated by the Institute of Obstetricians & Gynaecologists. I appreciate on the other hand that the Minister has some concerns about broadening the definition of appropriate location.

The Institute of Obstetricians & Gynaecologists have stated that the definition that Obstetrician/Gynaecologist ought for practical reasons, to extend to those acting in the role of Consultant Obstetrician/Gynaecologist who may be on a general division of the Register of Medical Practitioners, rather than in the Specialist Division. The merits of the two options are canvassed by the expert group (at pages 31-32 of its report).

On a minor note, simply to render the language of the heads of bill uniform, in Head 2(5) and Head 4(4) there be might substituted “the pregnant woman” for “the patient” , and “a medical procedure in the course of which, or as a result of which unborn life is ended” for the “termination”.

In Head 4(2) the heads of bill provide that at least one of the three medical practitioners consult with the pregnant woman’s general practitioner “where practicable”. The Minister in his statement to the Committee said it may be appropriate that the pregnant woman’s age is consulted with her permission and where practical and feasible. It would be desirable to provide expressly for the consent of the woman to the consultation with her general practitioner in Head 2(3) and Head 4(2), without deleting the qualification of practicability.

In relation to the review procedures provided for at Heads 6 and 7, it may be desirable to expressly state that the opinion of the medical practitioners on review that there is a real and substantial risk of loss of life of the pregnant woman that could only be averted by a termination of her pregnancy is to have the same effect as a certificate under Head 2(4) and Head 3(4). This is lest it be suggested the references in Head 2 and Head 4 refer to the relevant categories of medical practitioners related only to the first instance certification and not to the formation of an opinion by the review committee.

Head 19 creates an offence to replace sections 58 and 59 of the Offences against the Person Act 1861, which is repealed by Head 18. The explanatory notes recognise that the potential criminalisation of a pregnant woman is a very difficult and sensitive matter, but that the provision reflects the state's constitutional obligation arising from Article 40.3.3. That is probably correct: it is certainly a matter that would almost certainly give rise to a constitutional challenge. I think it may be possible to improve the words of Head 19(1). The proposed offence is at it were free-standing, and is not related to Heads 2, 3 and 4. There is also perhaps, the danger of starting a hare that the reference to doing any act with the intent to destroy unborn human life extended to the advocacy of abortion rights. It would seem to me preferable to provide that it would be an offence to carry out, or cause to be carried out any act with the intent and effect of destroying unborn human life save in accordance with the provisions of the act.

CONCLUSION

It might appear that a Bill that is so conceptually conservative is of little consequence in that it does not add to what is established by *X.* I do not think that is right. It is not simply that it introduces a scheme under which the rights established in *Attorney General v X* are given effect to. It is true that we are obliged to legislate for *X* because of the decision of the European Court of Human Rights in *A B C v Ireland*. The introduction of the Bill seems to me nonetheless a momentous event in the sometimes turbulent journey of Irish statehood. The rights enunciated by the Supreme Court do not remain external to or divorced from the Houses of the Oireachtas. The Bill achieves the repatriation of this fraught and deeply divisive question to where, subject to the Constitution, it primarily belongs. It reflects what is to be achieved through the dialogue within and between the institutions of this republic and with the people.

Frank Callanan SC is a member of the Irish Bar practicing in Dublin. His third level education was at University College Dublin, the College of Europe, Bruges and the Kings Inns. He was called to the Bar in 1979, and took silk in 1998. His area of practice includes constitutional law. Outside the law, he wrote *The Parnell Split* (1992), and a biography of T M Healy (1996). He is the Chairman of the Trustees of Fine Gael, but makes this submission to the Joint Committee in an entirely personal capacity.

Joint Committee on Health and Children

Public hearings on the Protection of Life During Pregnancy (Heads of) Bill 2013

Statement/Submission by Judge Catherine McGuinness Tuesday 21st May 2013

I appreciate the constitutional constraints which apply to the Government in bringing forward this legislation and in framing the General Scheme of the Protection of Life During Pregnancy Bill 2013. I am in general support of the Heads of Bill as set out and it appears to me that they are consonant with the provisions of the Constitution as interpreted by the Supreme Court in Attorney-General v X.

As I said in my previous oral evidence to this Committee, I see myself as expressing the middle ground in the debate which has surrounded the proposed legislation. Despite the emphatic, not to say virulent, nature of some of the argumentation on both sides I remain convinced that very many Irish people will approve the action of the Government in finally bringing forward legislation in accordance with the Constitution in this difficult area.

The Committee has kindly invited me to present my views on the proposed legislation. It would be fair to point out that, in addition to any legal expertise which I may possess, I am a member of the Working Group set up by the Standing Committee of the General Synod of the Church of Ireland which has already made written submissions to your Committee on the Heads of Bill as set out. I am in general agreement with these submissions.

From a legal point of view I consider that the Heads of Bill are well and carefully drafted so as to provide for termination of pregnancy where that is constitutionally permitted, and to clarify the position of medical personnel involved in such cases. I will add some brief comments on individual Heads, which can if necessary be enlarged in oral evidence.

Head 1 – Interpretation

"Appropriate location": I welcome the fact that termination of pregnancy will be allowed only in the 19 public obstetric facilities in the State, except in cases of emergency. I understand that some concern has been expressed that what are described as "Catholic hospitals/institutions" would be involved, but this is not the case. All the public concerned facilities are fully supported by the generality of the tax-paying public and thus may not be governed by any particular religious rulings.

"reasonable opinion": This definition gives adequate expression to the importance of good faith on the part of the person forming the opinion and usefully includes the phrase "as far as practicable". It is a definition which takes account of the realities of human life.

It is also welcome that the various definitions included in Head 1 and the provisions contained in later Heads make provision to ensure that there will be adequate regulation, registration, quality control and audit of the facilities carrying out termination of pregnancy and that the decision to carry out a termination of pregnancy will be taken at a senior clinical level.

"unborn": I accept that this definition is based on the Supreme Court judgement in the Roche case. However, it should be pointed out that this definition of the personhood of the unborn is not universally agreed.

Heads 2 and 3

These Heads have proved to be relatively uncontroversial. In that they deal with medical and emergency situations they are drafted in accordance with the present constitutional framework. It is perhaps unfortunate that the situation where the foetus is clearly unviable has not been included, and at least the situation where the foetus is dead before birth might have been dealt with by a change in the definition of "unborn".

Heads 4-8 Risk of loss of life from self-destruction:

There has been considerable opposition to these Heads by groups opposed to abortion, including an extreme level of lobbying of individual members of the Oireachtas. Nevertheless, this ground is included in the Supreme Court's decision in the X case. The removal of this ground for termination of pregnancy would require a further referendum. This constitutional position has been conceded, however reluctantly, by the more rational and legally aware representatives of anti-abortion groups. In my previous oral evidence to the Committee I dealt with the detail of the judgments of the Supreme Court in X, and with the importance of harmonious interpretation of the Constitution as

stressed by Chief Justice Finlay, and I do not wish to repeat this here. Repeated use of terms like "a flawed judgement" are in truth irrelevant, and are also often based on a failure to read either the actual judgments or the actual evidence in the case. I am aware of practical difficulties which can arise from the actual operation of this ground. The insistence on relying on a threat to the mother's actual life, rather than to her health, is likely to lead to the initiation of grounds such as this.

It is argued that the inclusion of Head 4 in the proposed legislation will lead inevitably to a widespread increase in termination of pregnancy. It seems to me that the procedure as set out in the Heads of Bill is quite sufficiently rigorous to ensure that very few cases indeed will be dealt with under this Head. From a practical point of view it could well be argued that the procedure is so rigorous that women in this situation would be most likely to choose the option of going abroad for a termination rather than applying under this Head.

I consider that discussion on the medical aspects of this Head is best left to the medical witnesses. I would, however, venture a comment on the fears so constantly expressed that this Head will "open the floodgates" to "abortion on demand". It seems to me that there is an illogicality in the arguments being made. On the one hand it is extremely strongly asserted that Irish people in general reject abortion and that the various forms of public lobbying demonstrate that this is the case. On the other hand it is argued that if the door is even slightly opened to the obtaining of a termination of pregnancy, even in the extremely narrow terms of the proposed legislation, there will be a flood of Irish women seeking abortions on false excuses and that these women will be supported by a numerous flock of Irish doctors willing to collaborate with them. Who are these supposed women if they are not Irish people? Where are these doctors? Surely there is an inherent contradiction here, and the "floodgates" argument assumes that the reality is that there is a large proportion of the Irish public who actually want wider access to abortion, and will get it unless they are legally prevented by a minority who oppose this access? The results of public opinion polls on the subject may be relevant to thinking about this.

Heads 10 and 11

These provisions on notification, recording and reporting to the Minister are welcome. It is very important that clear information on the operation of the legislation should be kept under review. I consider that all annual reports of the operation of the legislation should be published, while, of course, providing for anonymity of the individuals concerned.

Head 12

Conscientious objection is rightly limited to individuals rather than institutions under this Head.

Head 13

I accept the wisdom of including this Head. It does, however, underline the ambiguity (at least) of a situation where the fact is that abortion is quite widely availed of by Irish citizens despite the very terms of the constitutional provision and of the proposed legislation. This situation has been borne out by the results of the various referenda which have taken place over the years.

Head 19

The proposed long overdue repeal of sections 58 and 59 of the Offences against the Person Act 1861 is welcome and I accept that modern legislation covering offences is necessary. I am somewhat concerned at the level of maximum sentence where this may apply in the case of an individual offence by one woman and one doctor as opposed to a situation where a doctor or a body corporate carries out numbers of illegal terminations. Would it be desirable to differentiate these situations as regards maximum sentence? It will be rightly argued that both the discretion afforded to the Director of Public Prosecutions in 19(4) and the normal discretion of the judiciary in imposing sentence will apply in ensuring that injustice does not arise. However, it is not necessarily ideal to rely on the correct application of discretion. One might recall in this context the recurring controversy over the age of consent to sexual intercourse.

General

It might here be appropriate to refer to the issue raised by Archbishop Martin in his letter to The Irish Times published on 16th May 2013. The concern of the Archbishop is understandable, and in fact might possibly arise under other Heads of the Bill as well as Head 4 which the Archbishop specifically mentions. In my view this is an unfortunate outworking of the original insistence in 1983 of including the rights of the unborn and of the mother in a constitutional rather than a legislative provision. The situation where there is “a clear presumption that (the child) is viable outside the womb” is unlikely to arise where termination is forbidden after a certain stage of the pregnancy is reached. As is inferred by the Archbishop in the concluding sentence of his letter, this situation is covered in the laws of many other jurisdictions. As I understand it, the government has met criticisms on the omission of a similar prohibition of late abortions by pointing out that a human right under the Constitution cannot be time-limited in this way. It appears to me that the government is correct in this. We are therefore left with the position that because we sought in amending the Constitution to prevent abortion, we now find it inadmissible to introduce desirable and proper legislation for a time limit on termination. The warnings of the Attorneys General regarding the 1983 amendment are still relevant.

I am also reminded of the statement issued in 1982 by the Standing Committee of the General Synod of the Church of Ireland:

"In our opinion a proposed amendment to the Constitution and a referendum will not alter the human situation as it exists in this country, contribute to its amelioration or propose a responsible and informed attitude to the issue of abortion. We gravely doubt the wisdom of using constitutional prohibitions as a means of dealing with complex moral and social problems."

The issues dealt with in the Heads of Bill is always characterised as difficult and sensitive. This is true, but these very issues are made far more difficult by the behaviour and methods used by the more determined advocates of both lines of argument. Clearly all groups have the right to express their views publicly, but lobbying can descend to a level which can only be described as abusive, or downright bullying. It is to be hoped that public representatives who have been subjected to this kind of behaviour will not suffer any damage and will be able to stand clear of it and make their own judgment.

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Catherine McGuinness

16th May 2013

SUBMISSION

TO

JOINT COMMITTEE ON HEALTH AND CHILDREN

ON

PROTECTION OF LIFE DURING PREGNANCY

(HEADS OF) BILL 2013

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1. This submission is concerned with the ethico-legal aspects of the Protection of Life During Pregnancy (Heads of) Bill 2013. I wish to thank the Chairman of the Joint Committee on Health and Children for the invitation to make this submission and to make a presentation before the Committee in relation to it.

General

The Ethical Imperatives

2. The Medical Council, in its Guide to Professional Conduct and Ethics for Registered Medical Practitioners,[47] reminds all doctors that "Good medical practice is based on a relationship of trust between the profession and society, in which doctors are expected to meet the *highest standards of professional practice* and behaviour" (*emphasis* added).[48]

3. It goes on to note that this "involves a partnership between patient and doctor that is based on mutual respect, confidentiality, *honesty, responsibility and accountability*" (*emphasis* again added).[49]

4. As to how this duty ought to be discharged, the Council requires that, in addition to maintaining clinical competence, each doctor should, *inter alia*, exercise good judgement and communicate sound clinical advice to patients and search for the best evidence to guide professional practice, with a commitment to continuous improvement and excellence in health care provision.[50]

5. A failure to meet the appropriate professional standard, the Council states, may amount to (i) professional misconduct (on the so-called "falling below the expected standard" ground), i.e. "[c]onduct connected with his or her profession in which the doctor concerned has seriously fallen short by omission or commission of the

[47] Medical Council, Dublin 7th edition (2009)
[48] Guide to Professional Conduct and Ethics for Registered Medical Practitioners, para. 1.1.
[49] Guide to Professional Conduct and Ethics for Registered Medical Practitioners, para. 1.1.
[50] Guide to Professional Conduct and Ethics for Registered Medical Practitioners, para. 1.2.

standards of conduct expected among doctors”[51] or (ii) poor professional performance, i.e. “a failure by the practitioner to meet the standards of competence (whether in knowledge and skill or the application of knowledge and skill or both) that can reasonably be expected of medical practitioners practising medicine of the kind practised by the practitioner.”[52]

6. Thus, the regulator, by way of generic standard-setting, requires each doctor to search for the best evidence to guide professional practice and stigmatises the failure to adhere to professional standards as either professional misconduct or poor professional performance, depending on the issues under consideration.

7. Put another way, doctors are enjoined to practise evidence-based medicine in default of which sanctions may be imposed, the nature of which sanctions are not *ad rem* the present discussion.

8. The reason is very simple: as the Council set out in the introduction to its professional guide, “[t]he role of the Medical Council is to safeguard the public by ensuring that the quality of the doctor’s competence, behaviours and relationships that underlie . . . professionalism is maintained in the patient-doctor relationship”.[53]

9. In other words, the protection of the public – assuring quality in the care delivered and the safety of patients while receiving that care – requires adherence to the highest standards.

10. That, in turn, necessitates practice based on the highest quality of evidence available. It is not a matter of individual opinion, in any given case. There are objective standards by which the propriety of individual opinion may be measured, in most cases.

[51] Guide to Professional Conduct and Ethics for Registered Medical Practitioners, para 2.1.(b).
[52] Guide to Professional Conduct and Ethics for Registered Medical Practitioners, para 2.2.
[53] Guide to Professional Conduct and Ethics for Registered Medical Practitioners, page 7.

The Legal Imperatives

11. The emphasis on evidence-based practice is reflected, in our legal order, in developments related to determination, in the law of tort, of the standard required of doctors, in diagnosis and treatment.

12. This was variously articulated in different ways, over the years. However, detailed consideration is not necessary for the purposes of this submission. Suffice it to say that, in its classical formulation, a doctor must “possess such knowledge and skill as conforms to the recognised contemporary standards of his profession and, if he is a specialist, such further and particularised skill and knowledge as he holds himself out to possess. He must use such skill and knowledge to form an honest and considered judgment as to what course, what action, what treatment, is in the best interests of his patient. He must display proper care and attention in treating, or in arranging suitable treatment for, his patient.”[54]

13. If a “general and approved” practice is followed, subject to its not having inherent defects, that may be sufficient to discharge the duty imposed on a doctor.[55]

14. What, however, is a “general and approved practice”? The Supreme Court has stated that it “need not be universal but must be approved of and adhered to by a substantial number of reputable practitioners holding the relevant specialist or general qualifications.”[56] This has sometimes been characterised as “a *responsible* body” of doctors or “a competent *reasonable* body of opinion”[57] or a “*respectable* body of professional opinion”[58] (*emphases* added).

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[54] *Daniels v Heskin* (1953) 87 ILTR 189, [1954] IR 73 at 86, per Kingsmill-Moore J. The repeated use of the masculine is simply a reflection of the attitude of the time.

[55] *Dunne (an infant) v National Maternity Hospital & anor*. [1989] IR 91.
[56] *Dunne (an infant) v National Maternity Hospital & anor*. [1989] IR 91 at 110.
[57] *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 at 122, [1957] 1 WLR 583 at 587-588.
[58] *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635 at 639, [1984] 1 WLR 634 at 639, *per* Lord Scarman.

15. This deferential devolution by our Courts of the determination of what treatment is appropriate, it appears, is no longer sustainable. The High Court, more recently,[59] has indicated clear judicial approbation of professional guidelines and their (almost reflexive) incorporation into the assessment of what the appropriate standard of care is, virtually a declaration of equipollence.[60]

16. The Court, although it was argued that the guidelines under consideration "have the status of advice", was "convinced from all of the evidence . . . that the implementation of these guidelines is essential . . . . [did] not accept that the guidelines were so new or so radical that they required a period of analysis, or trial, before acceptance . . . ."[61]

17. The Court continued: "Ordinary care demands that [an obstetric unit] be kept reasonably up to date in important thinking in medical science. Since these guidelines were extremely important, involving a commonly occurring injury, and making practical and difficult to dispute suggestions, they should have been implemented."[62]

18. This was in the context of evidence actually having been given by an experienced clinician of her personal non-compliance with the guidelines in question – which were evidence based and published by the responsible professional body – after their promulgation.

19. This should, accordingly, reasonably be considered a herald, at least insofar as evidence-based professional guidance is concerned, and represents an understandable shift in how the courts assess doctors' behaviour. This can hardly be considered surprising, given that, in the nearly 25 years that have elapsed since the formulation of the applicable legal "test" in the Supreme Court,[63] the practice of

[59] *HM v HSE* [2011] IEHC 339 (20 July 2011) *per* Charlton J.
[60] In this case, the particular guidelines in question were those of the RCOG on the management of third and fourth degree perineal tears.
[61] *HM v HSE* [2011] IEHC 339 (20 July 2011) *per* Charlton J, at para. 16.
[62] *HM v HSE* [2011] IEHC 339 (20 July 2011) *per* Charlton J, at para. 25.
[63] *Dunne (an infant) v National Maternity Hospital & anor*. [1989] IR 91 at 108-110.

medicine and the drive to evidence-based practice has advanced at a very significant rate.[64]

20. Even more recently still, a unanimous Supreme Court has re-cast the duty owed by doctors to patients in constitutional terms.[65] The Court stated: "The Constitution identifies rights which are to be protected and vindicated because they belong to each human person because of their very humanity. Among the values which have been recognised by the Courts are human dignity, bodily integrity, and autonomy, that is the capacity to make informed decisions affecting one's own health. The duty to protect those rights is not confined to the Courts. *Each health professional is, and was always, under a similar duty*."[66] (*emphasis* added) The Court went on to note that although the finding in the case was in negligence, "what happened . . . was a betrayal of trust; it was an invasion and violation of the rights just identified . . . ."[67]

21. Thus, it merits noting, the courts consider that health professionals are, and always were, under a duty to protect patients' constitutional rights, which it did not attempt to identify exhaustively. It seems that mere respect for such rights is not (and never was) sufficient.

22. Although the parameters of the duty and whether or not they are co-extensive with those of the courts have not been fully articulated, the broad constitutional imperative, nevertheless, cannot be ignored. There is an affirmative duty: it ought reasonably be considered to reflect the ethical professional duty owed to patients in any event, and as set out, historically, in codes governing clinicians' ethical conduct.

[64] It merits noting, in this context, that nearly 60 years have elapsed since the decision of the former Supreme Court in *Daniels v Heskin* (1953) 87 ILTR 189, [1954] IR 73, from which the judgment in *Dunne*, itself, heavily draws.
[65] *Kearney v McQuillan & anor* [2012] IESC 43 (11 July 2012) (MacMenamin J (Denham CJ, Hardiman, Fennelly & Clarke JJ *conc*.)).
[66] *Kearney v McQuillan & anor* [2012] IESC 43 at para. 29.
[67] *Kearney v McQuillan & anor* [2012] IESC 43 at para. 29.

23. It cannot be asserted, therefore, that there is a divergence between a doctor's ethical duty and his or her duty to patients in our Constitutional order, as set out by the Supreme Court in its most recent decision on point.

24. Nor can it be asserted any longer that ethical (or lawful) practice can be reduced to mere matters of professional opinion. The fundamental requirement is for evidence justifying the practice, to fulfil the primary ethical injunction, *primum non nocere* – first do no harm.

25. Against that ethico-legal background, I propose next to address the Heads of Bill.

Heads of Bill

26. I do not propose to engage in any particular detailed analysis of the specific provisions of the Heads of Bill, or of the historical or legal background resulting in their being considered by the Committee – they are matters that will, undoubtedly, be addressed by other persons presenting before the Committee – but rather intend to confine my comments and observations to what appear to be the broad thrust of the Heads, insofar as the apparent policy and philosophy are concerned. In this context, by way of initial observation, there is, with respect, an air of some unreality in attempting to comment on the text of the Heads of a Bill, where the Bill itself has not been published and has not received its Second Reading.

27. The principal policy objective, as appears in the General Scheme of the proposed Protection of Life During Pregnancy Bill 2013, is identified in the proposed Short Title, *viz*. the protection of life during pregnancy. Absent the proposed Long Title, it is unclear what else is considered, or might be considered, relevant by the Oireachtas, in this context, such that further commentary, in that drafting vacuum (as already alluded to) is simply not possible.

28. Be that as it may, it is inescapable fact of biology that, insofar as life during pregnancy is concerned, there are two lives to be considered for protection. It is also an inescapable fact of ethical professional practice that a doctor, in treating a

pregnant woman, has two patients, to each of whom an ethical and legal duty is owed.[68] This underpins all professional practice, irrespective of a doctor's own personal or political views on the availability of abortion.

29. Insofar as achieving that policy objective is concerned, the Heads of Bill, as drafted, are philosophically confused; they are premised, perplexingly, on an inverted consideration of what is proper ethical, lawful and permissible clinical practice and fail to reflect such practice and its legal and Constitutional expression as already set out.

30. Thus, at the level of principle, providing for clinical decision-making to be lawful, and its outcome to be acceptable, if grounded in an opinion formed in good faith alone, and without reference either to evidence-based practice or to a requirement to comply with such practice, not alone reflects an old-fashioned approach (previously favoured by the courts and now difficult to justify) but is also inconsistent with the ethical (and legal) imperatives of proper clinical practice.

31. By way of observation, in this context, the approach advanced by the Heads of Bill, relying on *bona fides*, will inevitably yield to justification of whatever decision is made and outcome reached, given the real, practical difficulty of establishing *mala fides* in any clinical context.[69]

32. Deference to, or requiring compliance with, evidence-based practice at least has the merit of introducing an objective standard, which gives substance to the concept of

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[68] See, for example, the provisions of the Civil Liability Act 1961 section 58: "For the avoidance of doubt it is hereby declared that the law relating to wrongs shall apply to an unborn child for his protection in like manner as if the child were born, provided the child is subsequently born alive" and Council Directive 97/43/EURATOM ((Medical Exposures Directive) Article 10(1)(b), in the context of special precautions for the use of ionising radiation in women of childbearing age: "if pregnancy cannot be excluded, depending on the type of medical exposure, in particular if abdominal and pelvic regions are involved, special attention shall be given to the justification, particularly the urgency, and to the optimization of the medical exposure *taking into account the exposure both of the expectant mother and the unborn child*" (*emphasis* added).

[69] See, for example, the cases involving the Mental Treatment Act 1945, section 260 (now repealed).

accountability on which the Medical Council relies in its formulation of the requirements for good medical practice. In this context, the number of practitioners whose concurrence with the good faith opinion is necessary (insofar as the Heads of Bill are concerned) is somewhat academic.

33. That is not to say, however, that it is wholly unappealing conceptually: it may be properly considered desirable for transparency, but such transparency is necessarily limited unless there is some objective evidence-based template for measurement. It is inconceivable, in the aftermath of the Lourdes Hospital Inquiry, that any patient will be subjected to a caesarean hysterectomy to control massive, life-threatening haemorrhage, without at least a second look by a second senior clinician. That has the benefit of reducing the risk of overbearing clinical hegemony and aberrant practice; it has clear benefits, but that is a proposition of more general applicability.

34. This commentary applies irrespective of whether the problem to be addressed is maternal wellbeing in the context of physical or mental health risks, however assessed. By way of observation, in this regard, the formulation of Head 4 is, with respect, incomprehensible, having regard to the psychiatric evidence given before the Oireachtas Joint Committee on Health and Children on 8 January 2013 that there are appropriate psychiatric responses to and treatments for suicidality or cognate risks or conditions, but none that necessitate the termination of a woman's pregnancy.

35. As a reflection of a failure to take account of evidence-based practice, in this particular area, the Head fails to recognise or give effect to the ethical and legal, including Constitutional, imperatives of proper, ethical or lawful treatment.

36. The introduction of a statutory schema of the nature proposed by the Heads of Bill is profoundly illogical and, therefore, at the level of policy, highly questionable, if not frankly regressive and dangerous: it purports to legitimise interventions unsupported by evidence-based practice (the requirement to comply with which is both ethically mandated and has received express judicial recognition) and it fails to reflect the duty of doctors to protect patients' Constitutional rights.

37. Rather than seeking to implement a defensible policy in the area of protection of life in pregnancy, it assumes –without any evidentiary foundation – the legitimacy of generically defined “medical procedures” in the abstract without reference to the reality of practice. The Heads of Bill then invite clinical professional bodies to develop guidance on the operation of the legislation, an inexplicable inversion of any rational approach to the development of coherent policy.

38. How any regulatory or advisory body can legitimately respond to such an invitation, without violence to the ethico-legal requirements of proper practice defies logic.

39. In this context, any discussion of conscientious objection is utterly otiose. There can be no conscientious objection to ethico-legally permissible practice and the very inclusion of a provision, in this regard, underscores the ethico-legal frailty of the proposal.

Summary

40. In summary, therefore, the proposed Bill is deficient on the level of principle:

- it fails to reflect the *ethical* imperative of proper, professional practice, i.e. evidence based practice, required by the Medical Council, to protect the public interest and the health of individuals and the public more generally;

- it fails to reflect the *legal* imperative of proper, professional practice, i.e. evidence-based practice and protection of the constitutional rights of patients, required by the courts;

- it fails to recognise, in a substantive manner, the two-patient model that applies in pregnancy, and

- it is philosophically confused and reflects an inversion of proper ethico-legal principles in the treatment of patients;

41. Two further deficiencies, also arise, at the level of policy, in that:

- the approach to lawful clinical decision-making that it envisions is old-fashioned, it fails to reflect proper ethico-legal considerations and, for self-evident historical reasons, is likely to give rise to avoidable risk, and

- it is fundamentally illogical in what it purports to do, and highly questionable if not actually regressive and dangerous.

42. I shall, of course, be happy to expand on any of the foregoing and to answer any questions the Committee may have.

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Opening Statement to the Health Committee on the General Scheme of the Protection of Life during Pregnancy Bill, 2013

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The proposed legislation is welcome for its recognition of a public obligation to implement an existing constitutional right to life-saving abortion. But the proposed legislation does not do enough to meet the ethical obligation to value women's lives. I will focus this statement on 4 key points in relation to the definition of the unborn, the significance of risks justifying a termination of pregnancy, the limits on the right to conscientious objection, and the inappropriateness of criminalization.

Unborn – Head 1

Head 1 suggests that the unborn shall be defined to mean "following implantation", drawing on *Roche v Roche* concerning frozen embryos as precedent. With respect, the legal and ethical arguments for choosing the point of implantation as the significant moment for legal protection of unborn life have not been adequately addressed. Given past failures to interrogate the assumed wrongness of abortion and given the particular factual context of *Roche v Roche*, it is open to the Legislature to consider more fully the criteria by which the 'unborn' should be defined in this legislation.

The best ethical argument for legal recognition of the 'unborn' from its earliest stages is that it will, subject to assistance from the pregnant woman, become a person in the future. The future personhood argument does not apply to fetuses with lethal abnormalities. They are going to die after birth and therefore do not have a future as persons. They should be excluded from the legal definition of 'unborn' in the legislation. Moreover, the state itself argued in *D v Ireland* that it was possible that fetuses with lethal abnormalities were excluded from the legal definition of the unborn. The state has a moral obligation to deliver on that legal opinion in *D v Ireland* through this Bill's definition of the 'unborn'. In this way the Legislature can act to alleviate the suffering of women and couples who are carrying pregnancies with lethal abnormalities.

A second important aspect of the argument for protection from implantation is that it rests on the *potential* to become a person, not on *actual* personhood. Potential personhood is best regarded as

giving the unborn some moral *value* because of what it will become in the future. This potentiality may be ethically significant, but it is not as significant as the moral *status* that comes from sentience, that is the actual ability to feel pain or pleasure. Nor is it the same as the higher moral status which comes with personhood and the capacities for reason, will and communication. A person's interest in her own bodily and moral integrity may justify limitations on her duties to sentient beings. This is because part of what makes life valuable is the person's ability to reflect on her life over time, in particular factual circumstances, and make her own moral choices.

Conclusion: The following categories provide a better ethical rationale for the protection of unborn human life than the assumed significance of implantation.

- Pre-sentient foetal life has moral value rather than moral status. It should be taken into account in moral decision-making, but it does not impose harm-reducing duties on others.
- Sentient foetal life has moral status and may impose a duty not to be harmed on others.
- Self-aware personhood is a higher moral status than sentient life and may limit the duties owed to sentient life in important ways.

Recommendation 1: The unborn should be defined so as to exclude those foetuses which have lethal abnormalities and will not have a future independent life.

Recommendation 2: The unborn should be defined to mean "the foetus following the earliest moment at which sentience is possible"

Risk of loss of life justifying a termination of pregnancy – Heads 2-4

Heads 2-4 provide for the kinds of risk to a woman's life which will legally justify a termination of pregnancy. Others have commented more eloquently than I can on the need to remove obstacles to life-saving abortion care and on the troubling mistrust of women with suicidal ideation. Here I would like to focus on the narrowness of the 'risk to life' ground for abortion. This ground has been drawn very narrowly in part because it has been assumed that Article 40 3 3 *requires* the life of the pregnant woman to be treated *the same* as the life of the embryo or foetus.

Equality scholars, including those who work at the Equality Studies Centre at UCD, have long argued that equality does not mean sameness. Rather equal treatment requires the accommodation of actual differences between beings. Vindicating the life of the unborn with due regard to the equal

right to life of the mother should entail a full evaluation of the pregnant woman's interests as well as those of the unborn. To state the issue concisely, women are conscious, sentient beings with moral views and responsibilities to others, when foetues are not. Foetuses are the bearers of biological life and future persons, but this is not the same kind of life as that of breathing, feeling, thinking women. The current legal test treats women and fetuses as if they are the same, and in doing so, it devalues the significance of each form of life.

Recommendation 3:

The legal test should be: "It is not an offence to carry out a medical procedure, in the course of which or as a result of which unborn human life is ended, where there is a real and substantial threat to the life of the woman, including to her life interests in mental and bodily integrity."

Conscientious objection – Head 12

In principle the inclusion of a conscientious objection clause is defensible, subject to 2 conditions. It must be applied to individuals rather than organisations and only in circumstances where alternative provision is readily available. If respecting human life includes respecting the personal choices which give life meaning (Dworkin, 1992), then healthcare practitioners may avoid performing healthcare which infringes their moral values. As the Explanatory Notes acknowledge, conscientious objection is not an absolute interest. It is limited by the need to prevent harm to others, pregnant women in this instance. In circumstances where a healthcare practitioner cannot arrange alternative provision without undue delay, their right to conscientious objection may be limited by the duty to prevent harm to their patients.

Further, I would ask the Committee to note that this recognition of healthcare practitioners' consciences is inconsistent with the lack of legal recognition to date of pregnant women's consciences. If conscientious objection to the provision of abortion is legally acceptable then so is a 'conscientious objection' to the sustenance of an embryo/foetus within one's body. If a woman's conscience tells her that terminating a pregnancy is the best moral resolution of the various issues which may arise in a given pregnancy, then that conscience also deserves respect and legal accommodation.

Offence - Head 19

The criminalisation of women's decisions to end their pregnancies is a disproportionate and unfair response to the constitutional direction to vindicate the life of the unborn as far as practicable. Criminalisation does not achieve the objective of protecting foetal life. We know that 100,000s of Irish women have had abortions and that they will continue to seek out ways to control their fertility. Criminalisation makes the mental and physical experience of unwanted pregnancy worse by stigmatizing those with unwanted pregnancies and by inhibiting their healthcare providers. The Legislature has other options under Article 40 3 3. It does not, as the Explanatory Notes suggest, *have to* criminalise those abortions which fall outside the tests in Heads 2-4. The Legislature could regulate the terms under which women access abortion in the Irish health service without punishing those women who fall outside those terms. It could vindicate unborn life by investing in pregnancy-related care and research into miscarriage. In choosing to punish women rather than to adopt more neutral or positive measures for the support of foetal life in pregnancy, the Legislature would act unfairly. Head 19 is unfair because it asks women, rather than the state, to bear the weight of the public duty to vindicate foetal life.

Recommendation 4(a):
Repeal sections 58 and 59 of the Offences Against the Person Act 1861, without providing for a new offence.

Recommendation 4(b) (as an alternative to 4(a)):
If the Legislature is not willing to take the route of decriminalisation, it should at minimum define the offence so that it excludes attempts to end a pregnancy. The phrase "[A]ny act with the intent to destroy unborn human life" is too broad and may include those acts which are ultimately unsuccessful in destroying unborn human life. Secondly, the maximum penalty for the offence should be reduced significantly from 14 years. This penalty is disproportionate in punishing a decision which implements the defensible moral choices of women and their healthcare providers.

Submission to the Health Committee on the General Scheme of the Protection of Life during Pregnancy Bill, 2013

Dr Ruth Fletcher, Senior Lecturer in Law and Director, Centre for Law, Ethics and Society, Keele University

The proposed legislation is welcome for its recognition of a public obligation to implement an existing constitutional right to life-saving abortion. The state is under a duty to enforce existing constitutional rights, and failure to act is a clear breach of that duty. The movement away from absolutist protection of foetal life is welcome in a context which requires the balancing of public interests in protecting foetal life and in protecting women's lives. But the proposed legislation does not do enough to address certain material considerations for this legal balancing act. I will focus this submission on 4 key points in relation to the definition of the unborn, the significance of risks justifying a termination of pregnancy, the limits on the right to conscientious objection, and the inappropriateness of criminalization.

Unborn – Head 1

Head 1 suggests that the unborn shall be defined to mean "following implantation until such time as it has completely proceeded in a living state from the body of the woman". The reference to implantation as the beginning point for defining unborn life is justified by reference to the Supreme Court decision in *Roche v Roche*, which addressed whether stored embryos were unborns for the purposes of Article 40 3 3. With respect, the legal and ethical arguments for choosing the point of implantation as the significant moment for legal protection have not been adequately addressed. Given past failures to interrogate the assumed wrongness of abortion and given the particular factual context of *Roche v Roche*, it is open to the Legislature to consider more fully the criteria by which the 'unborn' should be defined in this legislation.

There are strong ethical arguments for choosing sentience as an alternative rationale for the protection of unborn life (Steinbock, 2011). Sentience is the capacity to feel pain or pleasure and is regarded by many moral theorists as the characteristic of living things which imposes obligations on others. Trees may be living things which are biologically valuable, but they do not have the capacity to be harmed in the same way that sentient beings do and so are not owed harm-reducing duties. A recent review of the evidence on foetal awareness by the Royal College of Obstetricians and

Gynaecologists (2010) came to the view that 24 weeks gestation was the earliest moment at which sentience was possible, and that the foetus may not be sentient or aware at all during pregnancy given the effect of the uterine environment. If protection of the unborn is about the protection of human life then sentience is arguably the best candidate for the key feature of human life that make it intrinsically worthy of legal protection.

Obviously there are candidates for justifying the protection of unborn life before sentience, the main contenders being the biological or human species argument, and future/potential personhood argument. But these are not strong enough to justify the kind of full legal recognition which the legislation assumes. One version of the human species argument would protect unborn human life from conception, because it is precious as God-given life. While individual people should be free to let this view inform their moral decisions, it cannot be a view which informs the law in a pluralist society of many faiths and none. Another version of the human species argument is the biological individuation view, that there is something precious about the embryo as an individual member of the human species. The problem with this position is that it does not tell us what it is about the human species that makes harm to a human wrong. If another species has capacities to think, to feel, to act, or to live, is it unworthy of protection because it is not human?

Probably the best argument for legal recognition of the 'unborn' from its earliest stages is that it will, subject to assistance from the pregnant woman, become a person in the future. If this is accepted as the justification for the reference to implantation, it should be noted that this does not apply to fetuses with lethal genetic abnormalities. They do not have a future as persons, and so should be excluded from the legal definition of 'unborn' in the legislation. A second important aspect of this argument is that it rests on the *potential* to become a person, not on actual personhood. Potential personhood is arguably best regarded as giving the unborn some moral value because of what it will become in the future. This potentiality may be ethically significant, but it is not the same as the moral status that comes from the actual ability to feel pain or pleasure. Nor is it the same as the higher moral status which comes with personhood and the capacities for rationality and communication. As Thomson (1971) has argued the person's interest in bodily and moral integrity may justify limitations on our duties to sentient beings. This is because part of what makes life valuable is the person's ability to reflect on her life over time and make her own moral choices.

Conclusion: The following categories provide a better ethical rationale for the protection of unborn human life than the assumed significance of implantation.

- Pre-sentient foetal life has moral value rather than moral status. It should be taken into account in moral decision-making, but it does not impose harm-reducing duties on others.
- Sentient foetal life has moral status and may impose a duty not to be harmed on others.
- Self-aware personhood is a higher moral status than sentient life and may limit the duties owed to sentient life in important ways.

Recommendation 1:
The unborn should be defined to mean "the foetus following the earliest moment at which sentience is possible"

Recommendation 2:
The unborn should be defined not to mean those foetuses which have lethal abnormalities and will not have a future independent life.

Risk of loss of life justifying a termination of pregnancy – Heads 2-4
Heads 2-4 provide for the kinds of risk to a woman's life which will legally justify a termination of pregnancy. Here I would like to focus on the narrowness of the risk to life ground for abortion. This ground has been drawn very narrowly in part because it has been assumed that Article 40 3 3 *requires* the life of the pregnant woman to be treated *the same* as the life of the embryo or foetus

As Irish equality scholars, Baker, Lynch, Cantillon and Walsh have argued, equality does not mean sameness. Rather treating entities equally requires the accommodation of their material and vital differences. Even if one accepts the contested view that the foetus ought to be legally protected as if it was a person with rights and responsibilities, that in itself does not determine how a conflict between the life of the foetus and life of the pregnant woman should be resolved. Vindicating the life of the unborn with due regard to the equal right to life of the mother should entail a full evaluation of scope of the unborn's interests vis a vis those of the pregnant woman. To state the issue concisely, women are conscious, sentient beings with moral views and responsibilities to others, when foetues are not. Foetuses have value as bearers of biological life and as future persons, but this is not the same kind of value as that of a breathing, feeling, thinking woman. The

current legal test treats women and fetuses as if they are the same, and in doing so, it devalues the significance of each form of life.

Recommendation 3:

The legal test should be:"It is not an offence to carry out a medical procedure when there there is a real and substantial threat to the life of the woman, including to her life interests in mental and bodily integrity."

If the Oireachtas is not willing to adopt this recommendation, the minimum alternative is to remove the discriminatory distinction between the evidence requirements for a risk to life from a threat of self-destruction and a risk to life from a threat of physical illness. This distinction is based on a particularly problematic view of women as morally untrustworthy, and does not address adequately the duty not to harm women's lives.

Conscientious objection – Head 12

In principle the inclusion of a conscientious objection clause is defensible, subject to 2 conditions. It must be applied to individuals rather than organisations and only in circumstances where alternative provision is readily available. If respecting human life includes respecting the personal choices which give life meaning (Dworkin, 1992), then healthcare practitioners may avoid performing healthcare which infringes their moral values. This is an interest which inheres in the individual as the moral agent of her own life, not in an institution such as a hospital which has a corporate personality. As the Explanatory Notes acknowledge, conscientious objection is not an absolute interest, and is limited by the need to prevent harm to others, pregnant women in this instance. Moreover, healthcare practitioners have a duty of care to pregnant women, which includes promotion of their health and well-being. Conscientious objection to the provision of healthcare is only defensible therefore in circumstances where it would not entail damage to women's interests in health and well-being. Delays in accessing healthcare could damage women's health and well-being because a woman is left living with the physical and mental stresses of unwanted pregnancy for longer, and because later terminations are riskier than earlier ones. In circumstances where a healthcare practitioner cannot arrange alternative provision without undue delay, their right to conscientious objection may be limited by the duty to prevent harm and promote health and well-being. In practice therefore, the wording of Head 12 does not give enough weight to the harm-reducing limits on the right to conscientious objection.

Secondly, the phrase “as per current medical ethics” should be removed. Medical ethics usually refers to philosophical inquiry into the ethically right courses of action in medicine. There is usually a range of ethically defensible courses of action in a given area of medicine and so a reference to ‘medical ethics’ in this sense raises more questions than it solves. If “current medical ethics” is meant to refer to the current ethical guidelines adopted by the Medical Council, then this should not be included in a statutory provision. It is unnecessary, and may cause confusion about the relevant legal standard should the Council Guidelines change.

Further, I would ask the Committee to note that this recognition of healthcare practitioners’ consciences is inconsistent with the lack of legal recognition to date of pregnant women’s consciences. If conscientious objection to the provision of abortion is legally acceptable then so is a ‘conscientious objection’ to the sustenance of an embryo/foetus within one’s body. If a woman’s conscience tells her that terminating a pregnancy is the best moral resolution of the various issues which may arise in a given pregnancy, then that conscience also deserves respect and legal accommodation.

Offence - Head 19

The criminalisation of women’s decisions to end their pregnancies is a disproportionate and unfair response to the constitutional direction to vindicate the life of the unborn as far as practicable. Criminalisation does not achieve the objective of protecting foetal life and it makes the mental and physical experience of unwanted pregnancy worse. The Legislature has other options under Article 40 3 3 and it does not, as the Explanatory Notes suggest, *have to* criminalise those abortions which fall outside the tests in Heads 2-4. The Legislature could regulate the terms under which women access abortion in the Irish health service without punishing those women who fall outside those terms. It could vindicate unborn life by investing in pregnancy-related care and research into miscarriage. In choosing to punish women rather than to adopt more neutral or positive measures for the support of foetal life in pregnancy, the Legislature would be acting unfairly. Head 19 is unfair because it asks women, rather than the state, to bear the weight of the public duty to vindicate foetal life.

Recommendation 4(a):

Repeal sections 58 and 59 of the Offences Against the Person Act 1861, without providing for a new offence.

Recommendation 4(b) (as an alternative to 4(a)):
If the Legislature is not willing to take the route of decriminalisation, it should at minimum define the offence so that it excludes attempts to end a pregnancy. The phrase "[A]ny act with the intent to destroy unborn human life" is too broad and may include those acts which are ultimately unsuccessful in destroying unborn human life. Secondly, the maximum penalty for the offence should be reduced significantly from 14 years. This penalty is disproportionate in punishing a decision which implements the defensible moral choices of women and their healthcare providers.

Opening Statement

Thank you for inviting me here to make some points in relation to the Heads of Bill. Any comments which I make are made in a purely personal capacity. As time is limited, I cannot visit many of the issues which have been raised by these Heads of Bill and instead I want to make four essential points regarding the proposed legislation.

Opinion of a psychiatrist necessary that risk to life of pregnant woman can only be averted by termination of pregnancy.

Firstly, I want to emphasise that in *The Attorney General v.* X, the Supreme Court formulated a test without the benefit of medical evidence or best practice. It did not actually have to consider and weigh expert medical and, in particular, psychiatric evidence as to whether abortion is ever a treatment for suicide or whether other treatments could be utilised to avert the risk.

It has already been alluded to in expert testimony that a concession was made that abortion was lawful under certain circumstances. In law a point not argued before a court is a point not decided by that court. So essentially I want to emphasise that the Supreme Court has been open to assimilating in its considerations developing insights gained from psychiatry and psychology. I am thinking in particular of their approach to psychological/psychiatric evidence in cases restraining criminal trials in relation to historic abuse cases.

The framers propose that in the case of a threat of self-destruction, a termination of pregnancy will not be permitted unless two psychiatrists form the opinion required under Head 4. However in X the evidence of a psychologist who was not actually advocating abortion as a treatment was considered sufficient to fulfil the test. Having regard to the expert testimony available to this Committee, it does not appear that the test in *X* is one which is based on best psychiatric practice. Although it is now proposed to involve psychiatrists in the decision making this is not mandated by X and legitimate concerns have been expressed as to whether the involvement of psychiatrists may be an attempt to medicalise what is in fact not a medical test. It is a legal test formulated by the Court without regard to any psychiatric analysis. Indeed it might well be asked why it is proposed to involve psychiatrists at all in the process.

However, having included the requirement that psychiatrists provide an opinion, a further concerns arises.

No Requirement to examine patient

The Heads of Bill (2 and 4) provide that the specialists "should" examine the patient. This can be contrasted with the requirement that under the same Heads the woman's General Practitioner *"shall"* be consulted. In law a mere exhortation is not mandatory or enforceable. While it is understandable that there would be a reluctance to subject a woman in distress to any rigorous or invasive procedure, this would not appear to be an adequate justification for bypassing standard medical practice in relation to diagnosis and treatment. A Court called upon to interpret legislation will look to the words used and not the aspirations of its framers.

The Explanatory Notes state that the Mental Health Act, 2001, has been seen as a model in the framing of the Heads. However the involuntary detention of a patient under that Act requires two separate and distinct examinations of the patient by a GP and a psychiatrist respectively. (Sections 10 and 14). Failure to conduct an examination of the patient will lead to the patient being in unlawful detention even if a collateral history is available to the doctor[70]. These examinations are deemed to be "vital essential safeguards for the patient"[71]. Surely in the case of suicide risk an equally robust regime should apply? Especially as best practice indicates that an examination of the patient should precede diagnosis. If it is considered that a psychiatric assessment is appropriate it is hard to justify not requiring an examination of the patient. Otherwise the Heads are open to the accusation that psychiatrists are being involved for optical purposes.

A further consequence of not requiring an examination of the patient is to increase the likelihood of forum shopping by the patient or indeed the doctors involved.

Risk of self-destruction – the foetus and potential viability

Unlike a physical threat, the risk in a suicide case is said to come from the existence of the pregnancy. In that sense the proposed treatment for risk of self destruction is in fact abortion (though the psychiatric evidence for the efficacy of this treatment all points the other way). The risk of suicide may manifest itself either before or after the unborn is potentially viable outside the womb. Under the Heads Doctors must make all efforts to sustain the unborn's life after delivery[72]. However under the Heads they are not mandated to terminate the pregnancy by a procedure which might ensure the baby would survive. If it is the existence of the unborn which poses the risk, allowing a viable foetus to be born alive may not in fact diminish this risk. Consequently the Heads do not exclude the abortion of an unborn who could be viable outside the mother. It is hard to reconcile the right to life of the unborn with such a position. Again this is a point not argued and therefore undecided in X.

If abortion under these circumstances is untenable, what would be the position if delaying termination for a couple of weeks would result in the baby being born alive? It is difficult to see where a principled line could be drawn on this issue. Abortion of a potentially viable unborn would appear also conflict with the Medical Guidelines which provide in relation to a

[70] SO v. Clinical Director of Adelaide and Meath Hospital of Tallaght [2003] IEHC 132
[71] Per Hogan J par 12
[72] Explanatory Notes to Head 4 (penultimate paragraph)

therapeutic intervention that if it is necessary to intervene to terminate the pregnancy to protect the life of the mother, every effort should be made to preserve the life of the baby[73]. It is hard to see why an unborn should have less protection in a case of risk of self-destruction than in a physical risk case.

Although the Heads provide for further *"safeguards"* it is doubtful whether these ends have been achieved.

Location of procedures

"Safeguards" proposed in the Heads include only permitting termination of pregnancies in an *"appropriate location"*[74] and in *"public obstetric units"*[75]. However the possibility arises under the Heads appears of the HSE itself establishing or entering into arrangements with third parties to establish facilities where terminations may be carried out in the future. There is no requirement that the consent or authorisation of the Minister or the Oireachtas be sought. Consequently there does not appear to be anything to prevent the HSE or a dedicated *"termination of pregnancy service provider"* with whom the HSE enters into an arrangement from establishing a *"termination of pregnancy clinic"* provided that is on site or somehow co-located with a general maternity and neo-natal service.
A further difficulty arises because the terms "medical procedures" and "termination of pregnancy" appear to be used interchangeably in the Heads. To be quite clear: Necessary medical treatment to save the life of the mother is not coterminous with "termination of pregnancy". Oncology treatment, general or cardiac surgery may be necessary medical procedures to save the life of the woman. However they cannot be described as "terminations of pregnancy" as sometimes the unborn, who is not the direct target of the procedure, may in fact survive. Thus some medical procedures which are necessary may not in fact result in the termination of the unborn's life Many of these *"medical procedures"* [76] are not normally carried out in public obstetric units but are carried out in general or indeed private hospitals. So it may prove unfeasible when drafting the Bill to continue to maintain the safeguard that "terminations" must only take place in "public obstetric units". Apart from the need to be entirely clear as to the important different in principle between a "medical procedure" and a "termination of pregnancy".

Sunniva McDonagh
17th May, 2013.

[73] Guide to Professional Conduct and Ethics for Registered Medical Practices par 21.4.
[74] Head 1
[75] Explanatory note to (subhead 1) in Head 1.
[76] E.g. oncology, general surgery

ORAL HEARINGS – PROTECTION OF LIFE DURING PREGNANCY BILL 2013
JOINT COMMITTEE ON HEALTH AND CHILDREN

21st May 2013

Closing Statement

Good evening Chairman and members of the Committee,

I am pleased to be here today at the closing session of these public hearings on the General Scheme of the Protection of Life during Pregnancy Bill 2013.

First of all, I wish to commend the Chairman, all the members of the Committee, those members of the Oireachtas who participated in these hearings, and all the invited guests for the balanced and respectful approach that we have witnessed over the past three days.

Secondly, I have been following the hearings as closely as I could manage, and have noted that there is a high level of consensus on most of the provisions contained in the General Scheme. There are also, of course, diverging opinions on some of the provisions – both within and between the legal and medical professions represented before the Committee.

I assure you Chairman, and the members of the Committee, that we will examine these issues from a policy and legal perspective with a view, where possible, to improving the operation of the Bill. I am confident that all of the submissions, and the report that this Committee will produce on your deliberations in recent days will greatly assist me, the Minister for Health, and officials in examining and refining the issues involved in the drafting of this Bill.

The aim of this Bill is to regulate access to lawful termination of pregnancy in accordance with the Supreme Court judgement in the *X* case, and the *A, B and C v Ireland* judgment of the European Court of Human Rights. The purpose of the legislation is to clarify in statute what is currently already lawful as a consequence of the judgement in the X case, and to set out clearly defined and specific circumstances in which this treatment may lawfully be provided.

I would like to address some of the issues that have been raised by contributors during the debate, to allay, if possible, some of the concerns involved.

I am aware, for example, that there has been considerable debate about Head 4 of the Bill, and the inclusion in the legislation of the risk of loss of life by way of suicide. The Supreme Court in the *X* case specifically recognised a risk to life arising from suicidal intent, which it referred to as a risk of self-destruction, as a legitimate basis for permitting termination of pregnancy – but only in circumstances where there was a real and substantial risk to the life of the mother; and where this risk could only be averted by the termination of her pregnancy.

Ireland, as a signatory to the European Convention on Human Rights, is under a legal obligation to implement the judgment of the European Court of Human Rights in *A, B and C v Ireland,* and must put in place a legislative or regulatory regime providing effective and accessible procedures whereby pregnant women can establish whether or not they are entitled to a lawful abortion in accordance with Article 40.3.3 of the Constitution as interpreted by the Supreme Court in the *X* case.

The Bill has taken account of the fact that assessment of self-destruction is more subjective and, therefore, requires more safeguards to be put in place. It specifies that three doctors are required to form an opinion and jointly certify that a termination of pregnancy may take place if it is necessary to save the woman's life. This provision is made in the Bill in recognition of the clinical challenges associated with accurately assessing suicidal intent, and the absence of objective clinical markers. The legislation specifies that one of the doctors involved must be an obstetrician/gynaecologist and the other two must be psychiatrists. It also allows that it may be appropriate that the pregnant woman's GP is consulted during the process of assessment, where practicable.

I am also aware that the lack of a gestational time limit in the Bill has been raised, and that concerns have been expressed in respect of where a termination of pregnancy is deemed necessary, and the pregnancy has reached a stage of gestation at which the foetus is or may be viable. In such situations, it must be stressed that the wording of Article 40.3.3° and the judgment in the *X* case make it crystal clear that the life of the unborn must be protected and vindicated where practicable. This means that where a woman has a pregnancy that places her life at risk, and her foetus is or may be viable, she may have a right to have the pregnancy brought to an end but not a right to insist that the life of the foetus be deliberately ended.

In circumstances where the unborn may potentially be viable outside the womb, doctors must make all efforts to sustain its life after delivery in accordance with existing medical practice with early deliveries. In this regard, I note that this aspect was referred to at some length by a number of the obstetrics experts who appeared before the Committee.

It should be noted, however, that this requirement does not go so far as to oblige a medical practitioner to disregard a real and substantial risk to the life of the woman on the basis that it will result in the death of the unborn. Essentially the decision to be reached is not so much a balancing of the competing rights- rather, it is a clinical assessment as to whether the mother's life, as distinct from her health, is threatened by a real and substantial risk that can only be averted by a termination of pregnancy.

I noted that there were concerns raised about ensuring that the monitoring systems provided for under Head 11 of the Bill would incorporate appropriate requirements to preserve the confidentiality of the patient and the certifying practitioners.

The provisions with respect to monitoring have been included in the Bill because there is a need to keep records on the terminations carried out, and the medical reasons that gave rise to same. Information is also required to inform policy, as well as to ensure that the various statutory principles and requirements are being upheld.

However, although the Bill provides for the collection of this data, it is not the intention that personal or identifying information will be published. I think it is clear in the explanatory notes to the Bill that it is not proposed that the Freedom of Information Act 1997 will apply to the records collected as part of the monitoring systems.

Conclusion

In closing, the main objective of the legislation, if I may reiterate again, is to clarify what is lawfully permissible in cases where there is a real and substantial threat to the life of a pregnant woman, and to set out clearly defined and specific circumstances in which a termination may lawfully be carried out.

As you will be aware a very significant amount of work was involved in producing the heads of this legislation. Over 50 drafts were composed as we moved to produce what we believe to be balanced proposals that meet our obligations.

Of course as the Committee is fully aware the next phase is the drafting and publication of the Bill. Following publication the Bill will go through the Houses of the Oireachtas, where there will be

further opportunity for parliamentary engagement and input. I look forward to working closely with colleagues in both chambers as we consider the Bill.

Finally, Mr. Chairman, I wish to thank you, your officials and all of those who have participated in any way in these public hearings for the invaluable contribution you have made to this issue both now and at the public hearings in January, and for the assistance you have provided to me, the Minister for Health, and our officials in this work.

Appendix 2
Hearing Transcripts

Heads of Protection of Life during Pregnancy Bill 2013: Public Hearings

Friday, 17 May 2013

The Joint Committee met at 09:30
MEMBERS PRESENT:

Deputy Catherine Byrne,	Sentor Ivana Bacik,*
Deputy Ciara Conway,	Senator Colm Burke,
Deputy Regina Doherty,	Senator John Crown,
Deputy Robert Dowds,	Senator Aideen Hayden,+
Deputy Peter Fitzpatrick,	Senator Imelda Henry,
Deputy Seamus Healy,	Senator Jim Walsh.*
Deputy Billy Kelleher,	
Deputy Mattie McGrath,	
Deputy Sandra McLellan,	
Deputy Eamonn Maloney,	
Deputy Denis Naughten,	
Deputy Caoimhghín Ó Caoláin,	
Deputy Mary Mitchell O'Connor,	
Deputy Robert Troy,	

* In the absence of Senators John Gilroy and Marc MacSharry, respectively.

+ In the absence of Senator Ivana Bacik, for part of meeting.

In attendance: Deputies Gerry Adams, Eric Byrne, Michael Conaghan, Joe Costello, Michael Creed, Bernard J. Durkan, Frank Feighan, Terence Flanagan, Dominic Hannigan, Simon Harris, Kevin Humphreys, Derek Keating, Michael Lowry, Finian McGrath, Joe McHugh, Peter Mathews, Seán Ó Fearghaíl, Aodhán Ó Ríordáin, Joe O'Reilly, John Paul Phelan, Brendan Ryan, Arthur Spring, Billy Timmins, Peadar Tóibín and Liam Twomey, and Senators Paul Bradford, Martin Conway, Rónán Mullen, Catherine Noone, David Norris and Labhrás Ó Murchú.

DEPUTY JERRY BUTTIMER IN THE CHAIR.

Heads of Protection of Life during Pregnancy Bill 2013: Public Hearings

Policy - Overview of Heads of Bill

Chairman:

I welcome everyone to this morning's session. Is it agreed that we begin in public session? Agreed. I remind members of the committee, witnesses and those in the Gallery, be they members of the media or members of the public, to ensure their mobile telephones are switched off for the duration of the meeting as they interfere with the broadcasting equipment even when they are on silent mode. It is particularly unfair to members of staff who have to wear headphones.

This is the first of the sessional meetings of the Joint Committee on Health and Children dealing with the heads of the Protection of Life during Pregnancy Bill. The fundamental role of the Oireachtas is to enact legislation and in doing so it must act within the parameters set down by the people in the Constitution, Bunreacht na hÉireann. The Constitution is a living, dynamic document which is applied by the courts and ultimately interpreted by the Supreme Court. It is within this framework that the Government and the Oireachtas must act. Both are constrained by its provisions and neither can go beyond what is constitutionally prescribed. In this context, the Government has asked the committee to discuss and analyse the Bill. It has referred the heads of the Bill for our consideration and scrutiny.

I thank committee members and those who have joined us for the duration of the meetings for their deliberations in advance. I wish in particular to thank members of the committee from all parties and the Independents for their co-operation with me and the clerk in the composition of the hearings. Our approach and the approach of the Government is that we will have analysis of the heads of the Bill over the next three days. I hope we will do so in a manner that is calm, tolerant and respectful of each viewpoint expressed by Members of the Houses of the Oireachtas, committee members and witnesses. I also hope that similar to other hearings we held on other legislative proposals that our deliberations will be constructive and will have a positive role to play in assisting the Government in the formulation of legislation.

As part of our hearings it is important that we gather information and that we listen to and engage with the views of witnesses who have voluntarily given of their time to come before the committee to assist with the scrutiny of legislation. I know that I speak for all of us on the committee when I say that I hope we will continue in the same vein and approach we took in the January hearings when the contributions were positive, helpful and courteous. Given that we are discussing a very sensitive matter with diverse viewpoints, it is incumbent on all of us to be respectful of all of the views expressed within this Chamber. I remind members that we are in the Chamber of Seanad Éireann and as a consequence there is a responsibility on all of us to uphold the dignity of the Houses of the Oireachtas.

This morning we will hear from the Minister for Health, Deputy James Reilly, the chief medical officer, Dr. Tony Holohan, and we are also joined by Mr. Ambrose McLoughlin, the Secretary General of the Department of Health and Ms Geraldine Luddy. I thank them for their presence this morning. Over the course of the day I hope that our hearings will be positive, constructive and that all members of the committee and of the Oireachtas will engage in the analysis of the heads of the Bill in a dignified manner. Each member will have three minutes for questions to the witnesses and the Chair will be impartial on adjudicating

on the time allocated. I ask each member to comply with the time constraints. I do not wish to be in any way disrespectful to members but the ruling on time will be strict.

Before we commence, I remind members and witnesses that witnesses are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to do so, they are entitled thereafter to only qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of the proceedings is to be given and they are asked to respect the parliamentary practice to the effect that where possible they should not criticise nor make charges against any person, persons or entity by name in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice or ruling of the Chair to the effect that they should not criticise, comment on or make charges against either a person or persons outside the House or an official either by name or in such a way as to make him or her identifiable.

I call on the Minister for Health, Deputy Reilly, to make his opening remarks.

Minister for Health (Deputy James Reilly):

Thank you, Mr. Chairman and members of the committee. I am pleased to be present today to open the hearings on the general scheme of the protection of life during pregnancy Bill. I look forward to the presentations of the invited guests. I am confident the hearings will provide very useful input as we come to finalise drafting of the terms of the Bill. I was struck by the balanced and respectful approach taken by all during the previous three days of hearings held by the committee in January, and I echo the Chairman's hope that the present hearings will be as productive.

As all are aware, on 30 April the Government approved the drafting of the protection of life during pregnancy Bill 2013, subject to any technical amendments that may be deemed necessary following consultation with the Attorney General, and the publication of the general scheme of the Bill. The general scheme aims to give effect to the Government's decision in December 2012 to legislate in this area within the parameters of Article 40.3.3° of the Constitution, as interpreted by the Supreme Court in the X case, in order to implement the judgment of the European Court of Human Rights in the A, B and C *v*. Ireland case.

Before I proceed it is worth reminding ourselves of the findings of the judgment. Three applicants, A, B and C, all of whom had crisis pregnancies, brought proceedings against Ireland before the European Court of Human Rights claiming violations of Articles 2, 3, 8, 14 and 13 of the European Convention on Human Rights. In its judgment delivered on 16 December 2010 the Grand Chamber determined that there had been no violation of the convention in relation to the first and second applicants, Ms A and Ms B. The Grand Chamber determined that there had been a violation of Article 8 of the Convention in relation to applicant, Ms C. The court found that Ireland had failed to respect the Ms C's private life contrary to Article 8 of the convention, as there was no accessible and effective procedure to enable her to establish whether she qualified for a lawful termination of pregnancy in accordance with Irish law. The aim of the general scheme is to provide such a procedure. However, it is worth noting again that the issues at stake here are extremely complex and engage with fundamental rights.

I will now go through the general scheme head by head. I do not wish to pre-empt the

committee's discussion but I am mindful that there might be issues still to be dealt with and my Department has already identified some provisions that might need to be revisited from a technical perspective. Furthermore, some of the participants in the hearings might also have identified additional technical issues that might need examination. I look forward to any suggestions that will lead to the improvement of the operation of the legislation.
Head 1 of the scheme deals with the interpretation of the Bill; it defines the meanings of some of the terms used for the purposes of the Bill, including appropriate location, reasonable opinion, and unborn. Head 2 deals with the risk of loss of life from physical illness. It provides that it is not an offence for a registered medical practitioner to carry out a medical procedure in the course of which, or as result of which, unborn human life is ended under certain circumstances. These are that the procedure is carried out in an appropriate location and two medical practitioners registered on the specialist division of the Medical Council register have certified that in their reasonable opinion there is a real and substantial risk to the life, as opposed to the health, of a pregnant woman arising from a physical illness that can be averted only by a termination of pregnancy.

Deputy James Reilly:

The process requires an assessment on medical grounds to determine if the test set out in the Supreme Court judgment in the X case is met. The Supreme Court held that the correct test was that a termination of pregnancy was permissible if it was established as a matter of probability that there is a real and substantial risk to the life of the mother, and this risk can only be averted by the termination of her pregnancy. It is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate.

The definition of "reasonable opinion" requires that this opinion must be formed in good faith and must have regard to the need to protect the right to life of the unborn and preserve unborn human life where practicable. The emphasis on preserving unborn human life means that a doctor will be obliged to make every effort to safeguard the unborn and, where it is potentially viable outside the womb, to make all efforts to sustain its life after delivery. The registered medical practitioners will be obliged to record this opinion in writing if certifying a procedure that will end unborn human life.

One of the two medical practitioners involved in the certification process will always be an obstetrician-gynaecologist and the other will be a medical practitioner in a specialty relevant to the risk to the life of the woman, for example an oncologist or a cardiologist. As indicated in the definition of reasonable opinion, the test requires a clinical diagnosis on the risk to the life of the pregnant woman and a foetal assessment. Therefore the expertise of an obstetrician will always be required. Second, a termination of pregnancy will most likely be carried out by, or under the care of, an obstetrician-gynaecologist, and therefore their inclusion here should be central in accessing services and ensuring patient safety. During the process of assessment it may also be appropriate that the pregnant woman's GP is consulted with her permission and where practicable and feasible.

Regarding appropriate locations, it is intended that these will be public obstetric units only. I believe the State's constitutional obligation and its responsibility to act in the common good demand that provision of terminations of pregnancy be only allowed in health-care facilities providing obstetric and mental health services and where relevant specialists are attached, which can be duly monitored and investigated, should the need arise.

Head 3 deals with emergency situations, where there is an immediate risk of loss of life arising from physical health conditions only. In an emergency situation, the opinion of one registered medical practitioner will be sufficient for the termination to be lawful. Doctors should not be prevented from saving a woman's life in a situation of acute emergency, because, for example, the required numbers of doctors are not available to certify or the woman in question arrives at a health facility that is not covered as an appropriate location under this Bill - that is to say, not a public obstetric unit. Therefore, in emergency circumstances, the reasonable opinion of one medical practitioner is required to certify that the termination is immediately necessary to save the life of a pregnant woman, but the medical practitioner who carries out the procedure will be required to certify the reasons for his or her actions, and notification of all emergency terminations will be sent to my Department.

Again, this opinion must be formed in good faith and have regard to the need to preserve unborn life where practicable. The emergency exception described will not apply in the case of a risk to life from self-destruction because of the more subjective nature of the diagnosis due to the absence of objective clinical markers.

Head 4 deals with a risk to the life of the pregnant woman from self-destruction. Assessment of self-destruction is more subjective and there are recognised clinical challenges in accurately assessing suicidal ideation, for example, the absence of objective clinical markers. Therefore, this assessment requires more safeguards to be put in place. In these cases, three medical practitioners registered on the specialist division of the Medical Council register must certify that in their reasonable opinion there is a real and substantial risk to the life of a pregnant woman arising from self-destruction that can only be averted by a termination of pregnancy. One of them must be an obstetrician-gynaecologist and the other two must be psychiatrists.

I am aware that the role of the obstetrician in this assessment has been raised. However, the test in this case will always be a multidisciplinary test, as it requires a clinical diagnosis on the risk to the life of the pregnant woman and a foetal assessment. Therefore the expertise of an obstetrician will always be required.

Head 5 provides for the notification to the Minister of the certified medical opinions referred to in heads 3, 4 and 5. It is undoubtedly important to record the number and nature of terminations of pregnancy carried out under this Bill, in order to monitor its correct implementation and detect any potential abuse of its provisions. Therefore, the legislation includes a clear requirement on providers to notify for all terminations carried out under this legislation within 28 days.

Head 6 provides for the establishment of a formal process to allow a woman to seek a medical review of her case. The establishment of a formal framework providing for an accessible, effective and timely review mechanism is one of Ireland's obligations under the judgment in the A, B and C *v*. Ireland case. The purpose of this formal medical review process is to provide a mechanism for the woman, where she so requests, to have access to a review of the clinical assessment made by the original doctor or team of doctors. In practice, this will only arise where the woman's request for a termination in line with the X case criteria has not been granted, or when she has been unable to obtain an opinion in this regard. It is important to note that this formal review pathway is in addition to and not in substitution for the option of a woman seeking a second opinion as with normal medical practice.

It is intended that the Health Service Executive will act as the convenor for the purpose of the formal medical review process and will appoint authorised persons to establish and convene a review committee drawn from a review panel. It will also establish a panel of relevant experts for the purposes of this formal medical review. Members will be nominated by the Institute of Obstetricians and Gynaecologists, the Irish College of Psychiatry, the Royal College of Surgeons in Ireland and the Royal College of Physicians of Ireland. The HSE will draw from this panel when it needs to establish a review committee to consider an application made under this head.

As soon as possible but no later than seven days after receiving a written request from the pregnant woman the HSE shall establish and convene the committee drawn from a panel maintained by the executive. The committee shall complete its review as soon as possible but in any event no later than seven days after the HSE has formed the review committee.

Head 7 sets out of the functions of the review committee in physical illness matters. These provisions precisely mirror the provisions in head 2 for the initial assessment in both the number and specialties of the doctors involved.

Head 8 sets out the function of the review committee in the case of risk of loss of life through self-destruction. These provisions precisely mirror the provisions in head 4 for the initial assessment in both the number and specialties of the doctors involved.

Head 9 sets out the general provisions for the committee for both physical risk and risk from self-destruction. It aims to empower the review committee to obtain whatever manner of clinical evidence it requires to reach a decision, and to call any relevant medical practitioners to give evidence in person and to vindicate a woman's right to present her case at the meeting of the review committee or someone authorised on her behalf.

Head 10 sets out that reports from all review committees must be reported to the Minister by the executive. Information that will have to be provided includes the total number of applications received; the number of reviews carried out; in the case of reviews carried out, the reason the review was sought; and the outcome of the review.

Again, this information is required to monitor the implementation of the legislation to ensure the principles and requirements of the system are upheld.

Head 11 provides for a notification system for all terminations of pregnancy carried out under the terms of the Bill. I consider it very important to record the number and nature of terminations of pregnancy to monitor the Bill's correct implementation and to detect any potential abuse of its provisions. Therefore, the legislation includes a clear requirement on providers to notify me, as Minister for Health, of all terminations carried out under the legislation within 28 days. This will be done without disclosing the names of the women involved.

Head 12 deals with conscientious objection. In this regard, professional health personnel, namely, medical and nursing personnel, will not be obliged to carry out or assist in carrying out lawful terminations of pregnancy if they have a conscientious objection, unless the risk to the life of the pregnant woman is immediate. Where a doctor or other health professional has a difficulty in undertaking a required medical procedure, he or she will have a duty to ensure

another colleague takes over the care of the patient, as is normal in current medical ethics. I should note that the right to conscientious objection is a human right, which is limited to persons only and cannot be invoked by institutions.

Head 13 reaffirms the freedom to travel and freedom to information as per the 13th and 14th amendments to the Constitution, for the avoidance of doubt. Head 14 on regulations is a standard provision in regard to ministerial powers to make regulations.

Head 15 states certain regulations must be made to provide for prescribed forms listed in heads 2, 3 and 4. In this regard, I will make regulations to set out the way in which medical practitioners will certify their opinions regarding the risk of loss of life to the woman, and whether a termination of pregnancy is required. These regulations will require, for example, certificates to indicate the clinical grounds for the opinion and other relevant details of the case at hand. Under this head I will also make regulations regarding the functioning of the review committee.

Head 16 also deals with regulations, this time on the prescribed notification form to be filled in under the terms of head 11 on notifications. Head 17 is a standard provision for the laying of the regulations before the Houses of the Oireachtas.

Head 18 repeals sections 58 and 59 of the Offences Against the Person Act 1861, as they will be replaced by the provisions made in head 19 of the Bill. Consequential amendments may need to be inserted in existing Acts subject to legal advice from the Attorney General and these are being explored.

Head 19 specifies the offence of performing or effecting, or attempting to perform or effect, a termination of pregnancy. This updates the law in this area. The penalty for the offence is up to 14 years imprisonment or a fine or both.

Head 20 contains a standard provision dealing with the Short Title and commencement date of the Bill.

I reassure the committee that the only purpose of the legislation I will bring before the Houses of the Oireachtas is to clarify what is lawfully available by way of treatment in cases where there is a real and substantial threat to the life of a pregnant woman, and to set out clearly defined and specific circumstances in which this treatment can be lawfully provided.

As the committee is aware a very significant amount of work was involved in producing the heads of this legislation. More than 50 drafts were composed as we moved to produce what we believe to be balanced proposals which meet our obligations. I commend the heads of the Bill to the committee and I look forward to hearing its discussion and deliberation on the proposals.

I am joined by the Chief Medical Officer, Dr Tony Holohan, who was closely involved in all of the work on the heads of the Bill. I am also joined by the Secretary General of the Department of Health, Dr. Ambrose McLoughlin, who is fully conversant with the detail of the proposals. We are also joined by Ms Geraldine Luddy and Ms Alessandra Fantini from the Department and they have done much work on the heads of the Bill. Dr. Holohan and Dr. McLoughlin will remain with the committee to be of assistance in ensuring the proposals in

the heads are fully understood and to answer questions on areas where members require explanation.

It is important in the first instance for the committee to have an opportunity to be satisfied there is no ambiguity as to what the heads mean. Of course, as the committee knows, the next phase is the drafting of the legislation. I look forward to working closely with colleagues in the Chamber as we discuss the final legislation and any amendments it may require on Committee Stage.

I again publicly state my gratitude to the committee for its earlier hearings which informed the composition of these heads. I thank the Chairman, committee members and all of those participating in these public hearings for the invaluable contribution they are making to this issue and for the assistance they will provide to me and my officials. I acknowledge Deputies on both sides of the House who have discussed these matters with me and I thank all those persons who recognise the great sensitivities involved and the need for our discourse to be respectful of differing views. I will now hand over to the Chief Medical Officer, Dr. Tony Holohan, who will provide further details on the principles underpinning the general scheme.

Chairman:

I thank the Minister for his opening remarks. As members were notified by e-mail yesterday afternoon, the Minister will leave us shortly. Before I call Dr. Tony Holohan, I acknowledge the presence of Ms Alessandra Fantini whom I forgot to mention at the beginning.

Dr. Tony Holohan:

I am pleased to be here on behalf of the Department to contribute to the hearings on the general scheme of the protection of life during pregnancy Bill. The Minister has already provided the background and a detailed presentation on the heads of the Bill. I will begin by setting out the principles which underpin the legislation and commenting on matters of professional medical practice which arise in the context of these heads. These guiding principles are derived from the work of the expert group chaired by Mr. Justice Sean Ryan of which I was a member. It is important the committee understands these and how they guided the drafting of the heads.

The first principle behind the general scheme is that it should provide legal clarity by way of legislation and regulations on the circumstances in which a termination of pregnancy is permissible, which is where there is a real and substantial risk to the life, as opposed to the health, of a woman. The aim of the general scheme is to bring clarity to the existing situation. As the Minister has already alluded to in his presentation, the scheme does not confer any new substantive rights to termination of pregnancy. Rather, it provides for rights which already exist, within constitutional provisions and the Supreme Court judgment in the X case. Its purpose is to confer procedural rights on a woman who believes she has a life-threatening condition, or whom others believe on her behalf she has a life-threatening condition, so she can have certainty as to whether she requires this intervention.

The second principle underpinning the legislation is that the State will uphold the right to life of the unborn as far as practicable, as per the constitutional obligations in Article 40.3.3°. This means that where a woman has a pregnancy which places her life at risk and her foetus

is or may be viable, she may have a right to have the pregnancy brought to an end but not a right to deliberately end the life of the foetus.

The third principle is that termination of a pregnancy must be necessary to save the woman's life. In these circumstances, termination of pregnancy will always be considered a medical intervention which operates within all the existing arrangements that pertain to other medical services and interventions, and standard medical practice should be adhered to as much as possible in its delivery.

I should note, however, that certain additional requirements are considered appropriate due to the fundamental constitutional rights at stake here, namely, the right to life of the pregnant woman and the right to life of her unborn child. The requirements provided for in the legislation include a process for assessment, a process which sets out the number of doctors required for this assessment, the process of certification, the locations where terminations might take place, a formal medical review process, and a notification system.

The requirements provided for in the legislation include a process for assessment, which sets out the number of doctors required for that assessment, the process of certification, the locations where terminations might take place, a formal medical review process and a notification system. We have heard those details outlined by the Minister.

The fourth principle deals with the issue of suicide and states that, given the more subjective process and recognised clinical challenges involved in the evaluation of suicidal ideation, the legislation should reflect this in the checks and balances that it provides for.

The fifth principle deals with the issue of consent which is enshrined in current ethical standards for doctors, set out by the Medical Council under the Medical Practitioners Act. This principle provides that it is always a matter for the patient to decide if she wishes to proceed with a termination of pregnancy following a decision that it is the only intervention which might save her life.

The sixth principle provides that there must be an ability to monitor the impact and operation of the legislation, so therefore it provides for a mandatory monitoring and reporting system. It specifies that, in order to ensure that the general constitutional prohibition on abortion is maintained, the State will regulate and monitor the exercise of a woman's right to lawful termination of pregnancy as stipulated by the Supreme Court judgment in the X case.

I would now like to expand briefly on the issue raised in principle 3, which I have spoken about, regarding adhering to standard medical practice. To reiterate that principle, where termination of a pregnancy is necessary to save the woman's life, the procedure is to be considered a medical intervention and standard medical practice should be adhered to as much as possible in its delivery. The general scheme has put this principle into practice by ensuring that, as far as possible, the processes it sets out for assessing the risk of loss of life do not go beyond what would normally occur in clinical practice. For example, in terms of setting out the assessment process, the general scheme provides for more than one medical practitioner to be involved. This reflects the fact that it increasingly the case that doctors do not act alone in assessing and managing patients where the complexity is of a similar order to that of a pregnant woman who has a real and substantial risk to her life.

Evidence-based practice in many disciplines provides more and more that doctors work as part of a team or consult with colleagues as a matter of course. Emergency situations are the exception here, of course, and these are considered separately - as we have heard from the Minister - by the general scheme, with different requirements set out where the risk of loss of life, for physical health reasons, is immediate or imminent. In addition, the general scheme does not preclude patients from seeking a second or subsequent opinion in relation to any or all members of their treating team, as per standard practice. This is a routine feature of medical practice enshrined within Medical Council guidelines.

Although the general scheme sets out the process to follow in assessing whether a termination of pregnancy is required, I must note that it is silent on how the certification might come about. This was deemed appropriate since clinical scenarios where the X case criteria might apply are bound to be complex and certainly unpredictable, and therefore attempting to predict and set out specific clinical referral pathways in legislation would be unsafe and unsound. Therefore, the general scheme expects and indeed necessitates that standard medical practice would apply as in all other medical practice.

I am the chief medical officer and I have confidence in the medical profession in this country. I believe in the integrity and professionalism of our doctors. We have a highly trained and motivated set of doctors working in this country. They have a track record of high quality, patient-centred care which puts patients first. While none of us is blind to the fact that by today's standards of service, we would not necessarily deem the practices and behaviours of the past - or some of them - as appropriate, I think it is absolutely fair to say that our doctors and our medical colleges have shown a consistent commitment to the public interest in the work they do. For many years they have relied on voluntary altruistic endeavour in the training of the next generation and in the pursuit of research knowledge and understanding, which is the bedrock of evolving evidence-based care. They are showing leadership in every aspect of all major health reforms that are under way, at a scale and pace that would simply be impossible without their active engagement. This is true of doctors right across the spectrum, whether they are GPs, obstetricians, psychiatrists or any other speciality. It is my hope and expectation that the doctors who will give evidence to this committee in the coming days will do so in a manner that reflects their duty of professionalism and respect for one another as colleagues, and that remembers their responsibility to ensuring that this committee and the wider public are informed through evidence and science.

It is perfectly rational and reasonable that society would seek to place limits and boundaries upon certain services provided by doctors where there is a public interest to do so, and to provide clear oversight and accountability arrangements for doctors in the delivery of these services. That is precisely what these heads seek to do, while recognising and respecting the latitude there must be for medical practitioners to carry out their duties in the interests of their patients with clarity and certainty about the legal framework within which they must operate. It is vitally important, therefore, that guidance is developed for doctors on the appropriate operation of this legislation. That is best done by the doctors themselves through the professional colleges and the Medical Council, all of whom have a strong track record in this regard. The Department and my office have a strong and very good working relationship with the colleges and professional bodies. I plan to work with them in preparing guidance to their members on the operation of this Bill. I will be meeting with them in the near future to commence this process.

In conclusion, I wish to thank the Chairman and his fellow committee members for the opportunity to address them today. I would like to wish them well with their work and look forward to the committee's report. I am at the committee's disposal for any questions or clarifications that members may wish to raise.

Chairman:

Thank you, Dr. Holohan. As agreed, there will now be an opportunity for questions and answers. This session will end at 11 a.m. Time will be allocated as 70% for members of the committee and 30% for non-members. I will indicate when the members' time is up. I now call on Deputy Billy Kelleher. I ask members to stand when they are addressing the committee, rather than sitting down.

Deputy Billy Kelleher:

I will pose questions rather than expressing opinions. In the context of an interruption to a pregnancy, a termination or an abortion - whichever terminology one wants to use - is there, or will there be, an obligation under this legislation, coupled with Article 40.3.3o of the Constitution, to vindicate the life of the unborn at whatever stage? In other words, if there is an interruption to a pregnancy for emergency medical reasons, non-emergency medical reasons or in the context of assessment for self-destruction, is there always an obligation on the medical practitioners who will be carrying out that termination to make every effort to deliver the child alive and make every effort thereafter to sustain the child's life? I would like to get clarity on that matter.

In the context of the panel for assessment for self-destruction or suicide - the words sound very callous at times - we will have an obstetrician and two psychiatrists. I want to get a flavour of how Dr. Holohan would see this particular panel working. Will this just be a panel that will make the assessment and adjudication as to whether the woman's life is at serious risk because she is pregnant, or will there be a patient-professional relationship with the psychiatrists and obstetrician when they are assessing the woman for that? In other words, do they just decide to assess her, make their decision and move on, or is there a type of patient-professional relationship on the panels themselves?

Head 11 of the Bill concerns reporting to the Minister. We do not expect all that information to be made public, including names, addresses, hospital locations and the professionals who carry it out, but will there be an overarching reporting process that will be available to the public concerning the number of terminations, in broad outline?

Deputy Caoimhghín Ó Caoláin:

In dealing with the heads of the Bill it is most unfortunate that the Minister has not remained for questions on these matters. I wish to ask a number of questions nonetheless. As regards the five obligations of the State, as laid out in the expert group's report, could Dr. Holohan give us his view as to whether this draft legislation fulfils these obligations? I am speaking of each of the five as laid out in the expert group's report. Does Dr. Holohan believe that the draft legislation before us fulfils all of those obligations?

As regards head 4 of the Bill - the risk of loss of life from self-destruction - the requirement is that one obstetrician-gynaecologist must be employed at that location and two psychiatrists,

one of whom shall be attached to an institution where such a procedure is carried out. What is the situation concerning the lead? Who is the lead person concerning that combination of expertise - that is, the obstetrician-gynaecologist and psychiatrists?

It must have some structure. What is Dr. Holohan's understanding of the lead practitioner in that regard and what is the situation regarding conscientious objection which may present regarding one or other of the psychiatrists, and particularly where the requirement is that one of the psychiatrists would be attached to an institution where such a procedure is carried out?

Regarding the certification where a non-emergency situation - a medical condition - would arise, the requirement is that two medical practitioners can certify. One must be an obstetrician-gynaecologist, another could be, as the legislation provides, a psychiatrist. It also provides for others with "specialist division" registration. What other areas of specialist division expertise would Dr. Holohan envisage? There is a significant list there. Depending on what circumstances might they apply?

With three minutes it is very difficult; my time is almost up. I suggest that in head 2, "Risk of loss of life from physical illness", it may be a requirement to revisit the words "an", "a" and "that" in the construction of the provisions. It is open to a number of interpretations as to the requirement of the obstetrician-gynaecologist being attached to an appropriate location. It goes on to say "that location" and "a location". It is open to interpretation as to exactly what is being required. This process is to try to inform how to better prepare the legislation so that it is fit for purpose.

Deputy Mattie McGrath:

I, too, welcome our guests today but express my deep dismay that the Minister is not staying with us. We were informed only yesterday by e-mail at 4.30 p.m. It is typical of the way this has been handled and I am very disappointed. In the absence of the Minister, can our guests provide specific examples indicating how the heads of the Bill were influenced by the evidence presented at this committee during the hearings held last January, especially regarding the unanimous evidence presented at these hearings clearly indicating that abortion is not a treatment for suicidal ideation and that it is impossible to determine that a person is suicidal?

As the Minister has left, this may be very unfair, but we have to ask the following question. I heard the Minister interviewed on the radio recently and he indicated that a child who survived a termination and whose mother did not want to parent the child, him or her, that this child will be put into State care. Yet the heads of the Bill which we are discussing here today make no provision for this eventuality whatsoever. Why?

Chairman:

I remind members that the Minister of State at the Department of Health, Deputy White, will be here at the end of our session to reply to the three days of hearings, so the Minister and the Government will be here at the very end as well.

Senator Martin Conway:

Well done, Chairman.

Dr. Tony Holohan:

I will try to answer those questions as quickly as I can. If I could describe how I think the panel might work in practice it might help in answering Deputy Kelleher's second question. The likelihood, and by no means the only scenario that could arise, is whereby a GP, for example, who is visited by a pregnant woman who is expressing suicidal ideation, and who has concerns, may make a referral to a consultant psychiatrist for his or her expert assessment. That psychiatrist may well then form a reasonable view that there is a genuine risk to her life, if he or she believes that to be the case. The psychiatrist would then seek the opinion or involvement of a second psychiatrist to essentially corroborate that view. If the view further extends to a potential requirement for an intervention such as a termination, they would then have to consult with or engage an obstetrician. That would be the likely mechanism through which one would end up with three different doctors coming together to assess. It is not a panel remote from the individual.

This is very much about treating a woman whose life is at risk or where there is a belief that there is a real and substantial risk to her life. We are placing a framework around the care the doctors who are caring for her will provide. This is a medical service the woman is receiving, not a remote panel. This is very much the group of doctors who are involved in caring for and looking after that woman in that situation. The requirement for reporting will give rise to an ability on our part to produce some form of annualised reporting of numbers, potential indications and so on. It will be open and available to us to have the information upon which we can make reports that people can use to assess the impact of the legislation.

On Deputy Kelleher's first question, arising from the Constitution there is a clear duty upon doctors to make every effort to save the life of an unborn child where that is reasonable, feasible and practicable. That is enshrined in current Medical Council guidelines. While I would not in any sense seek to direct the council in the guidelines it would set out, I would expect that the council will, when any new legislation is prepared in this area, seek to update and change its guidance to set out that form of expectation. There may well be room then for colleges, for example, to set out what that means in practice. Without my saying this is what will happen, this will be very much open to obstetricians. It might well be set out that there would be a requirement for a certain form of imaging to take place as part of the foetal assessment process. That brings detail to what would be required to make an assessment of and take steps to vindicate the right to life of the unborn child.

To answer Deputy Ó Caoláin's first question, yes, we believe they fulfil the conditions set out in the expert group report. My answer to Deputy Kelleher's question may help to answer Deputy Ó Caoláin's question on head 4. I would see the initial psychiatrist as the person who would be primarily looking after that individual person, but I would like to think, as I said in my opening statement, that the colleges would begin to set out guidance on the detail of medical practice that will arise to give effect to the services that will be governed by this broad framework of legislation.

Deputy Ó Caoláin raised the question of conscientious objection. That is provided for in Medical Council guidelines. Am I not answering his question there?

Deputy Caoimhghín Ó Caoláin:

The requirement is that one of the psychiatrists would be attached to an institution where the procedure is carried out. What if the situation presented where that person, the only person then available, was a conscientious objector? It is not beyond the bounds of possibility.

Dr. Tony Holohan:

Yes, there are some technical issues to which the Minister alluded, that we will be looking at in the context of these linkages between doctors and locations of practice. That is the first part of the answer to that question. The other part is that doctors who raise a conscientious objection are not free of obligation to the individual in that situation. They must make appropriate arrangements to ensure there is an appropriate onward referral. They cannot simply step away from the care of that woman. The woman in that situation where the doctor has a legitimate conscientious objection will not find herself in a situation where there is nobody to care for her. That is the intent of this legislation but we will be looking at some of those technicalities to which the Minister alluded.

Regarding the other areas from a physical health point of view, the likely areas are various aspects of oncology, cardiology and renal medicine, and these are by no means common necessarily. Those would be the dominant physical specialists who could be involved, although I understand the College of Physicians will make a detailed presentation that will go into much more detail on that subject.

I am not taking comprehensive enough notes. Could Deputy Ó Caoláin remind me of his question regarding the "Risk of loss of life" under head 2? I apologise.

Deputy Caoimhghín Ó Caoláin:

I referenced what I believe to be a need to revisit the construction of that. I drew attention to the words "an", "a" and "that. I think it creates a spaghetti junction of possibilities and needs to be much more precise.

Dr. Tony Holohan:

The Deputy is quite correct. That is something we accept and will look at. In the spirit of what the Minister said about looking at some of these technicalities that will improve the operation of the legislation, that is, in a sense, what these hearings are about.

Deputy Mattie McGrath asked about abortion and suicidal ideation. I understand that the College of Psychiatrists of Ireland will make a statement and present itself for questioning, as will a number of other psychiatrists. There are widely held and sometimes conflicting views among psychiatrists. The Supreme Court judgment in the X case has created a requirement for us to make provision for this situation, which is what we have done.

As to the issue of a child requiring care, we already have appropriate arrangements for children where other arrangements - for example, normal parenting and so forth - do not provide such care. This legislation neither adds to nor takes away from that situation.

Chairman:

Members' time ends at 10.44 a.m. and nine members have expressed an interest. Non-members have also indicated. Members should keep their questions tight, as we will end this session at 10.44 a.m. I call Senators Burke and Walsh and Deputy Naughten, in that order.

Senator Colm Burke:

I welcome the delegation. I have two questions. First, section 1(*b*) in head 4 calls for an obstetrician and two psychiatrists. A question arises as to whether an obstetrician is competent to make a decision on a psychiatric issue. For example, the evidence of an obstetrician on a psychiatric issue would not be accepted in the High Court. Should two psychiatrists make the decision and only involve the obstetrician after the decision is made?

Second, what if the expectant mother is an infant? For example, in all matters of personal injury involving infants, the courts must approve a settlement. There is no indication in the heads that the court must sign off on the decision where it is an infant who is pregnant. This is a technical issue, but it may arise at some point.

Senator Jim Walsh:

My questions will relate to head 4, the proposals in respect of suicide. Clear evidence was given to the committee at our last hearings and, despite Dr. Holohan's comments, was unanimous. All of the psychiatrists, including those who were pro-choice, stated that it was almost impossible to diagnose suicidal ideation. According to a study in Britain, such a diagnosis was accurate in only 3% of cases, with 97% false positives. In January, the committee received a submission from St. Patrick's University Hospital, whose staff are the recognised experts in this field. It clearly stated that mental health professionals were unable to predict suicide and that no test or clinical assessment was valid or reliable in that regard. It also stated that no evidence in the literature or from its own work indicated that the termination of pregnancy was an effective treatment for any mental health disorder or difficulty.

Dr. Holohan will accept that no psychiatric evidence was presented to the court in the X case. I am sure he will acknowledge that, in the interim, there have been significant advances in medical science that inform our knowledge today and indicate that abortion is not a treatment. The Minister stated that our hearings informed the compilation of the heads, but why did he and his Department ignore this medical evidence?

Deputy Denis Naughten:

I thank the witnesses for their evidence. Regarding head 6, the Minister and Dr. Holohan referred to how the formal review pathway was in addition to, rather than in substitution for, a woman's seeking a second opinion. If so, and I believe it should be the case, does it mean that a woman who is unsatisfied with the first decision can, instead of going through the appeals process, search for two other consultants until she gets a determination that suits her? How will the system work in reality?

On a related point - namely, suicidal ideation and self-destruction - two psychiatrists are required to make a determination of a risk of suicide. The review process also involves two psychiatrists. This country has only three perinatal psychiatrists. In January, the committee heard evidence that no service was available to women outside Dublin. The majority of

women with suicidal ideation during pregnancy want to give birth to healthy babies. Will we spread limited resources thinly and concentrate on a small cohort to the neglect of women who have serious mental health issues? Will the witnesses assure members of the committee that adequate resources will be provided to treat those women with suicidal ideation who want to continue their pregnancies?

In Dr. Rhona Mahony's evidence to the committee in January, she asked whether a "substantial risk to life during pregnancy" was "a 10%, a 50%, an 80% or a 1% risk of dying". I do not see in the heads of the Bill an answer to that question. Perhaps the witnesses can provide an answer for us.

Dr. Tony Holohan:

Senator Burke asked about provision for an obstetrician and two psychiatrists. It is not proposed by any stretch that the obstetrician has expertise or a function in assessing suicidal ideation. That is not the reason for the obstetrician's being a part of the certification process. The Supreme Court test requires that, first, the criterion of a real and substantial risk to the life of the woman be satisfied and, second, the termination is necessary to save her life. This assessment can be made only by an obstetrician. As the Minister stated, it requires, in part, an assessment of the foetus's viability and such matters.

The obstetrician might be the person who carries out a necessary termination. It would not be workable if this process of certification of necessity did not involve the person carrying out the termination. Therefore, we require two psychiatrists, for the purpose of creating greater certainty around some of the uncertainties to which we referred that arise in the assessment of suicidal ideation, and an obstetrician for those reasons that I have just indicated. They all form part of the process of certification. We are not in any sense suggesting that obstetricians have miraculously found a capacity to assess suicidal ideation.

I presume the Senator was referring to a minor rather than an infant.

Senator Colm Burke:

I am sorry; yes. I was referring to the X case, which involved a 14 year old.

Dr. Tony Holohan:

That situation will be governed by the existing law on minors and so on. This legislation does not seek to change that. Whatever arrangements might pertain to a child who is pregnant at that age, whether she is in care or not, are enshrined in existing legislation and we do not seek to change it.

Senator Walsh mentioned the uncertainty in the diagnosis of suicidal ideation. I must point out that psychiatry is a clinical science, one that is based on scientific method and endeavour. It is not a hocus-pocus assessment. There is a genuine clinical method and evaluation. The simple assertion that there is uncertainty in that clinical evaluation in no way negates the science behind the practice of psychiatry.

Deputy Naughten asked about the formal review panel. We view it as something that is activated by the woman if she receives a decision from the initial process with which she is

not satisfied, which will mainly be a decision in the negative. If she is unhappy with the decision that a termination is necessary, she has the right to withdraw her consent, which addresses that particular scenario. The review is essentially a rerun of the initial process, in that three doctors will take over her care and have the duty of care responsibilities to the woman to which I referred in the context of the initial assessment.

It will, therefore, be only activated at the request of the woman and in practice will arise only where the woman gets a judgment with which she is not satisfied.

Regarding the question of perinatal psychiatrists, we do not believe it is necessary that suicidal ideation in pregnancy be assessed only by perinatal psychiatrists. The assessment of suicidal ideation is well within the scope and sphere of competence of general and child and adolescent psychiatrists of which there are more than sufficient in numbers relative to the likely rarity of these circumstances such that it is not going to cause any difficulty in either access to services or resources and so forth. It will not be the case that only perinatal psychiatrists can be involved in the assessment of women who might express suicidal ideation during pregnancy.

Deputy Denis Naughten:

In January Dr. Rhona O'Mahony asked if a substantial risk to life during pregnancy was a 10%, a 50%, an 80% or a 1% risk of dying. I do not see an answer to that in the heads of the Bill. Will Dr. Tony Holohan provide us with an answer to that?

Dr. Tony Holohan:

I am certainly not going to put a percentage on it. It is a real and substantial risk. Doctors would evaluate that risk and it would be upheld in the eyes of their peers if there were to be an examination of that particular decision. If a doctor is making a clinical decision, as is the case with any other aspect of medical practice, he or she must make it in such a way that the decision, the care, the interventions and so on are likely to meet a standard that would be upheld by their peers. I do not think we want to put a precise numerical definition on it. I do not think the Deputy would be surprised for me to say that.

Deputy Catherine Byrne:

I thank the delegation for attending the committee this morning, particularly the Minister. What about the treatment of women who are suicidal and decide to continue with the pregnancy? Will there be a process to help them along? Could the delegation explain what that treatment might involve?

Many people have asked me about the proposed head 4. When someone presents herself as suicidal, what will be the process for assessing her and how long will it take? Will it be hours, weeks or months before a decision is made on when the termination of the unborn will happen?

Senator Jillian van Turnhout:

Under head 1 on interpretation of reasonable opinion, why does it not also include for the life of the pregnant woman? If it were, it would give more of the equal esteem that is in Article 40.3.3° of the Constitution.

Regarding heads 2 and 4, is there a reason there is no clause requiring consultation with the pregnant woman? We are ensuring consultations are taking place but not actually with the pregnant woman.

Under head 4 also, is there a reason there is not a clear and reasonable time limit for a decision, given the physical and mental strain under which the pregnant woman might be? There should be a statutory requirement for the assessment, which I would suggest should be seven days. I have similar concerns regarding head 6.

Regarding head 19 and the scope of offence, I believe it is a broad scope of an offence for the criminalisation of any act with the intent to destroy human life. Has the Minister considered being more clear and precise about the activities that would be subject to criminal proceedings?

Deputy Robert Dowds:

I welcome our guests. If I understand correctly, fatal foetal abnormality is not covered by the legislation. Is there any way this Bill could be amended to include the possibility of a termination in the case of a woman who has the misfortune of having a pregnancy where there is no chance of life for the foetus outside the womb? If not, is that because of the 1983 constitutional amendment?

Dr. Tony Holohan:

In the case cited by Deputy Catherine Byrne, a pregnant woman presenting in that situation will be treated exactly as she is at the moment. Women are likely to present to psychiatrists expressing suicidal ideation in pregnancy and they are cared for as things currently stand. Nothing in this legislation will change that or the duty of care of the doctors who attend these women. This legislation will have no implications for such cases.

On the suicidal process, I outlined earlier what I believe the process is likely to be. I gave a picture of what a routine scenario might be of how someone goes about accessing a service if they believe themselves to require a termination as a result of suicidal ideation.

Head 1 on the reasonable opinion makes specific emphasis on the whole question of the requirement to also assess the right to life of the pregnant woman. The reason we are here in the first instance is because of the real and substantial risk to the life of the mother. By definition, there is consultation taking place with the woman because we would not be in this situation unless there was consultation-----

Senator Jillian van Turnhout:

Yet there is no statutory requirement.

Dr. Tony Holohan:

I cannot see how it could practically occur that one could propose the procurement of a termination on a woman's behalf without consultation with the individual woman.

The time limit is in the legislation. There is a seven-day period for the Health Service Executive, HSE, to convene and a seven-day period within which it must actually make that assessment.

The length of time for the assessment will be dictated by the clinical circumstances. There may well be a situation of someone expressing suicidal ideation or indeed something arises from physical health point of view where time is much more of an issue than in other situations. One can have a real and substantial risk to life that need not be imminent in a physical health situation. The time period that should elapse will vary on clinical grounds and, therefore, should be the subject of the clinical guidance that needs to be developed by doctors that I spoke about in my opening statement.

It is not proposed that this legislation and the heads approved by the Government would cover the question of foetal abnormality. That is not to say that we at a personal level have enormous sympathy for women who find themselves in that situation.

Deputy Robert Dowds:

Is that due to the 1983 constitutional amendment?

Dr. Tony Holohan:

That is a component of it.

Deputy Peter Fitzpatrick:

Over the past number of weeks both I and my constituency office have been completely inundated with questions and queries about this debate. As an elected representative of my constituency, I have given an undertaking to my constituents that I would raise their questions at this committee. Accordingly, the questions I am about to ask are on behalf of the people of Louth and east Meath. I thank the delegation for making itself available.

Does the definition of an appropriate location allow the HSE to enter into arrangements with organisations such as the Irish Family Planning Association, the Marie Stopes International and the Well Woman Centre in order to allow these organisations carry out abortions under the proposed legislation?

Will doctors and nurses who wish to have no part in abortions under head 4, either directly or indirectly, be significantly protected in their professions and livelihoods?

Is the delegation satisfied that the proposed legislation will provide for the mandatory care of newly born children resulting from later stage termination in order to vindicate their equal rights in the Constitution?

Deputy Seamus Healy:

Could Dr. Holohan clarify the question of non-viable fatal foetal abnormality?

My understanding is that the Government in A, B and C *v*. Ireland referred to this matter and indicated that there was a belief that it was constitutional. Certainly, evidence presented to this committee in January was very strong in the belief that Article 40.3.3° covered this area. Could Dr. Holohan tell us whether this issue was considered, what the outcome of that consideration was and the reason this was excluded from the Bill?

In respect of appropriate location, the heads refer to health care facilities providing obstetric and mental health services. Does this mean that public hospitals where there are obstetric units but no inpatient acute psychiatric units are not covered as appropriate locations under the Bill? I agree with Senator van Turnhout regarding the repeal of sections 58 and 59 of the Offences Against the Person Act 1861. The penalties arising in the Bill from that appear to be excessive and further clarification is needed. Could Dr. Holohan comment on that?

Senator Ivana Bacik:

I have three very brief questions relating to the need to ensure this legislation provides an accessible and effective procedure under the terms of the A, B and C *v.* Ireland judgment. Head 4 concerns the specific requirements in respect of the two psychiatrists, namely, that both should be employed at a centre registered by the Mental Health Commission and one should be attached to an institution where the procedure is carried out. Is that overly restrictive, particularly in view of the possibility that they will be dealing with minors, who ideally will have to see a child or adolescent psychiatrist, and the fact that the maternity hospitals in Dublin are not part of a general hospital with a big psychiatric department attached?

My second question relates to the review provided for in head 6. Seven days seems unduly long where a woman is seeking to vindicate her right to life. Could this practicably be reduced to three days?

In respect of head 19 and the criminalisation aspect, I share the concerns of others about the penalty and the overly broad wording. It falls foul of the Constitution in terms of creating a criminal offence that is too vague and broad in its current drafting. I also suggest that the woman concerned should not be criminalised. If we are looking at the Criminal Law (Suicide) Act 1993 as a model, given that the note to the head specifically refers to that Act, we can see that it does not criminalise the person who attempts suicide.

Deputy Mary Mitchell O'Connor:

I want to address head 4. Members of the public fear that this head will open up the floodgates to abortion or will be the first step in opening up the floodgates. Could Dr. Holohan tell me how many women he expects to seek and be granted terminations of pregnancy under head 4? He gave details of likely processes in other areas today. Could he tell us whether the number will be less than ten? Is he talking about 20, or hundreds? What numbers does he expect to see?

Chairman:

I will call on Dr. Holohan and then we will move on to non-members' time.

Dr. Tony Holohan:

I will firstly deal with Deputy Fitzpatrick's questions. In respect of the definition of appropriate location, the intention is that the service be provided through all of the 19 public obstetric units in the country. It will not be possible under the heads as proposed for organisations that are not governed - and I use that word loosely - by HIQA and its framework, which is the 2007 Act, to be involved in the provision of these services. Without going into the names of individual organisations, some of those mentioned by Deputy Fitzpatrick are not so governed as things stand.

In respect of the care of children, I think I answered the question earlier by saying that the same obligation arises. If there are children who require care, there are other pieces of legislation that govern the situation.

In respect of Deputy Healy's question on viability and gestational age, the legislation is silent on gestational age. I know there has been a substantial amount of media and public comment on that particular point. We believe the making of an assessment as to the viability of a pregnancy is best placed in the hands of the doctors who are making the assessment. It does not mean that we believe doctors - who have a duty, as I noted earlier, to vindicate the right to life of the unborn child - are going to engage in what might be termed late-term terminations. The situation that currently pertains is that doctors will see patients as things stand, where, perhaps as a consequence of suicidal ideation or some physical illness, it is necessary and indicated that a early delivery take place. That is something that happens in the here and now and perhaps gives rise to children being born at an earlier time than might otherwise be the case. This legislation does not change that situation in any way. Issues relating to assessment of the health and viability of the foetus are subject to change as obstetric and neonatal practice improve so it is appropriate and prudent that we would not enshrine specific time periods in the legislation but rather to leave it to doctors to make that assessment in the individual situation.

Chairman:

Deputy Healy may speak regarding a point of clarification.

Deputy Seamus Healy:

The point I was raising concerned fatal foetal abnormality.

Dr. Tony Holohan:

I apologise if I misunderstood the Deputy's question. The test that arises in this situation relates to the risk, real and substantial, to the life of the mother. It does not relate to the health or potential viability of the foetus. That is the situation as provided for under the Constitution.

In respect of the question about whether the provisions relating to the two psychiatrists under head 4 may be overly restrictive, the intention is to create a situation whereby this service can be accessed, perhaps through a GP or direct referral from an obstetrician in all of the 19 obstetric units in the country. If we need to look at aspects of how things have currently been framed in terms of their impact, the Minister has indicated that we will do that. That is the intention.

I take the point about Senator Bacik's preference for a three-day period over a seven-day period. There can sometimes be practical difficulties in convening groups of people over holiday weekends and periods so the seven-day period is very much an outer limit as opposed to a minimum period.

Senator Bacik echoed a point made earlier about head 19, and we take that point. Again, it is something we can look at in the context of drafting.

In respect of head 4, I will not get into giving what I think will be the likely number of terminations that will occur as a consequence of the Bill. My general expectation is that it is not likely to be significant. We have made provision for the grounds of suicide because it arises as a consequence of the constitutional position and the Supreme Court judgment and because it would be impossible to rule out the possibility of suicidal ideation and a risk to a woman's life as a consequence of self-destruction that could only be averted through termination. Removing this provision entirely would be based on a belief that it could never arise. I would not expect it to be a very widespread or common occurrence but I would not say that it would never happen and I will not put a number on it.

Chairman:

Deputy Healy indicated that he wished to speak. I ask him to be brief because he has already spoken twice.

Deputy Seamus Healy:

In respect of the reply to the question regarding appropriate facilities, the heads refer to health care facilities providing obstetric and mental health services. There are obstetric units in the country where mental health services are not provided.

Dr. Tony Holohan:

To clarify, every inpatient obstetric unit where women are looked after and where antenatal mental health issues such as antenatal and postnatal depression arise are capable of providing a mental health service. There is no obstetric unit in which a woman might find herself in which access to a mental health service is not possible. It is our intention that all of the public obstetric units where such services could be provided would also be capable of providing mental health services.

That is the policy intent of the heads of the Bill. There may well be little aspects, technicalities, that we can look at to achieve that policy intention.

Chairman:

We now move on to non-committee members' time and already there are seven speakers for a 15 minute slot. I will add time at the end to allow for the overlap. Members should try to be brief rather than speak at length. I call Deputies Joe McHugh, Billy Timmins and Michael Creed in that order.

Deputy Joe McHugh:

I want to raise two items in respect of head 4 concerning mental health. I think a better explanation is needed for the different ranges and definition of mental illness. I refer to the definitions of real, serious, long-lasting and permanent and specifically within that category schizophrenia and recurrent psychotic depression. That is one level. Public concern focuses on a different level, that of a person presenting at a GP's surgery saying she is suicidal, with the corollary that there will be a termination. That is the fear and concern among the public and the opening of floodgates as Deputy Mitchell O'Connor pointed out. Can we please highlight better the pathways that are and will be available to women who present saying that they have just harmed themselves or are about to do so, or threatening suicide, be they counselling, help or support, the better to manage the crisis? That conversation is not being held at the moment and I ask that this be done in a better way, even in the explanatory memorandum of this legislation to avert terminations where possible.

In respect of heads 19 to 20, the Offences against the Person Act 1861 was already mentioned. Under the changes with respect to criminal prosecution, what are the consequences of accessing abortive pills over the Internet, within the first trimester?

Deputy Billy Timmins:

I cannot think of a more appropriate or important place for the Minister of Health to be this morning than this Chamber.

Members:

Hear, hear.

Deputy Billy Timmins:

His name is on the witness list.

Chairman:

The Deputy missed my remarks at the beginning. The Minister of State will reply at the end of the three day discussion on behalf of the Government.

Deputy Billy Timmins:

I was here and I heard those remarks but they do not give me any consolation.

My points are aimed at the Minister but maybe the Minister of State or Dr. Holohan can answer them. Dr. Holohan stated that the guiding principles which underpin the legislation derived from the work of the expert group. It is very important that the origin of the principles has a sound foundation. For the past few months I have been trying to get some information through parliamentary questions and the parliamentary party but I have not been able to access it. I want clarification on the terms of reference of the expert group and the paragraph on page 8 of that report where Mr. Justice Ryan states:

> The only brief that the Minister gave this Group was to deal with the requirements of the European Court of Human Rights judgment and to advise the Government on how to give effect to existing constitutional provisions.

That appears to contradict the terms of reference if it is the only brief the Minister gave this group. I want to know whether the Minister briefed the chairman of the group separately or did anyone brief him or has the judge misinterpreted his terms of reference? I sought to have Mr. Justice Ryan come before the committee but he was not one of those chosen. It is important to clarify that point.

In addition, based on responses to parliamentary questions that I tabled, it appears that nominations to that group were sought from various bodies but those forwarded by the Irish College of General Practitioners, the Institute of Obstetricians and Gynaecologists and the College of Psychiatry were not the ones accepted. I would like clarification on that because I may be incorrect, although in the case of the College of Psychiatry the nominees certainly were not in the group because I heard Dr. McCarthy say in interview that the college's nominee was not picked. Why were these nominees not picked? Who was picked instead and who nominated those people?

We were told that the purpose of these hearings is to inform the legislation. I sat through the hearings in January and the clear message that came through to me was that termination is not a treatment for suicidal intent. Dr. Holohan said that would be very rare. From the evidence we received, it seems that the ratio for this is 1:500,000. Weighed against that, the assessment can be inaccurate in 97% of cases and termination is not a treatment for suicidal intent, yet head 4 puts this into the legislation. Is there any point in our listening to evidence presented at these hearings when the legislation does not reflect what happened at the hearings or are we just going through a charade?

Do we have any statistics on minors in the care of the HSE who come before the court and go abroad for terminations on the grounds of suicidal intent? Those statistics must be available somewhere and, if so, are they accessible?

With regard to the issue of conscientious objection, if, for example, staff in a hospital in Ballinasloe or Tralee or wherever decide that they will avail of this clause, where does that tie-in with the fact that the hospital cannot avail of that facility? If all the staff oppose it, what is the solution to meet the requirements of the legislation as proposed?

Deputy Michael Creed:

I have two questions for our guests this morning. Deputy Mitchell O'Connor referred to opening the floodgates and that is a genuine fear of people who are probably not prisoners of either extreme in this debate. There is a provision under heads 10 and 11 for an accountability structure to give the Minister an anonymised version of numbers of applications, etc., but there is no role envisaged in the heads for the Houses of the Oireachtas to be informed, consulted or asked for their opinion on this information. Can Dr. Holohan tell me whether there is resistance at any level in his Department to bolstering and enhancing that review mechanism and involving the Houses of the Oireachtas? Section 18 of the Offences against the State Act 1998, for example, provides that the relevant section "ceases to be in operation" on and from a particular date "unless a resolution has been passed by each House of the Oireachtas resolving that that section should continue in operation". Would it not be appropriate, in order to allay the floodgates fear, to put a structured review mechanism into the legislation to ensure its continued operation, particularly in respect of head 4 making provision for termination on the grounds of suicidal intent? I heard the witnesses say that termination is not an appropriate treatment for suicidal intent. I note Dr. Holohan's comments

about the numbers which I hope are correct but we do not know. We are fallible so we may get it wrong. Given the fears about the appropriateness of the treatment and the international experience which shows that people in good faith introduced legislation to cover mental health grounds that was subsequently exploited, would such a review not be appropriate? I would like to hear Dr. Holohan's comments on that point.

Article 40.3.3° refers to the equal right to life of the mother and child. Under heads 4 and 6 there is provision for an application for a termination on the grounds of suicidal ideation and under head 6 the pregnant mother is entitled to an appeals process if her original application is not granted. Given that Article 40.3.3° provides for an equal right to life, would it not be an appropriate provision, under either or both heads but particularly head 6, that some authorised officer of the State – I have suggested elsewhere that this might be Dr. Holohan – would be empowered to appeal a decision, also to that body, if the right to a termination was granted because all of this has to tie-in with Article 40.3.3° and the equal right to life? Would consideration be given to that in the final draft of the legislation?

Chairman:

There are four more speakers in this slot but first I will call Dr. Holohan.

Dr.Tony Holohan:

In response to Deputy McHugh's first question, the issue is the risk to life that arises through self-destruction and not through any other category.

I take the point that perhaps more can be done to highlight the available pathways that exist to deal in the hear and now with women who express suicidal ideation during pregnancy. That is something on which perhaps we can all collectively do a better job. It is something that I am more than happy to take up with the college of obstetricians and the college of psychiatry to see if we can make more clear those arrangements that currently exist and will continue to exist into the future, and in which I have expressed confidence in terms of how they allow doctors to deal with patients who express suicidal ideation or have any other mental issues in pregnancy.

Deputy Timmins made some remarks on the terms of reference and on the nominations and process around the expert group. We have confidence both in the chair and in how he carried out the work that he did. The nominations were made on a confidential basis by the various different bodies, although I know that some have made their nominations public. We have moved to a position now where we have a set of heads of a Bill based on that work. We have confidence in the work that was undertaken by the expert group under the chairmanship of Mr. Justice Ryan.

Deputy Timmins asked in regard to the numbers under the care of the HSE. We do not maintain numbers in regard to that point, therefore, I am not in a position to answer that question. I think the scenario Deputy Timmins painted regarding the conscientious objector is one where all practitioners in a given setting might conscientiously object. I guess that is a theoretical problem and I would see it as one. It is unlikely to become a practical problem and in that situation there will still be a duty on the provider, which would be the HSE or perhaps one of the voluntary institutions, to make arrangements to ensure that the woman - let us remind ourselves that this is a woman who is in a situation where there is a real and

substantial risk to her life - has access to an appropriate service, even if that is not available at that particular location, but I rather doubt that this situation will arise in clinical practice.

Deputy Creed asked about accountability back to the Minister. I take the points he made. There certainly is not any resistance in the Department and I am not aware of any other pockets of resistance, as it were, to the proposal that the Oireachtas might have some particular role. This information will be available to us and to the Minister and we intend to report on it in public as part of the routine reporting we do of many things. I am not aware of any resistance to what the Deputy is proposing. That would allow us to make an ongoing evaluation of the impact of the legislation, which I think was the import behind his question.

Deputy Creed's final point related to the question of appeal. This is something we have explored and on which we have dealt with the Attorney General. The appeal mechanisms we provided for in the legislation provide for a right of appeal for a woman in a given situation where she is not happy with the determination that is made by the panel. The assessment that is undertaken by the clinicians requires them to have a regard to the equal right to life of the unborn foetus. We are not making provision for any other appeal mechanisms, through me or through anybody else, in the legislation.

Senator Rónán Mullen:

I want to register my disquiet and this is no fault of the Chairman, but he has been put in charge of an express chair which is not at all satisfactory to the purposes we have to achieve. It certainly illustrates the difference between the notion of a hearing and an inquiry.

I did not quite understand the answer that Dr. Holohan gave in regard to a review in terms of the equal right to life of the unborn. Given that the unborn is a constitutionally protected actor, why is there not the requirement that there would be a voice, an advocate for the unborn, to test whether the initial certification is even necessary by the definitions provided?

Dr. Holohan referred to the third principle, that termination of pregnancy is always a medical intervention. Is there any other example he can give where doctors are called on to make a certification of a procedure in the absence of any evidence-base, particularly where it has such far-reaching consequences, fatal and final consequences, for a constitutionally protected actor? It was clear that there is no evidence that abortion is a treatment for suicidal ideation. There was unanimity on that point at the hearings.

Dr. Holohan suggests that the only reason that we have head 4 is that the Supreme Court requires that we make provision for this, but surely he is aware of the separation of powers and that it remains the prerogative of the Oireachtas, of the Legislature, not to activate an interpretation of the Constitution by the Supreme Court where it would consider that to do so would be dangerous and unjust. It was for that reason that we did not have legislation and why the former Taoiseach, John Bruton, said he would not legislate for the X case because it would have the effect of bringing abortion into Ireland. That is a legal point but I am sure it is one on which Dr. Holohan has taken advice.

I also note that Dr. Holohan said that the numbers were quite likely not to be significant. Will he accept, however, that the consequences will be very significant for whatever children are involved? I refer in particular to head 4.

The subjective nature of the psychiatric assessment is one Dr. Holohan acknowledged in his presentation. Given that subjective nature, has he had any regard to the experience of other jurisdictions such as California and New Zealand where similar apparently extremely tight grounds were set up in the area of mental health - with we should note suicidal ideation being an even more subjective issue to assess - and where it was noted, even by the Californian Supreme Court, that it was surprising the extent of abortions that took place on foot of that?

Will Dr. Holohan accept that, in reality, the only checks and balances he is talking about is that there will be two psychiatrists and that the obstetrician will have no role in disputing whether the abortion is necessary to end the real and substantial risk and will have a role only in the mechanics of carrying out the abortion and other related physical issues? Therefore, the only check and balance will be one psychiatrist backed up by another, two people who have a psychiatric qualification in an area that is subjective.

Deputy Peter Mathews:

I thank Dr. Holohan for his presentation. I want to go straight to the heart of this matter. We are here to uphold the Constitution which provides for the equal right and value of lives of mothers and children. Two points in the discussions this morning come to mind. The first is a question raised, in the first instance, by Deputy Mattie McGrath, which has not been adequately answered. I will read it again. Deputy McGrath asked can the Minister provide specific examples indicating how the heads of the Bill were influenced by the evidence presented to this committee during the hearings held in January, especially in regard to the unanimous evidence presented at those hearings indicating that abortion is not a treatment for suicidal ideation or intent and that it is impossible to determine with any degree the probability that a person is in fact suicidal. There are other aspects to the scheme of arrangement with which I am not happy. Words are not being used correctly. I refer, for instance, to the risk to the life of the mother as opposed to the health, there is no opposition between the life and the health, it is "as distinct from".

On a careful, robust and rigorous reading of the document Dr. Holohan produced, I do not believe one would understand the impression it gives. I believe that the discipline of rigorous thought and rigorous appraisal has been lost in this debate and the consequences for Ireland, its people, its mothers and its daughters are far too important to be racing into this. We have to be very clear. It is very clear, even from Dr. Holohan's paper, that the medical profession, with its current peer reviews and peer checks and balances, is carrying on very well with a duty of care - that word "care" coming from the words "heart", "core" - not measurement, rulers or calibration, but care and intent.

Deputy Timmins is correct in his comments about the base and foundation of the expert group and so on. One cannot have a sound building on bad foundations.

Senator Labhrás Ó Murchú:

It would have been helpful if the Minister could have remained to answer some questions on the contribution he made. Clarity is what we have all been focused on in this debate in recent times. The hearings are about the heads of the Bill.

I ask for clarification on three points which have been touched on. Is Dr. Holohan happy that the rights of the unborn child are given sufficient weight in the heads of the Bill? Is there sufficient clarity for the medical profession in that regard?

We accept that medical procedures and best practice must be evidence-based. Is Dr. Holohan happy that this is the case in the heads of the Bill when it comes to suicidal ideation?

The Minister is on record as saying that where a child survives and where the mother does not wish to parent the child, the child will be placed in State care. Is Dr. Holohan happy that this issue is covered in the heads of the Bill? If it is not covered, does he not believe it is a serious omission?

Deputy Terence Flanagan:

I ask Dr. Holohan what physical changes to infrastructure will be made in Irish hospitals in the light of this cultural shift, if abortion is introduced. What changes to work practices will be involved? What method of abortion will be used in these instances, as there are different methods that can be used? Has HIQA been involved in departmental discussions on the provision of abortions in Irish hospitals? Like previous speakers, I am concerned. I attended the committee hearings in January. I ask if Dr. Holohan can provide specific examples to indicate how the heads of the Bill were influenced by the evidence given at the January hearings.

Deputy Peadar Tóibín:

We are being told this legislation is not really new. Is there a precedent in legislation to deal with damage done to another human being as a result of treatment for suicidality? Is the Bill a new legal departure for the State?

Head 4 of the Bill refers to the viability of the unborn child. Will the Bill provide for a definition of viability?

I refer to the issue of women disabled by symphysiotomy. How will the State provide for children who suffer a disability as a result of being born prematurely? Will they be able to sue the State for any disability they suffer?

Senator Paul Bradford:

I welcome our visitors. I express my disappointment that the Minister is not here. I find this bizarre.

I want to take up the question raised by my colleague, Deputy Billy Timmins, which Dr. Holohan may not have had time to answer. It is a very important question relating to the expert group. We are here because of the decisions taken by the expert group, of which Dr. Holohan was a member. The expert group was given three terms of reference, which gave it a broad spectrum of decision-making powers, yet in its report as presented by Mr. Justice Ryan, it is indicated that the Minister had provided only one briefing for the group in which the solution or solutions the group could offer were confined. I ask Dr. Holohan to clarify the position. I have tried to clarify it directly with the Minister at the parliamentary party meeting. Apparently, there has been a parliamentary question. Was the expert group advised

or briefed on the type of solution it would bring forward? The terms of reference are broad, yet we have been advised of this briefing by the Minister that the answer would have to be within the confines of the X case judgment. It is very important that we know. We are debating the heads of the Bill because of the expert group's report. I am worried that the expert group's hands were tied in order to bring about a pre-designed answer. Dr. Holohan sat at the table. I want him to tell me that this is not the case and then to explain why these remarks are included in the report from Mr. Justice Ryan about that briefing.

Dr. Tony Holohan:

Because of the number of questions asked, I am happy to be interrupted, if I skip some of them. It is not a deliberate attempt to avoid answering some of the questions asked.

On the appeals mechanism, we are presenting a set of heads which are based on the advice we sought and received from the Attorney General. That is the reason we make provision for appeal in certain circumstances and not in others. It is very much based on the advice received from the Attorney General.

Reference was made to suicidal ideation, in particular, and the consequences being so significant, particularly in relation to head 4. I maintain that the consequences for an unborn foetus, whether the risk to the life of the mother is physical or due to mental health reasons, are exactly the same.

Senator Jim Walsh:

One is evidence-based, the other is not.

Chairman:

I am sorry, Senator, but we have one Chairperson - me, until the committee wants to get rid of me. The Senator's help is noted by the Chair.

Dr. Tony Holohan:

I stand over what I said in my opening statement that psychiatry is a clinical science based on scientific method and research. It is not some form of hocus-pocus that operates without evidence.

(Interruptions).

Chairman:

I will chair the meeting and decide who is the next speaker.

Dr. Tony Holohan:

Deputy Mathews made reference to the unanimity of the evidence. I did not sit in the Chamber, but I had the opportunity to go through all of the various submissions made by the different parties. The point has been made by a number of speakers this morning that on that

occasion the committee was presented with a unanimous view with regard to suicidal ideation and self-destruction. That is not my reading of the evidence presented to the committee.

(Interruptions).

Chairman:

One speaker, please.

Dr. Tony Holohan:

Although it was attributed to me that I had simply said it was only as a consequence of the Supreme Court situation that we were making this provision, there is a second reason, that we simply cannot say the circumstance of a real and substantial risk to a woman's life could never occur as a consequence of suicidal ideation. That is the reason that provision is included in the heads of the Bill. I did say I do not believe it would be prevalent or very common, but I could not say it would never occur.

(Interruptions).

Senator Jim Walsh:

Is it a treatable-----

Chairman:

Please respect the witness, Senator Walsh. You have spoken already and were allowed to make an intervention. You are not helping.

Dr. Tony Holohan:

A remark was made about my use of the words, "as opposed to the health". That language came from the Supreme Court's decision; it is not, in fact, used in the heads of the Bill.

(Interruptions).

Chairman:

One speaker, please.

Dr. Tony Holohan:

I was simply using the phrase presented by the Supreme Court in its judgment.

A question was asked about rigorous and thorough appraisal, but I do not quite remember its import.

Deputy Peter Mathews:

It was the point made by Deputy Billy Timmins on the foundation and the setting up of the expert group, the mandate-----

Dr. Tony Holohan:

I am happy to deal with that question and Senator Bradford raised the same point. I know that the expert group and its chairman had an opportunity to address this committee. We have taken our direction from the Government's decision with regard to the heads of the Bill. As I said earlier, I stand over and have confidence in the work carried out by the expert group. The terms of reference were framed at the time to make it clear that some of the potential public discussion around changes to the Constitution was outside the terms of reference of the expert group, at least for the work of and purpose of the expert group.

Senator Ó Murchú sought clarification with regard to whether sufficient weight was being given. I must ask the Senator to clarify his first question. I have written down my answer, but I am not clear on the Senator's question.

Senator Labhrás Ó Murchú:

I asked Dr. Holohan for clarity on whether the rights of the unborn child were given sufficient weight in the heads of the Bill and if there was sufficient clarity for the medical profession in that regard.

Questions were asked previously but I just want to get clarity on that point.

Dr. Tony Holohan:

There is sufficient weight and, as I said earlier, we took advice from the Attorney General on that point and what the obligations were, in a general principle sense, on doctors in that situation. As I said earlier, it is clear there is a need for more detailed guidance - profession-specific guidance and specialty-specific guidance - for doctors to interpret what that might actually mean in the day-to-day practice of medicine. For example, obstetricians might determine that it requires a foetal ultrasound at a particular point in time and so on. I would simply leave it to the colleges to work out-----

Senator Labhrás Ó Murchú:

Would it be helpful to expand on that in the heads, or in the legislation?

Dr. Tony Holohan:

No, I think it would be most unsafe for us to expand on what the requirements of medical practice would be. Based on my confidence in the profession and in the colleges, it is appropriate and reasonable that we leave matters of professional practice and guidance to the doctors themselves.

Deputy Terence Flanagan referred to the type of abortion, and I think some points were made earlier - I may have forgotten to cover this particular point - on the procurement of abortion services by way of Internet access and so on. The legislation does not deal in any way with the method through which termination is effected. All forms of termination, however

effected, will be covered by the legislation. It does not talk about obstetric interventions necessarily, or surgical interventions. HIQA, along with a number of other organisations, as part of our ongoing preparatory work, were involved in discussions.

Deputy Terence Flanagan:

I had asked about the work practice changes and infrastructural changes in Irish hospitals.

(Interruptions).

Chairman:

I chair the meeting.

Deputy Mattie McGrath:

He asked to be reminded.

Chairman:

We do not need a fourth official yet. If we do, I will ask the Deputy.

Deputy Mattie McGrath:

I am not saying that but he asked to be reminded if he-----

Chairman:

I appreciate that.

Dr. Tony Holohan:

Deputy Tóibín mentioned the assessment of suicidality and the question of viability.

Deputy Peadar Tóibín:

The first question was whether there was a precedence for damage being done to another human being as a treatment for suicide in legislation in this State. The second question was about defining viability and what rights a child would have if the State was to disable the child by bringing him or her to term as a premature child.

Dr. Tony Holohan:

In regard to the first question, I am not aware of any such provision. On the question of viability, I dealt with that, in part, earlier on. We are not seeking to define an age beyond which, or below which, the provisions of this legislation would or would not apply, rather we are entrusting it to the assessments the obstetricians, in particular, will make as to whether viability has been arrived at. It is very difficult, as I am sure the Deputy is aware, to define that in time terms alone. Sometimes viability can relate to the weight and other aspects of the health of a given foetus. Viability may be arrived at a week or two earlier in the case of some

foetuses. It would be unsafe for us to seek to define something which, as I mentioned earlier, is likely to shift as a consequence of the developments in the different relevant specialties.

Deputy Peadar Tóibín:

What about the disability of child?

Dr. Tony Holohan:

That is interesting because this kind of allows me to deal with a certain misunderstanding which might be out there as to what this legislation is likely to give rise to. As things stand, and without this legislation, a woman who expresses suicidal ideation and who is pregnant can attend a psychiatrist or an obstetrician seeking help and a decision or a determination can be made by those two individuals in consultation with one another that early delivery is necessary. That is already the situation. As things stand, we may well have - numbers of which I cannot answer - women who have earlier than otherwise would be necessary deliveries as a consequence of the expression of suicidal ideation. This legislation does not create that circumstance.

The Deputy's question relates to the disability that arises as a result of that. That is something that arises in the here and now, and the operation of the legislation will make that no more or no less prevalent than it might already be.

Senator Rónán Mullen:

My question was whether there was any evidence base, or any example where doctors are called on to make a certification in the absence an evidence base. Dr. Holohan is saying that it was established that there is unanimity that abortion is not a treatment for suicidal ideation. He is questioning that by saying there are conflicting views among psychiatrists, but it is a conflicting view in the absence of evidence. Is there any other situation where doctors are called on to make a certification in the absence of an existing evidence base, because this is all being presented to us as medicine?

Dr. Tony Holohan:

I believe it is medicine and I do not accept the Senator's implied assertion that the practice of certain parts of medicine are without an evidence base, nor do I accept his assertion that there is unanimity around the view that self-destruction cannot be a ground upon which termination might indeed necessary.

Senator Jim Walsh:

Is Dr. Holohan saying abortion is a treatment for suicidality? That is the key question.

Chairman:

I thank Senator Walsh for his intervention.

Senator Jim Walsh:

It is a very simple question.

Chairman:

I thank Senator Walsh. I appreciate him speaking again but he spoke already.

Senator Jim Walsh:

Dr. Holohan has not clarified whether it is a treatment or not.

Chairman:

I will adjudicate. I thank Senator Walsh for his assistance. I appreciate his help.

Senator Paul Bradford:

I respectfully ask that we get an answer to a question asked by Deputy Timmins, Deputy Mathews, myself and many others in the Dáil Chamber and at very various parliamentary party meetings about the guiding terms and the various interventions at expert group level, because I take what has been said that we are debating this report-----

Senator Ivana Bacik:

On a point of order, the committee decided that the questions would be directed to the heads of the Bill, and many of us have respected that today.

Chairman:

Could we all take a collective deep breath, be calm and be respectful of one another?

Senator Paul Bradford:

All I am asking is for a truthful response in regard to the expert group, its terms of reference and the comment by the chairperson in his report on what he described as the only instruction-----

Chairman:

Dr. Holohan has replied to the question and we are dealing with the heads of the Bill.

Senator Paul Bradford:

He has not replied to the question.

(Interruptions).

Chairman:

I appreciate Senator Walsh's help in trying to chair the meeting.

Senator Jim Walsh:

Is abortion regarded by Dr. Holohan as an appropriate treatment for suicidality?

Chairman:

Will Senator Walsh please resume his seat?

Senator Jim Walsh:

I am only asking for Dr. Holohan's view.

Chairman:

Will Senator Walsh resume his seat?

Senator Jim Walsh:

Everybody else who came in said it was not.

Chairman:

I thank Senator Walsh for his help in trying to chair the meeting. Will he resume his seat?

Senator Jim Walsh:

I am trying to get the information.

Dr. Tony Holohan:

What I am happy to say is that what we are providing for in this set of heads is a set of circumstances in which a woman who has a genuine, real and substantial risk to her life can receive a service by doctors who can operate with certainty as to their protections under the law in acting in the interests of that woman who, because of the risk to her life, will be in a situation where she has recourse to and dependence on that treatment. We must have a situation where doctors who operate in that environment, in the best interests of the woman who has a real and substantial risk to her life, do what is necessary to provide for that.

Chairman:

We have reached the end of this session. I thank members for their contributions. In particular, I thank the Minister, Dr. Holohan, Dr. McLoughlin and Ms Luddy.

Deputy Mattie McGrath:

On a point of order, the Minister did not answer any questions. The Chairman thanked him for answering questions but he did not answer any. He ran out of the Chamber.

Chairman:

Will Deputy McGrath resume his seat?

Deputy Mattie McGrath:

It is a farce. The Minister ran out of the Chamber.

Chairman:

I thank Deputy McGrath.

Deputy Mattie McGrath:

The Chairman is making it an even bigger farce by condoning that. If he wants to be fair and impartial, he should ask the Minister to reply to some questions.

Chairman:

I thank Deputy McGrath. As I said at the beginning, the Minister of State, Deputy Alex White, will reply on behalf of the Government at the end.

Deputy Mattie McGrath:

It is a joke.

Chairman:

We will resume at 11.45 a.m.

Sitting suspended at 11.30 a.m. and resumed at 11.45 a.m.

Regulatory and Representative Bodies

Chairman:

I apologise to witnesses for the delay and thank them for coming in. I remind members of the committee, witnesses and those in the Gallery, be they members of the media or members of the public, to ensure their mobile telephones are switched off for the duration of the meeting as they interfere with the broadcasting equipment even when they are on silent mode. They also interfere with the sound coming through headphones to members of staff.

The witnesses are very welcome to our second of the sessions on the heads of the protection of life during pregnancy Bill which the joint committee will be holding. I welcome representatives from the Institute of Obstetricians and Gynaecologists, the Irish College of General Practitioners, the Irish Medical Council, the Irish Medical Organisation and the Royal College of Physicians of Ireland. They are all very welcome. I remind members and witnesses that the balance will be 20/30 and the Chair will be very strict about adhering to it during this session. I remind members of the need for balance and calm in the discussion we are having and of the requirements of respect and tolerance.

I remind members and witnesses that witnesses are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to do so, they are entitled thereafter to only qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of the proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise nor make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice to the effect that they should not criticise, comment on or make charges against any person or persons outside the House or to an official either by name or in such a way as to make him or her identifiable.

I ask Professor Kieran Murphy of the Irish Medical Council to begin.

Professor Kieran Murphy:

On behalf of the Irish Medical Council, or IMC, I welcome the opportunity to provide the Joint Committee on Health and Children with views to assist it in formulating its report to Government on the heads of the protection of life during pregnancy Bill 2013. The IMC is a statutory body with responsibility for the regulation of doctors in Ireland. Its purpose is to protect the public by promoting and ensuring the highest standards among doctors. In the interests of patient safety and the protection of the public, the IMC has been vested by the Oireachtas with responsibility to ensure that only those doctors with the necessary education, training and skills are registered to practice in the State. The IMC also specifies standards of practice for doctors in the areas of professional conduct and ethics. The IMC provides principles-based guidance to doctors on matters relating to conduct and ethics in its *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*. The seventh edition of the guide was published in 2009, following extensive consultation with doctors, the general public, medical schools, post-graduate medical training bodies, Departments, employers and a range of other stakeholders.

While doctors are expected to adhere to the IMC's guide in their professional practice, it is important to note that it is not a legal code. In drafting its ethical guidance, the IMC sought to incorporate and reference relevant legislation to ensure that doctors would be aware of the legal framework within which they operate. The guide is a principles-based document which must be relevant to each of the approximately 18,000 doctors registered to practice in Ireland, regardless of specialty, interest or discipline. It covers issues as diverse consent, confidentiality, end-of-life care, clinical trials, prescribing practices and referral of patients. It has been designed to support doctors in decision-making with regard to conduct and ethics and to complement other sources of clinical guidance developed by professional bodies, expert groups, the HSE and others. While the IMC's guidance sets out the principles which are the cornerstone of each doctor's practice, it is the role of expert bodies and employers to devise procedures and protocols for use by doctors in day-to-day practice.

The IMC has a number of general comments on certain matters arising in relation to the heads of the protection of life during pregnancy Bill in respect of which provision must be made in primary legislation or by way of regulations.

The Medical Council is of the opinion that the process underlying the certification of the decision regarding termination of pregnancy should be the same for grounds of risk of loss of

life from physical illness and risk of loss of life from self-destruction. Accordingly, the council is of the opinion that head 2 and head 4 should be merged into a single head. In circumstances in which the pregnant woman's capacity to consent is or may be impaired, the council believes it is not clear from the draft heads how a decision regarding termination of pregnancy will be made and how the woman will be enabled and supported in participating in this decision. The opinions of all registered medical practitioners certifying a procedure that will end unborn human life must be recorded in writing. The council expresses concern about the ability of the pregnant woman to access treatment by the required registered medical practitioners as currently outlined under heads 2 and 4 in all areas of the country. Processes for a monitoring system should incorporate appropriate requirements to preserve the confidentiality of the patient and the certifying practitioners. All processes for an appeal mechanism, either by way of High Court appeal or judicial review, should be incorporated where the pregnant woman is not satisfied with the decision.

The council provides the following responses to the heads. In view of the time constraints today, I will provide an overview of the main points contained in the council's submission. In regard to head 1, the Medical Council has no specific comment on the provisions. The council is of the view that it is in the public interest that doctors have legal clarity when making clinical decisions.

In regard to head 2, the Medical Council is of the opinion that head 2 should be merged with head 4 into a single head. The text in subhead 2(1)(*a*) should be amended to read: "that procedure is carried out by a registered medical practitioner registered in the Specialist Division in the relevant specialty at an appropriate location" to ensure the registered medical practitioner has completed specialist training recognised by the council. The text in subhead 2(1)(*b*) should be amended to read:

> (*b*) two medical practitioners, registered on the Specialist Division of the register of medical practitioners established under section 43(2)(*b*) of the Medical Practitioners Act 2007 under a relevant specialty, have, in accordance with this head, jointly certified in good faith that -
>
> > (i) There is a real and substantial risk of loss of the pregnant woman's life, and
> > (ii) In their reasonable opinion this risk can be averted only by that medical procedure.

The amended head 2(1)(*b*) thereby renders head 2(2) redundant. Where the clinical decision is made to proceed with a termination of pregnancy, if neither of these registered medical practitioners is an obstetrician, at least one of the two registered medical practitioners shall then consult with an obstetrician employed at the appropriate location.

In regard to head 3, the Medical Council is of the opinion that the text in subhead 3(1)(*a*) should be amended to read "registered medical practitioner" to ensure it defines a medical practitioner who is registered with the Medical Council. The text in subhead 3(1)(*b*) should be amended to read "immediate real and substantial risk" in line with drafting in other heads. The text in subhead 3(1) should be amended to include a provision that, in forming his or her opinion, the registered medical practitioner should consult with another registered medical practitioner where practicable.

In regard to head 4, the Medical Council is of the opinion that head 4 should be merged with head 2 into a single head. The text in subhead 4(1)(*a*) should be amended to specify that the procedure should be undertaken by a registered medical practitioner registered in the

specialist division in the relevant specialty. The text in subhead 4(1)(*b*) should be amended to read:

> two psychiatrists, have, in accordance with this head, jointly certified in good faith that -
>
> > (i) there is a real and substantial risk of loss of the pregnant woman's life by way of self-destruction, and
> >
> > (ii) in their reasonable opinion this risk can be averted only by that medical procedure.

Where the clinical decision is made to proceed with a termination of pregnancy, at least one of the two certifying psychiatrists shall then consult with an obstetrician employed at the appropriate location. Not all psychiatrists work in centres registered by the Mental Health Commission, as referenced in head 4(1)(*b*). It is not clear why one of the certifying psychiatrists must be attached to a location where such a procedure is carried out. The majority of psychiatrists are not attached to such institutions.

In regard to head 5, the Medical Council is of the opinion that the formal framework developed to record a medical opinion should be independent, accessible, transparent and timely, and preserve the confidentiality of the pregnant woman.

In regard to head 6, the Medical Council is of the opinion that the text in subhead 1 should be amended to read "registered medical practitioner" rather than "medical practitioner." Subhead 6(1) does not make clear which registered medical practitioner is vested with the duty to inform the woman of the formal review option. Criteria in subhead 6(1) have not been set out to ensure that information is conveyed to the woman in an effective, accessible and timely manner. A timeframe has not been set out in subhead 6(7) for notification of the outcome of the committee's review to the woman who made the application, and, if applicable, the person who made the application on her behalf, and the executive. The council is of the view that subheads 5 and 6 are not necessary as these provisions are adequately covered under heads 7 and 8.

In regard to head 7, reflecting the council's recommendation that heads 2 and 4 be merged, the Medical Council is of the opinion that head 7 and head 8 should also be merged and the processes from head 8 adopted in the legislation. The text in subhead 7(1) should be amended to read: "in the case of a pregnant woman who believes there may be a real and substantial risk of loss of her life, a committee established by an authorised person shall consist of two medical practitioners registered on the Specialist Division of the register of medical practitioners established under section 43(2)(*b*) of the Medical Practitioners Act 2007 under a relevant speciality". The text in subhead 7(1) should be further amended to include an additional sentence: "Where the clinical decision is made to proceed with a termination of pregnancy, if neither of these registered medical practitioners is an obstetrician, at least one of the two registered medical practitioners shall then consult with an obstetrician employed at the appropriate location." A timeframe has not been set out in subhead 7(4) for notification to the woman who made the application and, if applicable, the person who made the application on her behalf, and the executive, of the outcome of the committee's review. The text in subhead 7(6) should be amended to read: "The procedures set out in this Head are without prejudice to Head 3, which shall apply where there is an immediate risk of loss of the life of the pregnant woman, and therefore the provision of Head 3 shall apply irrespective of review procedures which are in train."

In regard to head 8 specifically, the Medical Council is of the opinion that the text in subhead

8(1) should be amended to read: "in the case of a pregnant woman who believes there may be a real and substantial risk of loss of her life, a committee established by an authorised person shall consist of two medical practitioners registered on the Specialist Division of the register of medical practitioners established under section 43(2)(*b*) of the Medical Practitioners Act 2007 under a relevant speciality". The text in head 8(3) should be amended to include a further sentence: "Where the clinical decision is made to proceed with a termination of pregnancy, if neither of these registered medical practitioners is an obstetrician, at least one of the two registered medical practitioners shall then consult with an obstetrician employed at the appropriate location". It is not clear in subhead 8(1) why one of the certifying psychiatrists must be attached to a location where such a procedure is carried out. The majority of psychiatrists are not attached to such institutions. Not all psychiatrists work in centres registered by the Mental Health Commission.

As referenced in our submission on head 7, there is no time limit set in subhead 8(4) for notification to the woman who made the application and, if applicable, the person who made the application on her behalf, and the executive, of the outcome of the committee's review. In regard to head 9, the opinion of the Medical Council is that the text in subheads 8(1) and 8(2) should be amended to read "registered medical practitioner" rather than "medical practitioner". A subhead should be inserted to enable the committee to have access to legal expertise on a formal basis.

In regard to head 10, the Medical Council is of the opinion that the formal framework developed to support the collation of information on the workings of the formal medical review process should be independent, accessible, transparent and timely, and preserve the confidentiality of the pregnant woman.

In regard to head 12, the Medical Council is of the opinion that subheads 8(1) and 8(4) are largely consistent with the Medical Council's 2009 "Guide to Professional Conduct and Ethics for Registered Medical Practitioners", which states:

> 10.1 As a doctor you must not allow your personal moral standards to influence your treatment of patients.
>
> 10.2 If you have a conscientious objection to a course of action, you should explain this to the patient and make the names of other doctors available to them.

The Medical Council suggests head 12 be expanded to ensure the holding of a conscientious objection does not absolve the registered medical practitioner from his or her responsibility to a patient in emergency circumstances. The view of the council is that the right to conscientious objection must be balanced against the right of the patient, particularly in the case of a medical emergency. The Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners states: "10.3 Conscientious objection does not absolve you from responsibility to a patient in emergency circumstances". The text of subhead (1) should be amended to specifically include the term "conscientious objection". It is not clear whether subhead (1) applies exclusively to the carrying out of the procedure or whether it also applies to involvement by certifying registered medical practitioners in the assessment of risk, the certification process and the review process. Subhead (2), as drafted, is unclear.

With regard to heads 14,15 and 16, the Medical Council is of the opinion that the underlying principles in the development of regulations should ensure procedures developed are

independent, accessible, transparent, timely and preserve the confidentiality of the pregnant woman.

With regard to head 19, the Medical Council is of the opinion that subhead (1) should be modified to read as follows: "It shall be an offence for a person to do any act with the intent to destroy unborn human life other than in accordance with the provisions of Heads 2, 3, and 4 of this Bill".

We are grateful for the opportunity to engage with the committee on this important issue and commend both the Chairman and the committee for seeking a range of expert views as part of the process. If our future input can provide support at later stages, we will engage with the Department of Health to assist in its processes.

Chairman:

I also welcome Ms Caroline Spillane, chief executive officer of the Medical Council. I call Professor Harrison, Institute of Obstetricians and Gynaecologists. I welcome him and ask him to introduce his colleagues.

Professor Robert Harrison:

I am chairman of the Institute of Obstetricians and Gynaecologists. Professor Fionnuala McAuliffe will give our presentation and will be ably backed up by Dr. Cathy Allen and Dr. Meabh Ní Bhuinneain. They are both doctors in the area and as they are in practice, they will be able to answer and help with any of the questions raised.

Professor Fionnuala McAuliffe:

The Institute of Obstetricians and Gynaecologists at the Royal College of Physicians of Ireland is the body that officially represents and advises on obstetrical and gynaecological opinion, professional standards, patient care, education and research in Ireland. As such, the IOG has a compelling interest in the contents of the final Bill. We have a responsibility to ensure it will be the best way to protect women's' health and lives, and also allow for the necessary flexibility to cater for future advances in obstetrics.

Maternal health services in Ireland are among the best in the world and pregnant women and their families should be reassured that they are receiving the very best of care during pregnancy. Recent accurate figures have been collected in Ireland in the past three years which show that approximately one woman per 12,000 pregnancies dies in pregnancy. This low rate compares very well with that in the United Kingdom and the rest of Europe. However, we are never complacent and it is our absolute priority to ensure pregnant women receive the very best of care. To maintain these high standards and improve on them, we need to continue to adequately resource maternity services. The situation where termination of pregnancy or delivery of a very premature baby is required in order to avert a substantial threat to the life of the mother is rare, although these situations do occur. The heads of the Bill provide a process that can be accessed to deal with this rare clinical situation when there is a concern about maternal life. This process will require underpinning with robust multidisciplinary guidelines from the Department of Health and the HSE; input will be required from the Royal College of Physicians, the Royal College of Surgeons, the College of Psychiatrists of Ireland, the College of Anaesthetists of Ireland, the Irish College of General

Practitioners, An Bord Altranais, the Irish Nurses and Midwives Organisation to mention a few. Robust Medical Council guidelines will also be required.

At all times we remain acutely aware of the potential negative consequences for the unborn when cessation of pregnancy is necessary to protect maternal life. We highlight the fact that enormous additional challenges to clinical management arise when termination is being considered in gestations approaching foetal viability but still extreme prematurity. In current practice, all efforts are exhausted within medical margins of safety to prolong the pregnancy in the foetal interest. Additionally, once the baby reaches a stage when it can survive, it is current practice that every effort is made to support the life of the baby after birth, if medically appropriate. We do not see this Bill in any way providing for late terminations, nor the destruction of the baby and our members would not support this. These are complex difficult cases and a multidisciplinary team approach is required. However, obstetricians are the experienced clinicians in the care of pregnant women and should be central to the assessment of sick pregnant women and any decision-making process when there is a substantial risk to the mother's life.

In this submission we represent the majority view within obstetrics and gynaecology in Ireland following a planned, structured consultative process. In preparation of this opinion on the heads of the Bill we used the content of our positional paper from January 2013, the final text of which had been approved by the institute and circulated to all of our members. Following a request for an opinion on the protection of life during pregnancy Bill, an initial draft was considered and discussed in detail by the executive of the institute and the final text was approved at a meeting on 7 May. The final version has been circulated to all members. In addition, direct contact was made with representatives of all maternity units for comments directly on this document. The response overall was supportive of the institute's written submission.

A number of areas require amendment and the following are the main points. Our full opinion is contained in the written submission. We propose adding a definition of "termination" under head 1. When there is a real and substantive threat to the life of a pregnant woman, the gestation at which the pregnancy is interrupted is the critical factor influencing outcome for the unborn. We suggest restricting the use of the term "termination" to situations where there is no chance of survival after birth such as when a pregnancy is ended before a foetus is viable. The definition of "obstetrician-gynaecologist" for pragmatic reasons will need to be expanded to include those acting in the role of consultant obstetrician-gynaecologist who may be on the general medical register rather than in the specialist division. All Government approved general hospitals, including the 19 maternity hospitals, will need to be regarded as suitable venues to provide these procedures, as necessary. Pregnant women with a severe illness requiring specialised inpatient treatment are often cared for in a general hospital setting with access to coronary care and intensive care units. General hospitals, therefore, must be included. Failure to make these two changes could result in delays in accessing life saving treatment in pregnancy and it is the institute's opinion that they must be made.

Under head 2, in non-emergency situations, whatever the indication, two obstetricians-gynaecologists must be involved in the decision-making process; one obstetrician would be required to examine the patient and sign the documentation and the support of a second obstetrical opinion sought. In addition, where the condition warrants but only then, other consultants on their own specialist register form a team assessment.

With regard to head 3, we accept that, although consultation between two obstetricians-gynaecologists is desirable in the acute emergency case, this may not always be possible and a single opinion would suffice. It is the institute's view that emergency procedures should only be carried out in a hospital setting and I suggest changing the term "health facility" to "hospital setting".

Head 4 concerns the risk of loss of life from self-destruction. The Institute of Obstetricians and Gynaecologists does not differentiate in terms of logistical arrangements between physical or mental reasons for considering a termination. One obstetrician would be required to examine the patient and sign the documentation, and the support of a second obstetrical opinion would have to be sought. We accept there is a need for two psychiatrists, however, as it would be their expertise that the obstetricians would rely upon to determine whether suicidal ideation is true intent and poses a real and substantive risk to the life of the mother.

On heads 6 to 11, inclusive, we support the review process and would like to emphasise the importance of accurate documentation and regular auditing of cases.

Head 12 pertains to conscientious objection. We endorse the current Medical Council Guidelines of 2009, 10.1 to 10.3, inclusive, regarding the options and responsibilities for clinicians with a conscientious objection to participating in certain clinical treatments.

Head 14 concerns regulations. The Institute of Obstetricians and Gynaecologists supports the legislative option of legislation plus regulations, suggested by the expert group on the judgment on A, B and C *v*. Ireland. We believe this option best addresses the need to protect women as well as health care professionals involved. The regulation aspect of this would allow the necessary flexibility to incorporate future developments in the area of obstetrics.

We ask the Minister to ensure, when developing regulations with the Department of Health, that they are initiated without delay so that robust, safe guidelines of practice can be enacted promptly by the HSE and the Department of Health on this issue. This will necessitate appropriate funding and infrastructural provision. Any changes to regulations, in our view, should be put before the Oireachtas before enactment. Our full opinion on the heads of the Bill is contained in the written submission from the Institute of Obstetricians and Gynaecologists. We would appreciate it if careful attention were paid to it.

The location should include all Government-approved hospitals. The definition of "obstetrician and gynaecologist" should be expanded, and detailed multidisciplinary guidelines should be generated. We are grateful for the opportunity to present to the joint committee the views of the institute. We request that obstetricians have an input into the final Bill as we are the doctors most intimately connected with this issue and who will need to deliver the service.

Chairman:

Our next speaker, representing the Irish College of General Practitioners, is Dr. Margaret O'Riordan, medical director. She is very welcome. She has ten minutes.

Dr. Margaret O'Riordan:

Deputy Buttimer, members of the Joint Committee on Health and Children, ladies and gentlemen, I am thankful for the invitation to the Irish College of General Practitioners to present on the protection of life during pregnancy Bill. This is an extremely important Bill. The college welcomes the opportunity to be involved in the legislative discussions.

The general practitioner has a key role in supporting women during pregnancy. By way of introduction, I am a general practitioner and medical director of the Irish College of General Practitioners. I am accompanied by Dr. Seamus Cryan, president of the Irish College of General Practitioners, Dr. Darach O'Ciardha, chair of communications, and Mr. Kieran Ryan, chief executive officer.

Established in 1984, the Irish College of General Practitioners is responsible for postgraduate specialist medical education, training and research in the specialty of general practice. The college also provides an extensive range of practice management services focused on the effect of organisation of general practice. The college has a national advisory role in relation to clinical standards and it interacts regularly with the number of bodies, including the Medical Council, the Department of Health, the Department of Children and Youth Affairs, the Health Service Executive and the Health Information and Quality Authority, among others.

As a membership organisation, the Irish College of General Practitioners is responsible for providing continuing medical education for established general practitioners, who number more than 2,500 at present. The mission of the college is to serve the patient and its members, general practitioners, by encouraging and maintaining the highest standards of general medical practice. The core values of the college are quality, equity, access and service to the patient. The college has provided guidance for its members on the management of crisis pregnancy since 1995 and the latest guidance is available on open access on the college’s website.

At this point I would like to clarify that I am representing the specialty of general practice. Individual general practitioners have diverse views on this issue.

In the majority of cases, a termination of pregnancy is a decision taken as a last resort and in great distress. The college believes that the structures, resources and systems to support women during a crisis pregnancy should be enhanced. There is a need to improve access to social supports, counselling and psychology services. Perinatal psychiatry should be a priority for the Government in supporting women in crisis pregnancy.

The general practitioner is usually the first point of contact a pregnant woman has with the health service. The general practitioner has a key role in supporting women during pregnancy. All pregnant women are entitled to free antenatal care under the mother and infant scheme.

Current obstetric practice does not place a patient in the care of an obstetrician until 16 to 20 weeks gestation. General practitioner care is immediately available to every pregnant woman, and general practitioners routinely play a supportive role to women through the provision of antenatal and postnatal care. The general practitioner has knowledge of the woman's past medical and psychological health and of her social supports. In many instances, this knowledge extends over a number of years. General practitioners view every patient as an individual and care for them in their unique circumstances. Therefore, the general practitioner

has a vital role in the assessment of risk. This role is supported by the expert group's report, which suggested "it may be appropriate that general practitioners are consulted as a matter of best practice in the course of the diagnostic process. This would provide access to their knowledge of the patient and establish continuity of care for the woman after the treatment has been delivered".

Consultation with a general practitioner should take place only with the woman's consent, and the importance of confidentiality should be emphasised in all aspects of the Bill. The current heads of the Bill could be strengthened in this regard. The legislation should not be enacted until a specific, well-defined referral pathway is in place with appropriate professional support. General practitioners will usually be the first persons to whom a woman with a crisis pregnancy presents, and they will need to know exactly how to refer the woman in a timely manner. The general practitioner has an important ongoing role as patient advocate and in providing non-judgmental support to women who have been involved in this process, regardless of whether they have had a termination.

The Irish College of General Practitioners recommends that the Department of Health commission an independent guideline consortium to develop evidence-based national clinical guidelines to underpin implementation of the legislation. Following the guidance provided by the national clinical effectiveness committee, this process should involve health care professionals and patients in the guideline development process and employ internationally agreed standards of guideline development methodology. The Irish College of General Practitioners has experience in this area and is willing to take an active role in the development of these guidelines.

Chairman:

I thank Dr. Margaret O'Riordan. Our next speaker is Dr. Matthew Sadlier, president of the Irish Medical Organisation. He is joined by Ms Vanessa Hetherington, policy executive. They are very welcome. Dr. Sadlier has ten minutes.

Dr. Matthew Sadlier:

I thank the Chairman, Deputies and Senators. On behalf of the Irish Medical Organisation, which represents more than 5,000 doctors of all craft groups and specialties in the country, I thank the committee for inviting us to address it today. I know that everyone here agrees that the matters before this committee are of enormous importance and sensitivity for people throughout the country and deal with issues on which people have very strong, and often very opposing, views.

Within the Irish Medical Organisation, we have debated the issue of abortion on a number of occasions, and when we have done so, we have found that the diversity of opinion that is found in the wider community is reflected among our own members. Our official position on this dates back 20 years to 1993 and states that the Irish Medical Organisation endorses the principle of respect for all human life, both born and unborn, and that it rejects abortion. More recently, at our recent annual general meeting in April, the issue was debated in a number of motions, but our policy did not change.

However, the Irish Medical Organisation accepts that whatever our policy position might be, our members operate within a legal framework. Therefore, without turning our backs on the

formal policy position we have adopted, we have an obligation to engage in the debate about the legal framework that is being established. We understand that it is the role of the people through referenda and Deputies and Senators through the Oireachtas to frame the laws under which this country operates. Furthermore, we accept that the Government is now moving to introduce a legislative framework on this issue.

In that context we have a number of general concerns regarding the legislation: that the patient's health and welfare is of paramount importance; the legislation must provide adequate clarity and protection to health care professionals who must operate under it; the legislation must be practical and realistic for application in a hospital and health care environment; the legislation must be sufficiently resourced; where issues of morals are concerned, such as in abortion, the laws must provide adequate flexibility to ensure that an individual can abstain from engaging in an activity which he or she may deem, in conscience, to be immoral without jeopardising the right of the relevant patients to all the facilities and treatments for which the law provides.

I will give a brief summary of our issues in respect of each head of the Bill. In head 1, we believe the term "reasonable opinion" should be replaced by the term "opinion" and the term "unborn" replaced by the more medical term "foetus". In head 2, the opinion of two medical practitioners is required to certify jointly that there is a real and substantial risk to the life of the mother and where the risk can only be averted by the termination of the pregnancy. Where a pregnant woman presents with a physical condition that poses a real and substantial risk to her life, clear clinical guidelines are required in order to identify, monitor and treat such patients. While such cases are rare, public obstetric units must be appropriately resourced to ensure that patients are adequately cared for according to clinical guidelines and that no delay to life saving procedures arises due to under-resourcing. A system should be in place to allow medical practitioners to declare a conscientious objection and protocols must be in place to deal with situations of conscientious objection as they arise.

Medical practitioners who have no conscientious objection must receive appropriate training either during postgraduate training or as part of compulsory CPD programmes organised and resourced by the State. The health and welfare of the patient is paramount and therefore women must be provided with appropriate follow-on care, both physical and psychological, following any termination.

Head 3 deals with the risk of loss of life from physical illness in a medical emergency. Again, such cases are likely to be rare and clear clinical guidelines must be in place. Patients must be attended by a practitioner that has no conscientious objection and is appropriately trained to perform such procedures. Patient consent must be obtained where possible - we will deal with the issue of consent later in our submission. Women must be provided with appropriate follow-on care, both physical and psychological.

Head 4 refers to the risk of loss of life from self-destruction. Under that head the opinion of three medical practitioners - one obstetrician-gynaecologist and two psychiatrists - is required to certify jointly that there is a real and substantial risk to the life of the mother and where the risk can only be averted by the termination of the pregnancy. Imposing a requirement for three doctors may cause unnecessary delay and is in excess of the maximum of two doctors recommended by the expert group. It also adds an extra burden of resources an already stretched services.

Obstetricians should not be required to certify risk of loss of the pregnant woman's life by way of self destruction. This should be done by two psychiatrists in consultation with the woman's general practitioner. The Bill requires the psychiatrists to be employed in an institution registered with the Mental Health Commission. We believe this is an unnecessary specification. Specialists are required to be registered with the Medical Council and this should be the only stipulation. Such cases again are likely to be rare and, again, clear clinical guidelines must be put in place. Patients must be attended by specialists who have declared no conscientious objection. As it stands, mental health services throughout the country are significantly under-resourced. Adequate resources must be provided to ensure that patients at imminent risk of suicide receive appropriate psychiatric care. Additional resources must be provided to ensure that there is no drop off in existing services as clinicians are tending reviews specified under this Bill.

Regarding head 5, medical opinion to be in the form and manner prescribed by the Minister, we believe the medical opinion should be given in the form and manner prescribed through clinical guidelines established by the relevant professional colleges, not by the Minister.

The issue of mental capacity is relevant to the Bill in a number of areas. Given the importance of this legislation and that decisions may be contentious, it is important that the legislation removes the potential for ambiguity and gives a clear definition of the criteria for determining capacity to make a medical decision. It is quite possible that in many of the cases that will occur the woman will lack capacity temporarily either due to a mental health problem or physical illness. The legislation should also clearly state what should be done in cases where a woman is found not to have the capacity to make a medical decision. Also, the legislation should define at what age a woman has the legal capacity to ask for a termination as there is ambiguity regarding the Non-Fatal Offences Against the Person Act 1997, which defines the age to give consent for medical treatment at 16 years, and the Mental Health Act 2001, which defines the age of medical consent in mental health issues at 18 years.

Head 6 deals with formal medical review panels. Under this head the HSE is to establish and maintain a panel of medical practitioners for the purpose of review. Practitioners who declare a conscientious objection must be excluded from such panels.

Regarding head 7 and head 8, the establishment and convening of a review committee and the review procedures combined may take up to 14 days. This is an unacceptable delay. During this time there is a risk that the patient's health could deteriorate significantly. Resources must be put in place to ensure that patients are adequately cared for and receive appropriate support during the period of the review. The opinion of the review committee should be made in accordance with appropriate clinical guidelines.

Head 11 and head 12 detail that the reviews and medical procedures permitted and carried out under this Bill are to be notified to the Minister. This seems unnecessarily prescriptive. The HIPE, hospital in-patient enquiry, data currently records the numbers and types of procedures carried out in acute hospitals and the Medical Council is the body authorised to investigate complaints relating to the performance of individual medical practitioners. Patient confidentiality must be guaranteed and patient anonymity is welcomed in the heads of the Bill. There must be no possibility of identification of the women in respect of whom the termination was carried out. To protect both the patients and the medical practitioners involved and to avoid sensationalist media reporting of such procedures, the names of medical practitioners involved should not be publicised.

Finally, head 12 deals with conscientious objection. Recent debate at the IMO's annual general meeting shows that there are a number of physicians who object strongly to the termination of pregnancy on moral and ethical grounds and the IMO welcomes the provision for conscientious objection under head 12. However, patients who present with life threatening illness must be reassured that they will receive adequate care and the necessary termination to protect maternal life. Clear protocols must be in place to ensure appropriate and timely referral of patients to other colleagues in the case of conscientious objection.

Chairman:

Thank you, Dr. Sadlier. The final witness to give a presentation is from the Royal College of Physicians of Ireland. I welcome Professor John Crowe, who has ten minutes to make his presentation.

Professor John Crowe:

I represent the Royal College of Physicians of Ireland, the body responsible for postgraduate training in all medical specialties - paediatrics, pathology, public health, occupational health and obstetrics and gynaecology. We thank the Joint Committee on Health and Children for the invitation to make a submission on the recently published heads of the Protection of Life During Pregnancy Bill 2013.

To discuss the Bill and to prepare a submission, a meeting was convened of Fellows from the relevant specialties within the Royal College of Physicians of Ireland as well as the chairman of the RCPI Institute of Obstetricians and Gynaecologists, Professor Robert Harrison, and Professor Fionnuala McAuliffe. Professor Harrison presented to the meeting the institute's submission to the Joint Committee on Health and Children. The institute's submission represents a majority view from institute members on the draft heads of the Bill. Our meeting considered the heads of the Bill, the institute's submission and the involvement of consultant physicians in the very rare clinical instances where a decision is required to terminate the pregnancy of a woman whose illness during pregnancy poses a real and substantial risk to her life. The recommendations of that meeting were conveyed to the 32 members of the council of the Royal College of Physicians of Ireland. The council fully supports the submission of the constituent institute, the Institute of Obstetricians and Gynaecologists, with the following additions.

Head 2 relates to risk of loss of life from physical illness, not being a risk of self destruction.

We believe that in addition to the support of a second obstetrical opinion, and where the patient's condition warrants the opinion of another medical practitioner from a different specialist register, two specialist opinions from that register should be involved.

We accept that while only one specialist is required to examine the patient, the opinion of an additional independent specialist should be sought. In an elective situation, and where practical and in conformity with best practice, a multidisciplinary team would consider a decision to terminate pregnancy. It should be noted that in modern clinical practice generally it is considered appropriate in complex or difficult cases, regardless of whether the patient is pregnant, for a specialist to seek a second opinion and, where practical, to have the issue discussed within a multidisciplinary team. That is modern medicine. Clearly, in emergency

situations this may not be practical and we agree with the content relating to emergency situations under head 3.

In conclusion, it is important to recognise that legislation should not seek to define treatment pathways that are more appropriately and safely dealt with through professional judgment in a given clinical situation. Doctors seek to treat patients in line with best clinical practice which is continually evolving. The guidelines for the operation of the legislation will be complex and will require the input of the relevant professional bodies. The Royal College of Physicians is prepared to participate with the Department of Health and the HSE in the development of guidelines on the operation of the legislation. I thank the Chairman.

Chairman:

We will now move to members' time, which will comprise 70 minutes, and non-members' time, which will comprise 30 minutes. The time will be adhered to strictly and I will end the discussion at the end of each session, irrespective of who has or has not spoken and replied. There will be no ambiguity; that has been agreed by the committee.

Deputy Billy Kelleher:

I thank the Chairman and welcome the witnesses. We have a very short period of time so I will try to be brief. I have questions rather than opinions, and would welcome hearing opinions on my questions.

In terms of GPs having conscientious objections, should there be an obligation on a GP, when a patient arrives at a surgery and has reason to believe there is a substantial risk to her life because of pregnancy, to inform her of his or her conscientious objection to a termination of pregnancy in the context of a threat to life by suicide or physical health grounds? According to the Bill, when a woman presents to the panel or review group comprising an obstetrician and two psychiatrists, there is a provision whereby a GP can be informed if she so wishes but, equally, the GP is not informed if she declines. Who will provide aftercare treatment for a woman who goes before a panel which deems that her life is at real and substantial risk for physical or mental reasons? If the woman does not want her GP to be made aware of that, where in the Bill should there be some obligation for aftercare to be provided without her GP being informed of the termination? Clearly, a certain amount of aftercare would be required in that context.

I refer to the comments of Professor McAuliffe. We need clarity. An issue which has been spoken about around the country is foetuses on the cusp of viability. Does an obstetrician, in making a decision about an intervention for physical or mental reasons to save the life of the mother, take into account the viability of the foetus? If he or she can delay intervention for a number of days or weeks without further threat to the life of the mother, is that taken into account? I refer to the two patient approach which has often been spoken about. Is foetal viability of secondary consideration? Many people are agitated and confused about current medical practice. Article 40.3.3° is quite clear and specific in that there is an obligation to make every effort to vindicate the life of the child. I ask the witnesses to elaborate on current medical practice in maternity units throughout the country.

I note the comments of Professor Murphy. The IMO guidelines in 2009 included the risk of suicide as grounds for termination in the State. Is that based on clinical evidence or is it

because of the legal obligations under the current Constitution, as interpreted by the X case? Do our maternity hospitals currently have the physical and personnel capacity to implement the Bill if it is passed with the current heads?

Deputy Caoimhghín Ó Caoláin:

I thank each of the witnesses. Unfortunately, the time allowed will not allow us to question each of them and elaborate but their contributions are very valuable.

I ask Professor McAuliffe to answer a question on the risk of loss of life due to physical illness. She talked about two medical practitioners, one of whom shall be an obstetrician or gynaecologist who must be employed at a specific location. How will this work in practice? I ask her to assure me that this could not mean that a woman might be examined in two locations, one being that where the procedure could be carried out. Surely it is about bringing the necessary professional expertise to the woman. The IMO presentation made a number of points in regard to patient confidentiality. Would the Institute of Obstetricians and Gynaecologists agree it is something which should be addressed?

Head 3, the risk of loss of life from physical illness in a medical emergency, allows one medical practitioner to carry out a termination in an emergency at any location. I note from its presentation that the institute views that such emergency procedures should only be carried out in a hospital setting. I ask the witnesses to elaborate on that. Would they take the view that, while the Bill provides for any registered medical practitioner to carry out such a procedure, such a person should be somebody who is registered on a specialist division? I would like further clarification, if possible, on that.

I may be open to correction, but from my preparation for this committee I note that, in regard to the requirement for notification to the Minister, notification of all emergency terminations will be sent to the Minister. As the Bill is currently drafted, that does not require the involvement of an obstetrician or gynaecologist. Should the same apply in regard to non-emergency situations such as physical or general illnesses and the risk to life as a result of mental illness and the associated possible risk of self harm or self termination?

Would the institute envisage there would be oversight and a review of notified terminations carried out? Would an effort be made to at least confirm the efficacy of the decisions taken and to win the widest possible public confidence for them? For some considerable time that will be an issue and focus. It would be desirable and helpful if that were to be the case.

I refer to Professor Murphy and the Irish Medical Council. Deputy Kelleher made reference to the guide to professional conduct and ethics. My sense of the guide in the 2009 publication - the witnesses can tell me if I am wrong - is that its wording does not change by the passage of this Bill. Detail regarding the outworking will require revisitation, but the specific guide on how and when it is permissible for an intervention that results in termination would not change.

Deputy Seamus Healy:

Several contributors referred to the provisions regarding appropriate locations, which refer to public obstetric units where there is a mental health facility. The witnesses have indicated a preference that this be broadened to include public hospitals in general. Will they elaborate

on this? Will they comment on the availability of medical personnel to operate the system as outlined under the heads, particularly in smaller hospitals in locations throughout the country? Will Professor Murphy elaborate on the issue of conscientious objection?

Chairman:

I invite the witnesses to respond to that group of questions.

Professor Fionnuala McAuliffe:

Deputy Billy Kelleher asked about after care. We must bear in mind that we are talking about rare clinical cases where a mother's life is in danger or there is a risk of loss of life. It would be a small number of cases and we would offer follow-up in the hospital setting. These are patients with complex medical disorders or perhaps life-threatening obstetrical emergency conditions. As such, they would always be offered after care in the hospital setting. It would be rather unusual for such patients not to inform their GPs of what had transpired, given that, as I said, they are patients with complex medical disorders of which their GPs would usually be aware. They would require long-term follow-up care for that medical disorder, whether it be mental or physical. It would be unusual for the GP not to be aware of the patient's situation. We would always follow up with the patient in the hospital in the first instance.

On the important issue of viability, Article 40.3.3° remains in the Constitution. We are committed to the health and life of mother and baby. It sometimes happens that we have a very sick mother around the time of viability, in which case every effort is made to prolong the pregnancy to allow the baby to get to a stage where there is some chance of survival. If we feel prolonging the pregnancy could jeopardise the mother, where, for example, she might develop overwhelming infection, uncontrollable blood pressure, seizures or life-threatening bleeding, we would have no option but to terminate the pregnancy or, depending on the gestation, deliver the baby pre-term. We work very hard with the family and each other to promote foetal viability in order that the baby will get to a stage where it can survive. After the baby is born, intensive care would be offered. if medically appropriate. That is current standard medical practice.

Deputy Billy Kelleher also asked whether we had capacity for this Bill. To reiterate, we are talking about rare medical disorders and small numbers of cases. We already look after such cases. The Bill merely provides a legal framework for our current clinical practice. I do not anticipate large numbers of patients suddenly becoming suitable for these procedures where previously we have seen only very small numbers. However, it is important to note that we have approximately half the number of obstetricians per head of population in Ireland as there are in the United Kingdom; therefore, we are dreadfully under-resourced and would welcome improved resourcing.

Deputy Caoimhghín Ó Caoláin asked how many obstetricians would be required to examine the patient. Again, we are talking about complex medical disorders where multidisciplinary teams are required. In current medical practice it is often the case that more than one obstetrician would assess such a patient in order to achieve a consensus view. However, if a colleague felt there was no option but to terminate the pregnancy, we are not saying two obstetricians would be required to examine the patient but that a second obstetrical opinion be sought just to underpin the approach. In complex cases such as these there is always consultation with more than one person and often with a very large team. We would want the

obstetrician who examines the patient to seek support, which could be in the form of a telephone conversation, for instance, or a case review. We are totally supportive of patient confidentiality at all times and there would no difference in such cases.

In regard to head 3, the Bill refers to a health facility and talks about locations other than those recognised. We are concerned that emergency treatment should only be offered in a hospital setting, not in a clinic or an outpatient setting such as a GP's surgery. These are emergency life-saving procedures and it is our view that they should only be carried out in a hospital setting.

The specialist division of obstetrics and gynaecology came into being in 2005 or thereabouts. Consultants appointed prior to that time will be on the general medical register but may not be in the specialist division. This means that a number of very experienced consultants who are very capable of making patient assessments are not in the specialist division. For this reason, we have asked that the provision be expanded to include an obstetrician or gynaecologist acting in the consultant role who is in the general division only. Otherwise, the concern is that patients who present requiring emergency treatment might not be able to receive it if the consultant who sees them is not on the specialist register. This is an historic issue that will be resolved over time. In the meantime, however, we have several experienced obstetricians who are not on the specialist register.

In terms of notification of cases, we are totally supportive of the requirement for audit and documentation. In fact, within our own hospitals these cases are already recorded and discussed. I suggest this matter is best dealt with in guidelines, with these unusual cases being reviewed, say, on an annual basis. Members may be aware that the National Perinatal Epidemiology Centre is collecting data on cases of severe maternal morbidity. This means that many of the cases are already captured in a national context.

Deputy Seamus Healy referred to the provisions regarding appropriate locations. In our previous submission we explained in detail that we were talking about patients who were medically very unwell and needed access to specialist physicians, coronary care units and intensive care units. Many of our maternity units are not co-located. The units in the three Dublin maternity hospitals and one in Limerick, for example, are stand-alone units. The patients to whom we are referring are usually cared for in hospitals with a general intensive care unit and coronary care unit. It is imperative, therefore, that general hospitals are able to carry out these procedures. That is where these patients will be treated because they are too ill to be looked after in a stand-alone maternity unit.

The Deputy also asked about the availability of personnel throughout the country. There are 19 maternity units in this country providing high quality maternity care. They are also providing emergency care, which would include termination of pregnancy. That is current practice. What the legislation does is put a framework around it.

I will defer to my colleague, Dr. Méabh Ní Bhuinneáin, to provide detail on the smaller units.

Dr. Méabh Ní Bhuinneáin:

The smaller units in this country are not small by international standards. In fact, there are no single-handed or dual-handed practices in operation at this time. All of the facilities are delivering more than 1,000 babies per annum and, in total, 20,000 mothers receive their care,

including emergency care, in these units every year. Consultant-provided care is delivered in all 19 units on a 24-7 basis. There is a three-tier on-call system, involving a registrar, a senior house officer and a consultant. There are systems to support obstetric emergency provision in the cases to which Professor McAuliffe has alluded, where there is haemorrhage, bleeding, infection or uncontrollable high blood pressure and, in the case of complications of miscarriage, where a foetal heartbeat may still be present. There is the to provide that at this point in time.

The smaller units will be affected more by the logistics of implementing the services, but the networks and governance established through Medical Council best practice and ethical practice and through college governance will ensure a woman has access, regardless of which maternity unit she attends. For maternal survival, access to a unit that can save her life is essential. The timeliness of moving to a city unit and bypassing a rural unit could certainly confound maternal survival possibility.

Dr. Margaret O'Riordan:

In response to Deputy Billy Kelleher's questions, the Medical Council guidelines are very clear in regard to conscientious objection. A general practitioner would have to inform a patient if he or she had a conscientious objection.

In regard to the follow-up of patients, the Deputy has hit on a very important point.

Sometimes in these circumstances we forget the long-term consequences. In the immediate aftermath of an event there is much focus on and a need for follow-up in a hospital scenario, and in the long term there is a need for a general practitioner. It would commonly be found by GPs, for example, that a woman who has suffered a miscarriage feels an impact on the date she was expecting to have the baby. It is then that she needs support, as much as she needs such support immediately after the event. We must first and foremost respect a patient's autonomy, and patients have the right to choose a general practitioner. That goes without saying. In the second instance we must focus on support for women in the long term after these events.

Professor Kieran Murphy:

I will take Deputy Healy's question first, as he asked for an elaboration on the Medical Council's position with regard to conscientious objection. Perhaps it might be helpful for Deputies and Senators if I outline the current guidance. Before doing so it may be worthwhile for me to articulate how the Medical Council came to produce such guidance. Approximately every five years, the council completely revises its ethical guidance, doing so in a way that engages a range of stakeholders. We engage with members of the profession, employers and patient groups. We want to ensure that the guidance we produce to assist doctors will be useful and informed by our engagement with stakeholders. It is also important to say that the guidance produced by the Medical Council is a principle-based document, meaning it cannot deal with every day-to-day eventuality; it deals with principles rather than operational day-to-day matters.

The guidance, as mentioned earlier, follows on from legislation. As legislators, Deputies and Senators are tasked with ensuring that appropriate legislation is in place. Once the legislation is in place, it is the task of the Medical Council to draft guidance based on the legislation. As

we heard from the Chief Medical Officer this morning, once the new legislation has been passed, he intends to work with a range of stakeholders, including the professional bodies and the Medical Council, to ensure that the subsequent regulations will implement what is passed by legislators.

Deputy Healy asked a specific question on conscientious objection, so I will outline the current Medical Council guidance on the issue. There are a number of points taken from the guide to professional conduct and ethics for registered medical practitioners, and members may recall that during our submission in January, we circulated copies of the guide. We have not done so this time because we assume they have seen it already. If Members wish to see copies of the guide afterwards, we would be very happy to circulate them. With regard to conscientious objection, the guidance is as follows:

> 10.1 As a doctor, you must not allow your personal moral standards to influence your treatment of patients.
> 10.2 If you have a conscientious objection to a course of action, you should explain this to the patient and make the names of other doctors available to them.

That addresses the point made by Deputy Kelleher, which was also addressed by Dr. O'Riordan in her response. The council wishes to see this particular head extended in regard to the Medical Council's third point in the guidance, "10.3 Conscientious objection does not absolve you from responsibility to a patient in emergency circumstances." As we noted in our submission, the Medical Council suggests that head 12 should be expanded to ensure that the holding of a conscientious objection does not absolve the registered medical practitioner of responsibility to a patient in emergency circumstances. The view of the council is that the right to conscientious objection must be balanced against the right of the patient, particularly in the case of a medical emergency.

I will take the questions from Deputies Kelleher and Ó Caoláin together as they relate to the Medical Council guidance on abortion. It might be helpful for Deputies and Senators for me to outline the current guidance provided by the Medical Council to doctors on abortion. The guide states:

> 21.1 Abortion is illegal in Ireland except where there is a real and substantial risk to the life (as distinct from the health) of the mother. Under current legal precedent, this exception includes where there is a clear and substantial risk to the life of the mother arising from a threat of suicide. You should undertake a full assessment of any such risk in light of the clinical research on this issue.

To address Deputy Kelleher's point, the council formulates its guidance based on the current legal position. The council drafted its guidance in the light of the Supreme Court judgment. The guide continues:

> 21.2 It is lawful to provide information in Ireland about abortions abroad, subject to strict conditions. It is not lawful to encourage or advocate an abortion in individual cases.
> 21.3 You have a duty to provide care, support and follow-up services for women who have an abortion abroad.
> 21.4 In current obstetrical practice, rare complications can arise where therapeutic intervention (including termination of a pregnancy) is required at a stage when, due to extreme immaturity of the baby, there may be little or no hope of the baby surviving. In these exceptional circumstances, it may be necessary to intervene to terminate the pregnancy to protect the life of the mother, while making every effort to preserve the life of the baby.

It is worthwhile restating that this guidance was drafted and published by the council after extensive consultation with a range of stakeholders, particularly the Institute of Obstetricians and Gynaecologists. As I stated earlier, we ensured that this guidance would target to the doctors faced with these decisions and be useful in ensuring that doctors had the appropriate guidance.

Deputy Ó Caoláin asked if Medical Council guidance would change. We are engaged in a process today that will lead to the subsequent development of legislation, and nobody can predict at this stage how the legislation will look. Once the legislation is passed, the Medical Council will examine it and reconsider its advice based on the eventual legislation.

Ms Spillane wishes to make a point on specialist division of the register.

Ms Caroline Spillane:

Deputies Kelleher and Healy raised questions about the number of doctors. It might be helpful for the committee to understand that there are currently 18,000 doctors registered with the Medical Council across five divisions. Approximately 7,000 doctors are registered in the specialist division of the medical register, which indicates that doctors have been educated and trained to the highest possible standards in that particular specialty. The register is quite a dynamic listing and there are currently 481 doctors in the specialist division with the specialty of psychiatry, with 236 doctors registered in the specialty of obstetrics and gynaecology.

Dr. Matthew Sadlier:

I will make two points, although they are not in answer to a specific question, because most of those have been answered. I echo my colleague's comments on resources, as Ireland is significantly under-resourced per head of population with regard to the number of specialists compared to most European and other developed nations. Systems are already under stress and the expectation is that this legislation will not add a significant extra workload. Systems are already under severe strain.

With regard to the sites mentioned in head 1 of the Bill, particularly the interpretation of "appropriate location", the Irish hospital network contains interlocking and stand-alone units, with specialties in certain hospitals. Very few hospitals or health care facilities in the country have a broad range of medical specialties, so they rely on specialists coming from other locations, particularly when they are outside the larger urban centres. The definition as contained in the Bill is probably a little too prescriptive and takes in only a small number of facilities that could provide all those services.

Chairman:

Eleven speakers have indicated a wish to contribute and we may not get to all of them. I apologise, but this session is to end at 1.42 p.m.

Deputy Ciara Conway:

I thank our guests for their very interesting presentations on the heads of the Bill.

My first question is for Dr. O'Riordan on GP practice. It is great that she is present today because she is correct that for most women who are pregnant their first point of contact, be it a crisis pregnancy or a planned one, is with their local GP. It is important, therefore, that she is present. To ensure that as a country we are compliant with international human rights law and that women can exercise their right under the Constitution, the legislation must guarantee a clear referral pathway and timeframes for terminations that can take place, in particular under head 2. Is that something Dr. O'Riordan would agree that we need to include under head 2? Should the legislation state that the Minister shall make regulations regarding timely and appropriate referral pathways from primary to tertiary care, but also including self-referral? GPs will probably know more than others the time delays that can be experienced by people trying to get access to specialist services. That should be integral to the legislation. The evidence also shows that if there is a time delay in a woman getting access to treatment it could have lifelong detrimental consequences for her.

My second question is for Dr. Sadlier. In the submission under head 10 he refers to it being overly prescriptive in terms of the review of practice. Are we not in the aftermath of a situation where because no reviews were carried out on obstetric practices in a particular hospital in this country that women have to suffer lifelong consequences? We cannot discount that. Is it Dr. Sadlier's view that the Irish Medical Organisation came to the conclusion because there is a chilling effect and because of the criminalisation sanctions it places on doctors? Is that the concern of the organisation when it refers to the potential review process being overly prescriptive?

Senator Jillian van Turnhout:

The witnesses are all very welcome. I will not duplicate questions already asked. I was very interested to hear the Irish Medical Council propose that heads 2 and 4 should be merged. That was the conclusion to which I came following the January hearings. I went in with a different opinion but having listened to the submissions I questioned why we were differentiating. I am interested in hearing the views of the members of other bodies on how they feel about the differentiations that are being made.

Deputy Conway has made several points about time limits. I am not a medical practitioner and I do not know the answer, which is why I ask the question. The Medical Council made a distinction between registered medical practitioners and medical practitioners. What are the consequences of including the word "registered"? Who are we excluding?

Conscientious objection is something everyone can understand and appreciate but should we consider a requirement that as a general rule a practitioner would declare his or her conscientious objection rather than waiting until a situation got to a certain point? How do we ensure that hospitals would have an adequate number of medical professionals who have not declared a conscientious objection?

Deputy Catherine Byrne:

I thank the panel for their expertise, observations and suggested amendments. In practical terms one must consider the situation of where a woman goes if she finds herself pregnant. Where does one go, who does one contact and how does one make the initial contact? I put the question to the GPs. Senator van Turnhout asked one of the questions I wished to ask. Do

general practitioners believe that as the first port of call the information must come from them or their surgeries?

Professor Fionnuala McAuliffe:

I will respond on whether we should merge heads 2 and 4. The view of the institute is that no differentiation should be made between whether the risk of loss of life is mental or physical. It is our preference that the situations would be taken together. One must remember that these are rare, clinical conditions where two senior doctors consider there is significant risk of life to the mother which can only be averted by termination of pregnancy.

In terms of doctors who are conscientious objectors, in a large number of these cases we are talking about emergency situations and the practice and care currently being delivered around the country. We do not have any difficulty with the provision of emergency care around the country. We would defer to the Medical Council in terms of conscientious objection for non-emergency cases.

Dr. Margaret O'Riordan:

In response to Deputy Conway's question, we must remember that this is a very small group of women where there is a real and substantive risk to the life of the mother. Therefore, the need for the referral path may not occur very often in the average GP practice. That is all the more reason it should be clearly defined and timely when we need to avail of the referral pathway.

To answer Deputy Byrne's question, the situation is no different from any other situation and it is normal practice for patients to approach the health service through their general practitioners. In the vast majority of instances it is through the general practitioners in the first place.

Professor Kieran Murphy:

With regard, first, to Senator van Turnhout's question, I am very pleased that she agrees with the Medical Council position that heads 2 and 4 should be merged. As Professor McAuliffe has outlined, that is also the position of the Institute of Obstetricians and Gynaecologists.

On Senator van Turnhout's question on the difference between a registered practitioner and a non-registered practitioner, the Medical Practitioners Act, which regulates the profession, specifies that all doctors have to be registered. If one practises in this country and one is not registered, it is a criminal offence. It is very important for the legislation that it makes reference to the fact that all doctors working in this country must be registered.

To reply to Senator van Turnhout's question on conscientious objection, the Medical Council guidance on conscientious objection, item 10.2, specifically says that one must explain to the patient if one has a conscientious objection and make the names of other doctors available to them. This is an important provision because it protects the woman and ensures that she is able to access the most appropriate treatment for her. Care should not be dependent on any moral value the practitioner might hold.

Dr. Matthew Sadlier:

To answer Deputy Conway's question specifically, what we feel is unnecessarily prescriptive is the administrative element of head 10. Medical procedures carried out in hospitals are already reported to the Health Service Executive and to the Department, and it is proposed that we would put them into a separate report. Head 4 relates to mental health issues, which are already a stigmatised issue to be reported. We will not stand over practitioners not practising to the highest standards. The Medical Council is the body to investigate any difficulties or complaints against practitioners. It is too prescriptive to separate it out from the procedures of clinical audit and HIPE data already being sent into hospitals and from the procedures of the Medical Council or other professional bodies around practice and is creating another level of administration and unnecessary bureaucracy.

On Senator van Turnhout's question on conscientious objectors, as the representative body for doctors we would be insistent that our concerns regarding the use of information on whether a doctor is a conscientious objector would not become a stigmatising or discriminatory element in the interview and recruitment process to posts within hospitals.

Deputy Peter Fitzpatrick:

I thank the witnesses very much for making themselves available. My first question is whether doctors and nurses who wish to have no part in abortions under head 4, either directly or indirectly, will be protected in their profession and livelihood?

In the case of a patient who is suicidal but not mentally ill, is it ethical for a doctor to decide to end the life of one patient – the unborn – in order to change the condition of pregnancy for a second patient where no illness exists? The explanatory note under head 4 recognises the absence of clinical markers in accurately assessing suicidal intent.

Is it ethical, therefore, for doctors to partake in such a process under head 4 that ends the life of one patient, the unborn, and implements a life-changing decision for the other in ending her pregnancy?

Are the witnesses satisfied that the proposed legislation will provide for mandatory care for newly born children resulting from later stage terminations in order to vindicate their equal right to life in the court decision?

Senator Colm Burke:

I thank the witnesses for their detailed and constructive submissions. Professor Murphy of the Irish Medical Council spoke about a proposed amendment to head 4, an issue I mentioned this morning. He suggests two psychiatrists should sign off and then consult the obstetrician, whereas the head proposes that the three sign off. He obviously has very strong views on the matter and I know some obstetricians have questions about signing off on a psychiatric issue. I ask the professor to clarify this.

The Irish Medical Council's submission refers to the need for access to legal support. I ask Professor Murphy to expand on this, in particular the legal support provided for an expectant mother under 18 years.

I understand there are 236 names on the obstetrics-gynaecology specialist register. How many practising consultants are there in the 19 hospitals? Some 12 maternity units have only

three obstetricians-gynaecologists practising in them. Particularly at weekends, do these units need more structured support from the bigger units than they already receive?

Senator Ivana Bacik:

I thank the witnesses for their very informative presentations. I have some specific questions aimed at ensuring women have access to effective procedures, whereby their constitutional right to life could be vindicated in the very rare cases we are discussing, as we have all said. There is a proposal to merge heads 2 and 4 which makes sense. Is the Institute of Obstetricians and Gynaecologists suggesting two obstetricians should certify risk, as well as an additional doctor in the case of a physical risk, or an additional two psychiatrists in the case of risk of suicide? That seems unduly cumbersome and would render the process less accessible and effective for women. I believe Professor McAuliffe said the second opinion would be more informal rather than formal extra certification or examination.

The Irish Medical Council and the Irish Medical Organisation suggest the requirement that psychiatrists be attached to specific institutions is too restrictive. Particularly in the specialist maternity hospitals in Dublin which will not have large psychiatric departments attached, is it practical to ask that psychiatrists be attached to specific places or should it be a more general point that they should be consultant psychiatrists? What exactly do they mean?

Heads 6, 7 and 8 provide for a review procedure. The IMO and the ICGP have raised some very practical and important points about access for a woman to a review and the obstacles that might apply. Do they believe the time limit is unduly onerous? The IMO's submission points out that a 14 day delay - seven days and seven days - may be provided for and suggests a six day delay - three days and three days - might be better.

I do not believe any of the witnesses addressed head 1 on the definition of the unborn. Do they believe that definition should include a non-viable foetus - a foetus with no prospect of life - where, for example, the foetal heartbeat has stopped? In these circumstances should an obstetrician be legally permitted to deliver the foetus where there is no longer the prospect of life beyond the womb?

Professor Fionnuala McAuliffe:

In response to Deputy Peter Fitzpatrick, it is fair to say the lack of evidence on the role of termination in the treatment of suicidal pregnant women is an ethical concern for our members. However, we need to remember that we are talking about pregnant women, in respect of whom after consultation two senior obstetricians, plus or minus physicians or psychiatrists, feel there is a significant risk to her life which can only be averted by termination of pregnancy or early delivery of the baby. We are talking about a small number of cases of very sick women who need access to life-saving treatment. The general view of the institute - the majority view - is that we will not differentiate between causes of risk to life, whether they be mental or physical.

The Deputy asked if it was ethical to perform a termination for a suicidal woman. Again, we are down to the expert assessment of two psychiatrists, plus an obstetrician. The Deputy needs to remember what we are talking about. We are talking about risk of threat to the life of the mother which can only be averted by termination of pregnancy. Therefore, we are talking

about very serious conditions and we are talking about small numbers of cases. These are issues that we will resolve using a multidisciplinary approach.

There was a question about late terminations which I addressed in my opening submission. There is no question of late terminations in the Bill, as far as the institute is concerned. If the baby is delivered before viability, it will die unfortunately - that is a very sad consequence. If the baby is born after viability, every effort will be made to support its life. I hope that is clear.

Senator Colm Burke asked about the role of the obstetrician in suicidal cases. As obstetricians, we need to be centrally involved in any decision in terms of termination of pregnancy or early delivery of the baby because we are the experts in pregnancy and can assess it. There could be other comorbidities in the patient who is suicidal. There could be comorbidities that need to be assessed. She needs to be assessed for her health to assess whether she is even suitable for any procedure or process. Therefore, we in the institute strongly believe one obstetrician should examine the patient and sign the documentation, but he or she should seek a supportive second opinion - at least one. It is normal practice that there be multiple opinions, but we are stipulating that one obstetrician in all of these cases, regardless of the cause of risk to life, examine the patient and sign the documentation but seek the support of a second opinion.

In terms of the smaller units, we envisage that networks would be available. As the Senator knows, earlier this week proposed networks were published. It would be good clinical practice for smaller units. There are informal networks where people will refer to certain hospitals. I often receive telephone calls from my colleagues outside Dublin. I am happy to receive a telephone call at any time of the day or night and any day, including weekends. Therefore, we are there to support each other. I would certainly favour having a more structured referral pathway for all complex pregnancy disorders.

Senator Ivana Bacik mentioned location. The Institute of Obstetricians and Gynaecologists believes this should be available in all Government-approved hospitals which would include the 19 maternity units because these women are sick and need to have access to the appropriate medical care, whether it be psychiatric care or a coronary care unit or an intensive care unit. We believe very strongly that it needs to be opened up outside these maternity units. It needs to include Government-approved general hospitals.

In terms of the unborn, if a foetal heartbeat is absent, that is a miscarriage. There is no ethical dilemma that I am aware of around this. If a foetal heartbeat is absent, unfortunately, the baby has died and either the patient will miscarry naturally or we can give her medication or perform a procedure to speed up the process.

Dr. Margaret O'Riordan:

I endorse all the answers Professor McAuliffe has given to the questions asked. On the question addressed to the ICGP of access to the review panel and the 14 day period, yes, that would be of concern. Bearing in mind that this is a real and substantial risk to the life of the mother, if it is a real and substantial risk to the life of the mother, it implies that it is an emergency. Particularly in the case of suicide and the analysis of suicide one would have to wonder about having to wait for 14 days. Obviously in that scenario, we would have to take the psychiatrist's opinion into account but 14 days seems to be a long time.

Professor Kieran Murphy:

I will deal with Deputy Peter Fitzpatrick's questions first. He raised issues regarding the guidance on conscientious objection and also the guidance on abortion. As I previously read the detailed guidance for doctors, I do not propose to waste the members' time by going over the issue again. I have dealt with that issue previously.

The Deputy's point about the absence of markers for suicide is most appropriately put to representatives of the College of Psychiatrists of Ireland who will be before the committee on Monday.

Senator Burke asked for the rationale as to why the Irish Medical Council proposes heads 2 and 4 should be merged. The council clearly emphasises the significant role of the obstetrician in the process. It is the obstetrician who will perform the procedure so he or she must have a central role in the process. The issue for the council relates to ensuring all doctors work in their particular scope of practice. To deal with physical health under head 2, if a cardiac problem arises and it is judged by a cardiologist that there is a real and substantial risk to the life of the mother and the only intervention to save the woman's life is a termination it may be appropriate, and this would be up to the clinicians involved, that the two people best placed to make the decisions are cardiologists, but not necessarily so. It may very well be that one of the two is an obstetrician. If this is the case an obstetrician will be involved in the certification in the first part at least.

Head 4 relates to assessment of suicide risk. The council is concerned to ensure doctors work within their scope of practice. In the assessment of risk of, as the draft heads of the Bill state, a threat of self-destruction, the council's view is that psychiatrists are best placed to make the assessment. If the psychiatrists agree there is a real and substantial risk to the life of the mother and that the only way it can be dealt with is by a procedure of termination then, as the Irish Medical Council put in its submission, these psychiatrists should consult with the obstetrician. It is very important that Deputies and Senators understand the council's view is that obstetricians have a central role in the process but doctors must work within their scope of practice to ensure the safety of the woman is protected at all times.

Senator Burke also raised the issue of age of consent. In my verbal submission I did not make this point because of time but I will mention it now. In our written submission we state in circumstances where the pregnant woman's capacity to consent is, or may be, impaired it is not clear from the draft heads how a decision regarding termination of pregnancy will be made and how the woman will be enabled and supported to participate in this decision. Furthermore we state the draft heads do not make reference to the legal age of consent for minors. Specifically it is not clear who will have decision-making authority in circumstances where the pregnant woman is under 16 years of age. In accordance with national policy, the council believes the voice of the young person should be considered and appropriate provisions should be made.

I hope I have addressed the questions asked by Senator Bacik on heads 2 and 4. We address her final question in our submission, but it is worth stating again that it is very clear only a very small minority of psychiatrists are attached to the appropriate locations. Importantly, not all psychiatrists are employed in institutions which are registered with the Mental Health Commission. Ms Spillane wishes to make a further point on one of the questions.

Ms Caroline Spillane:

Senator Burke asked about the total number of practising consultants at present. As I stated previously, 18,000 doctors are on the medical register, the vast majority of whom work full time in this country. There are 7,000 doctors on the specialist division of the register. The register holds information about the area of specialty in which doctors operate but not the posts they hold. This information is held locally by employers such as the HSE.

Dr. Matthew Sadlier:

On conscientious objection, if legislation is passed it is meaningful only if it has sufficient resources and mechanisms to action what it contains. It is very much the responsibility of employers to have a system in place which includes professionals who do not have a conscientious objection, thus protecting those who do from engaging in practices with which they have a difficulty.

With regard to the time limit, 14 days seems to be quite long given that a pregnancy is a time-limited entity. Although provision is made for emergency cases it would be expected that most cases are urgent as opposed to routine. We do not have an opinion on an alternative specific number of days.

Professor Murphy dealt with the question on various services in various hospitals. Services are divided among various sites with one hospital providing a specialty to another so a network of referral processes and cover between individual sites will be required.

Deputy Mattie McGrath:

I welcome our guests. If two consultant psychiatrists agree a patient is suicidal and this constitutes a real and substantial threat to her life which can be averted only by the termination of her pregnancy, do the witnesses envisage any situation in which they would disagree with them? The heads of the Bill provide for a situation in which a physically healthy woman carrying a perfectly healthy baby of 20 weeks gestation could be determined to qualify for a termination of pregnancy on the grounds her life was at risk due to the threat of suicide. This baby is viable albeit extremely premature, and the heads require everything possible be done to vindicate the baby's right to life. What exactly would the witnesses do in this situation?

My next question is for the Irish College of General Practitioners, ICGP. At its recent AGM the ICGP voted that the Government should introduce clarity in the law founded on evidence-based medical guidelines where there are real and substantial risks to the life of the mother. How does it reconcile the position it outlined today with this mandate?

I understand new Medical Council office-holders will soon begin their term of office. Is it not possible and likely this new council will revise the ethical guidelines relating to the care of pregnant women? Is it not the case the witnesses have no means of predicting what form this revision is likely to take? In light of the heads of the Bill, is it possible the council's ethical guidelines could be amended to remove the requirement to make every effort to preserve the life of the baby?

Deputy Denis Naughten:

From the evidence given by the Irish Medical Council and the Institute of Obstetricians and Gynaecologists their firm position is that what they would like to see is regulations supported by primary legislation rather than the structure proposed under the various heads. Will the witnesses clarify this?

With regard to conscientious objection, what happens if in smaller units all three existing consultants decide they are not prepared to get involved in these procedures? Does this mean for any new posts created people's personal opinions would have to be determined before they could be recruited?

I have a question for Professor McAuliffe. She mentioned the destruction of the baby in her evidence. Does she believe there needs to be clarification in the legislation with regard to destruction versus induction? Will she comment on the evidence given earlier by Dr. Tony Holohan who stated early deliveries may have been carried out in this country on the grounds of suicidal ideation. Does Professor McAuliffe have any evidence of this?

Dr. O'Riordan made the point in her evidence that there needs to be more resourcing of perinatal psychiatry but Dr. Tony Holohan stated there was no need for additional resources in this area in that a perinatal psychiatrist will not necessarily be involved in these additional assessments.

The point was made that the current obstetric practice is that referrals would be made between 16 and 20 weeks. Is it not the case that referrals are being made later now because of delays in obtaining an appointment with an obstetrician? How will that affect determinations concerning a termination? Would it require earlier referrals and, on foot of that, additional resources to facilitate that?

Senator Jim Walsh:

I wish to put my questions first to the Irish Medical Council representatives. Why do they feel the desire to merge heads 2 and 4? Deputy Kelleher referred to the guidelines which cover the risk of suicide. I assume the IMC monitors its guidelines, so what do the records show with regard to terminations for suicidality since 1992? Also in that regard, does the IMC have records on women who subsequently committed suicide because of post-abortion trauma? Those statistics would be of interest and value to us.

I welcome some of the comments in the report of the Institute of Obstetricians and Gynaecologists. Its representatives said they "remain acutely aware of the potential negative consequences for the unborn and in current practice all efforts are exhausted within medical margins of safety to prolong the pregnancy in the foetal interest". In practice, under this legislation, how will the requirement to make those reasonable efforts for the life of the baby actually work? In other words, if the baby is born around the viability period of 22 or 23 weeks, what will effectively happen in practice?

With regard to premature deliveries, can the IOG representatives tell us the potential complications and risks to the baby? I have heard stories that, for example, with early deliveries at 23, 24 or 25 weeks there could be a 50% risk of cerebral palsy. We had a submission from obstetricians and gynaecologists back in January who said that "the psychiatric grounds for abortion on the basis of suicide risk appear non-existent in the view of the experts in this field. An obstetrician, the doctor with responsibility to patients, faced

with terminating a normal pregnancy on grounds of suicide risk, will be placed in an impossibly conflicted situation where there is no benefit to the mother". Do the IOG representatives share that view, or what is their opinion be in that regard?

Chairman:

The Senator is over his time.

Senator Jim Walsh:

As regards a mother presenting at 17, 18, 19 or 20 weeks - just short of viability - what is the IOG's view with regard to the need for medical psychiatric treatment for that lady over a number of weeks to carry her through, as one would do with any other patient who was not pregnant, to the stage where she could safely deliver that baby? I would put that question to the IMO as well, whose representatives have commented on the need for proper psychiatric care for patients who are pregnant and feel suicidal.

Senator John Crown:

In the legally ambiguous landscape of Irish abortion law, where our Constitution, as interpreted by our Supreme Court at least once and by our people five times in referendums, is in direct conflict with our Statute Book, we have heard testimony here in the January hearings that Irish doctors will perform abortions where the life of the mother is threatened and where the only safeguard for her life is a termination to the pregnancy. We have heard that there are approximately 30 such terminations per year. We have also heard evidence that suggests that suicidality is at most a vanishingly rare cause. It may never have occurred in Ireland, although there is some dispute about this. There is also some dispute as to whether it is ever necessary. However, in theory it could be. As I have said, we are legally prevented from excluding suicidality by two specific questions put to the people in referendums.

It is frequently being mentioned here that best medical evidence is not at the moment suggesting that suicidality is ever needed as a ground for termination. There has been some dispute about this and many have stated that it would occasionally be needed. However, this committee is not drawing up guidelines for medical practice - doctors do that. They live within those guidelines and practise according to the best evidence which is available. I would ask our various experts, especially the obstetricians here, to provide some research for those who somehow, for reasons I am not quite certain I understand, believe that the evidence base of medicine will change if this law is introduced, which allows for the theoretical possibility of suicidality as a necessity for abortion, to reassure these legislators that that in fact is not the case, and that doctors confronted with an individual patient will still have access to the best evidence base and will make the best decision for that patient who is in their charge at that time.

I cannot let this moment pass without paying tribute to Professor Desmond Carney, who is one of the fathers of Irish oncology. He is one of my role models in joining this specialty and he has probably saved the lives of more Irish women than nearly anybody else in this country. Thank you, Des, for all you have done for us.

Chairman:

He has a lot to answer for, for you. I thank Senator Crown for that. I now call Professor McAuliffe. We have seven minutes left in this slot for replies.

Professor Fionnuala McAuliffe:

Deputy Mattie McGrath was wondering if an obstetrician would disagree with two psychiatrists. Just to reiterate, these are rare situations involving complex medical disorders. We take a multidisciplinary team approach. No individual doctor, or two doctors by themselves, will make these decisions. However, it is our opinion in the institute that if two experienced doctors feel, in good faith, that there is a risk to a woman's life that can only be averted by termination of pregnancy, and if it is our assessment also, then we would be in agreement with that decision.

There were a couple of questions about viability, and Senator Walsh and Deputy Mattie McGrath also discussed this. Foetal viability changes over time. When I first started in medicine the earliest point of viability was 28 weeks. It is now about 23 or 24 weeks, so it is changing all the time. Therefore I would favour not putting gestational age into the law, because it changes. At present, foetal viability is 23 or 24 weeks, so if a baby is delivered at 20 weeks' gestation, there is unfortunately no chance of survival.

If we have to intervene in a pregnancy - for example, if a woman has overwhelming infection or there is some other life-threatening maternal cause at 20 weeks - if we could extend that pregnancy to 24, 25 or 26 weeks, of course we would. Every effort would be made and every effort is made. Regardless of what this Bill shows when it comes to fruition, we will continue our current practice of trying to get every pregnancy to a stage at which the baby will survive, but we have to do that if it is medically safe. If the mother died while we were waiting for that time, that would be a disappointing situation. We work together with our neonatal colleagues in multidisciplinary teams to try to advance gestational age.

With regard to Deputy Naughten's question, our institute's opinion is that we favour legislation plus regulation.

In terms of destruction, to reiterate, if a pregnancy needs to be ended before viability, the baby is delivered and it will die, unfortunately. If it is after the point of viability, the baby will survive.

I was asked if I was aware of any cases of suicidal ideation requiring early delivery. I cannot say that I am particularly aware of it without a review of cases. If a pregnant woman is sick and needs medication, we work together to get a plan in place. Sometimes that may involve pre-term delivery, but we have to take the mother and foetal longevity and life together. We do that every day.

A general point has come up with a lot of the questions. The institute's view is that this Bill will just put a legal framework around current practice. We do not see any significant changes to current practice. It will just give us a legal framework for current practice, so we do not see big changes to how we approach the equal rights to life of a mother and a baby in pregnancy.

The average gestation at which a pregnant woman presents to hospital is generally about 15 to 18 weeks. If she is identified as having a medical disorder she will be seen much earlier.

There are medical clinics available at all tertiary referral centres and patients can be seen there from as early as four or five weeks. We often see patients with medical disorders much earlier on. The patients we are talking about will be identified as having medical disorders by the general practitioner and will be referred to us. It is our experience that general practitioners appropriately refer patients in a timely manner.

As regards our opinion on suicide, it is a very rare situation in which a woman is suicidal and the only option is to terminate the pregnancy to avert the risk to life. This is a very rare situation. We have not seen this case, so we know that these cases are very rare. Of course, that does not mean that is not possible or would not happen.

Therefore, it is the institute's preference to put heads 2 and 4 together, as they both relate to risk of loss of life. I ask Dr. Ní Bhuinneáin to briefly address Deputy Naughten's question about what happens if three consultant obstetricians have conscientious objections in a smaller unit. I am not talking about emergency treatment.

Dr. Méabh Ní Bhuinneáin:

Emergency treatment excluded, the smaller hospitals are networked - now formally, previously informally. If it turns out that there are three conscientious objectors in one unit, the network and institutions will have to decide, where care is delivered, if it is safe and timely to hold that decision to treat until the woman can be transferred. If it is not safe and timely to hold the decision to treat, under current Medical Council standards, even conscientious objectors must provide care, because guideline 10.1 is essential - one must not allow one's moral standard to determine the care provided to the woman.

A Member:

So a transfer would be involved?

Dr. Méabh Ní Bhuinneáin:

Yes.

Dr. Margaret O'Riordan:

In response to Deputy Mattie McGrath, I made it quite clear in my opening statement that the ICGP supports guidelines to implement this legislation. In response to Deputy Naughten, the ICGP holds that there is a need for more resourcing for perinatal psychiatry. This is in the context of women suffering from mental health disorders when they are pregnant, not just in the context of the heads of this Bill. On the need for earlier referrals, GPs generally refer pregnant women as soon as they present. As Professor McAuliffe has explained, on receiving that letter women usually get an appointment when they are between 16 and 20 weeks or 15 and 18 weeks pregnant, depending on where they are in the country. If there is a need for a woman to be seen sooner we will of course put that in the referral letter and she will be prioritised on that basis.

Chairman:

As we are over time, could Professor Murphy be brief in his response, please?

Professor Kieran Murphy:

I will try. Deputy Mattie McGrath raises an important point, which is what happens if there is not agreement. It is very important that the members, as legislators, put the interests of the woman at the centre of all they do, which is what the Irish Medical Council does in all its own actions. If there is a disagreement and the woman is unhappy with the outcome of the process, there is a review mechanism within the draft heads of Bill which allows for an appeal process. The council is very supportive of this and would go further. In our submission earlier this morning I outlined that we believe there should be a further appeal process enshrined in the legislation to allow a woman to access an appropriate treatment if she feels this is what she wants to do.

On Deputy Mattie McGrath's comments on the new Medical Council, clearly, as an outgoing member of the current Medical Council, I cannot possibly comment on what the new Medical Council might do. Regarding what Deputy Naughten said, as the Taoiseach and our Minister for Health have said, it is important for doctors to have legal clarity when making clinical decisions. Consequently, it is the Members' role, as legislators, to ensure they can provide that legal clarity to doctors. Once that legal clarity is provided it will be up to other organisations - such as the colleges and the Medical Council, co-ordinated by the Department of Health - to ensure that the guidelines developed based on the legislation are appropriate to ensure that the woman, who is at the centre of all this, is protected.

Regarding the questions from Senator Walsh, I have already dealt with the rationale for a merger of heads 2 and 4. The principle underlying the council's submission is that we want to ensure all women have equal access to a process that will save their lives. That is all I will say, given the time.

Dr. Matthew Sadlier:

I will try to be as quick as possible. In response to Deputy Naughten's comment regarding employment of staff, we would be very opposed to a doctor's status of conscientious objection being a criterion in whether he or she attains a post in a facility. We would view that as similar to discrimination based upon religious, gender or other grounds. The other question that was directed towards us was Senator Walsh's question on proper psychiatric care. We would envisage that at all stages in this procedure - before the decision is made, during the decision and after the decision, whichever way it goes - all women involved in this would receive the maximum and best evidence-based medical and psychological care, including their family members if necessary. We included this in our submission to emphasise the need for adequate resources, because the health services are struggling and the mental health services are struggling more than most of the others.

Chairman:

We now have 30 minutes for non-members. We have five speakers who have indicated so I will be very tight on time.

Deputy Terence Flanagan:

The ICGP's submission asked how doctors who are willing to refer patients requesting a termination will be identified. Do they propose that there be a register of doctors who have no objection in principle to the direct and intentional killing of an unborn baby?

Professor McAuliffe distinguishes between terminations and pre-term delivery. What exactly does she mean by "termination"?

I have some questions for the Irish Medical Council. In taking a stand in favour of the Government's proposed legislation, I presume, as an evidence-based organisation, the council's members have had extensive discussions on the studies questioning whether abortion can be a treatment for suicidal ideation. Could they share with the committee the details of those discussions and indicate which studies supported the contention that abortion can be a treatment for suicidal ideation? In their comments on head 5, the witnesses expressed a preference for clinical guidelines established by the relevant professional colleges over prescription from the Minister. Would it be fair to say they fear legislation could be overly prescriptive and could tie the hands of medical professionals? In their comments on head 6 they suggest that "practitioners who declare a conscientious objection must be excluded from review panels". Is it the IMO's position that doctors should be screened for pro-life values and excluded on that basis, or that review panels should be made up exclusively of doctors who have no principled objection to the direct killing of an unborn baby? To be intellectually consistent as well as being fair in terms of the equal right to life of the unborn child, should practitioners who declare support for general abortion rights be excluded from panels determining whether abortion is an appropriate treatment for a threat of self-destruction?

Senator Paul Bradford:

I welcome all the guests. I get confused about who is who in the medical world. I have a very straightforward question for Dr. Sadlier of the Irish Medical Organisation. Notwithstanding the fact that we all have to work within whatever is, or may be, the law, could he confirm that the official position of his organisation, as per its recent conference, is one of opposition to this piece of legislation, yes or no?

I have a question for Professor Murphy of the Irish Medical Council. The Medical Council guidelines are quite interesting. They are referred to from time to time when constituents on all sides of the argument meet us. The Medical Council guidelines prescribe that abortion is legal arising from the X case where there is risk to the life of the mother, including the risk of suicide. Interestingly, the guidelines go on to demand of practitioners that such a risk must be evidence-based. I trust that over the course of the years since those guidelines have been passed, such risk has been examined and determined. Could he inform us of the result of that examination of risk?

Professor McAuliffe and Dr. O'Riordan, who made very interesting contributions, both strongly expressed a view that they hoped the proposed legislation would be dealing with very rare cases. The reason we are here, when we remove all the waffle, is the political dispute over head 4 and the risk of suicide.

When we remove all of the waffle, we are here because of the political dispute over head 4 on the risk of suicide. The constitutional amendment, per the Supreme Court, allows the right of abortion where the threat of suicide can only be resolved by abortion, not where it is just one

possible treatment. Has any member of the panel or any of their colleagues encountered a case in which an abortion was the only treatment for a threatened suicide?

Deputy Peadar Tóibín:

Much divides Members in the Houses, but much also joins them together. We all agree that mothers need more supports to help them to make the right choices for themselves and their children.

This morning, Dr. Holohan stated - I hope that I am citing him correctly - that this Bill was a significant change from the *status quo*. There is no precedent for the treatment for suicidality to involve the damaging or ending or the life of another human being. Will the Institute of Obstetricians and Gynaecologists comment on this issue?

Someone might correct me if I am wrong, but Dr. Holohan made another comment. Currently, if a woman has suicidal ideation and the unborn child is viable, an intervention may occur in which the child is brought to term prematurely. Is this the witnesses' experience? What are the typical outcomes for the children?

Regarding the issue of predicting the number of people who will need these services, this legislation is another change in the *status quo*. Currently, decisions are based on objective medical markers. If I am correct, the Bill will introduce subjective markers, which are scientifically more difficult to base predictions on. The actual number of suicides predicted by psychiatrists is low.

Chairman:

To allow for continuity in the replies, I will take Senator Mullen and Deputies Timmins and Mathews now. As we will conclude at 2.15 p.m., they will have three minutes each, although they will not need to take them. Two other Members have indicated.

Senator Rónán Mullen:

We have not seen the full submission of the Institute of Obstetricians and Gynaecologists to which someone alluded. We have only seen today's speaking notes. Does the submission include any concerns of obstetricians and gynaecologists about their role in certifying or carrying out abortions, particularly on grounds of suicide? Dr. Sam Coulter-Smith, who will address the committee later, stated on radio today that asking obstetricians to get involved in the termination of pregnancies when there is little evidence to show that they are appropriate interventions creates a moral and ethical dilemma for doctors.

Chairman:

The Senator should be careful about naming people who are not present to defend themselves.

Senator Rónán Mullen:

I am quoting him for the record. I sense a certain discrepancy between that statement and a general nod of approval for the legislation. Is there more information in the submission that would enlighten us about the concerns that many doctors have?

Turning to the Irish College of General Practitioners, as I understand it-----

Chairman:

I am sorry, but the witnesses present might not have heard the remarks to which the Senator is referring, so it would be unfair to ask them to comment. Does the Senator understand?

Senator Rónán Mullen:

That is fair, but I assure them that I am quoting from a verbatim transcript.

Chairman:

As Chair, I must be impartial and cannot take the Senator's word for everything.

Senator Rónán Mullen:

Go raibh míle maith agat. Glacaim le do neodracht.

Will the Irish College of General Practitioners provide guidance regarding the motion that was most recently passed? As I understand it, a motion approving of the Government's legislative proposal was amended in favour of a desire for evidence-based medical guidelines. I would appreciate clarity on this point. I would also like clarity from the Irish Medical Organisation, IMO, about what was passed at its most recent gatherings in respect of this issue.

Dr. Holohan made it clear that the right is not to have a life ended, but to have the pregnancy brought to an end. I am referring specifically to head 4. Senator Crown believes sincerely that this set of circumstances is rare to non-existent, if I have interpreted him correctly. Nonetheless, many doctors have a deep concern about this issue, possibly because they are conscious of the national and international politics of abortion. Since what is proposed is that psychiatrists, in the absence of an evidential basis, would nonetheless be in a position to certify that an abortion was the only means of dealing with suicidal ideation, and given the Government and Dr. Holohan's statement that the right is not to end a life, but to end an pregnancy, does it not by definition follow that the Irish Medical Council would a prefer a situation in which a person who has suicidal ideation would be protected to the end of her pregnancy? Regardless of whether one agrees with this approach politically, should it not follow that, by definition, the Irish Medical Council would recommend against any termination in the absence of evidence to the effect that an abortion is a treatment for suicidal ideation, given the fact that there is no right to end the life, *per se*, and in light of the fact that there is the possibility of protecting a person until the end of the pregnancy?

Deputy Billy Timmins:

I wish to make a couple of brief points. Everyone present would support any measure that could provide clarity regarding the protection of the life of the mother, particularly the

physical aspect. In terms of head 2 and setting aside head 4, however, where is the clarity in the Bill? Where is clarity lacking currently? Pages 7 and 11 read: "Due to the unpredictability and complexity of these rare medical cases it was felt not desirable to provide in legislation for a specific referral pathway." As is currently the case, it will be left to the medical practitioner, which was pointed out by Senator Crown. Time and again, I have heard the Government state that this Bill will improve clarity and protect the life of the mother, but in what respect will clarity improve?

Regarding the Irish Medical Council's guidelines, Professor Murphy mentioned that they reflect the current legal practice. Between 1992 and 2009, the guidelines were different, in that they maintained that the carrying out of an abortion was medical malpractice. This only changed 17 years after the X case. I may be wrong, but the guidelines changed in 2009 following the 2007 legislation, which put a majority of lay people on the council as opposed to medical people. How did the council operate between 1992 and 2009?

I have a brief question for the Irish College of General Practitioners and the Institute of Obstetricians and Gynaecologists. Were they required to nominate people to the expert group or did they have members on that group?

Deputy Peter Mathews:

An awful lot of words have been exchanged in this discussion - professional and expert words and simple words. For clarity, simplicity is needed. One must declutter. I am afraid that we are falling into the professional vanity of confusing and obfuscating.

(Interruptions).

Chairman:

Deputy Mathews without interruption, thank you.

Deputy Peter Mathews:

The Constitution is clear. The doctors have stated that their guidelines give them the sound basis for doing their work. Women and children have been extremely well served.

Senator Paul Bradford:

Hear, hear.

Deputy Peter Mathews:

People have done their work dutifully and well. Where people have fallen short in their professional capabilities, there have been accidents.

Chairman:

Does the Deputy have a question?

Deputy Peter Mathews:

Yes. Why do the professionals not say clearly and simply that they know what to do if there is a threat to the life of the mother and that they can get on with it? No one has discussed the post-abortion recovery counselling that is needed for those poor, unfortunate girls and women who have gone to England to have abortions. Their voices have only been heard by a few of us. In fact, they asked to be present and to be heard, but were told that, because of arrangements, it was not possible. This is a screaming void.

Chairman:

I call Professor McAuliffe. This session ends at 2.15 p.m.

Professor Fionnuala McAuliffe:

Deputy Terence Flanagan asked for a definition of the word "termination". I provided such a definition in my submission this morning and it is also in the written submission. Termination refers to circumstances where there is no chance of survival after birth, such as when a pregnancy is ended before the foetus is viable. Pre-term delivery is delivery of a baby after viability.

Senator Bradford asked if we had ever seen a case of a woman whose only treatment was termination of pregnancy. We have not seen a case of a woman who was suicidal in pregnancy and the only treatment to avert the risk of life was termination of pregnancy. However, that is not to say that there could not be even one such case. We work very hard in obstetrics to save mothers' lives and even one death is an absolute tragedy. To say we have not seen one case does not mean we will not see one case.

Senator Jim Walsh:

It is not about saving babies but about saving women only.

Chairman:

I ask Senator Walsh to show respect to the witnesses by having the courtesy to allow them to reply. He had an opportunity to speak and he spoke well.

Professor Fionnuala McAuliffe:

Deputy Peadar Tóibín asked about suicidal ideation and pre-term delivery. If a woman is psychiatrically unwell, she will receive medication. I have not been personally involved in any case of a suicidal ideation requiring pre-term delivery. I revert to Dr. Houlihan and whether he is aware of such cases.

As to what numbers we are anticipating, the view of the institute is that this legislation provides a legal framework for existing, current medical practice. We are facing pregnant women whose lives are threatened by the pregnant state and need either termination or pre-term delivery. This legislation provides a process for that so that we are not working in a legal vacuum or unsure as to whether a woman's life is in immediate danger or in danger down the line. It provides us with a legal framework for current medical practice. That is our stated view.

In terms of the lack of evidence, an issue raised by Senator Rónán Mullen, the institute acknowledges that there is a lack of evidence of the role of termination of pregnancy. This poses an ethical dilemma for our members. We went through a planned consultative process and we represent the majority view within obstetrics and gynaecology in Ireland. Members will have an opportunity this afternoon to hear views from individuals and individual units, but the view presented in our submission is the majority view that emerged from a consultation process that involved consultation with the executive members and representatives of each of the 19 maternity units involved. Members are, therefore, hearing the majority view within the specialty this morning.

Deputy Timmins wondered about the clarity of the Bill. We believe it will give us a legal framework to allow us to carry out high quality medical care.

We received a request to put forward some names for the expert group and we participated in that process.

To respond to Deputy Mathews, the view of the institute is that we favour legislation plus regulation. Professor Robert Harrison will comment on our submission as I understand the committee did not receive a full written statement.

Professor Robert Harrison:

I am slightly shocked and dismayed at this because I am the rapporteur. The statement was submitted last Wednesday within the legal timeframe.

Chairman:

The members of the committee received the submission.

Senator Rónán Mullen:

I understand that is not the case.

Chairman:

That is the case.

Senator Rónán Mullen:

I was informed by an official that it was not the case.

Chairman:

My understanding is that members were to receive all written submissions in advance of the meeting today. That was the decision taken by the committee.

Senator Rónán Mullen:

I was given to understand by one of the officials that was not the case.

Chairman:

All I can do, as Chairman, is-----

Senator Rónán Mullen:

Will the Chairman revert to us on the issue after lunch?

Chairman:

No.

Senator Rónán Mullen:

It is an important issue.

Chairman:

Thank you, Senator.

Professor Robert Harrison:

The submission was definitely sent and acknowledged before the deadline of 5 p.m., despite the institute only being given seven days' notice, which included a bank holiday.

Dr. Margaret O'Riordan:

To respond to Senator Mullen, the submission raises the question as to how doctors who are willing to refer patients requesting terminations in these circumstances will be identified. That is a genuine question to which I do not have an answer. I am raising it because it is an important issue.

On the guidelines, we have clearly stated that we support guidelines to underpin the legislation.

To respond to Senator Bradford, I am not aware of any general practitioner colleagues who have encountered a case where a termination was the only treatment available. I will leave it at that.

Professor Kieran Murphy:

With regard to the questions raised by Deputy Terence Flanagan, which largely related to the Medical Council's guidance, as I stated earlier, the Medical Council constructs and publishes its guidance following extensive consultation. We engaged with a range of different stakeholders, including the Institute of Obstetricians and Gynaecologists, to ensure the guidance we produced will be the most helpful guidance in assisting doctors in their day-to-day practice.

Senator Bradford made comments about the appropriateness of the use of non-scientific markers in the assessment of suicide. This morning, we heard the Chief Medical Officer

describe psychiatry as a clinical science. It has also been noted that there are a number of markers that are associated with assessment of suicidal ideation and suicidal intent. I suggest that these questions would be more appropriately put to the College of Psychiatrists of Ireland which will come before the joint committee on Monday.

I regret that Senator Mullen does not appear to support some of the submissions of the Medical Council. It may be helpful for Deputies and Senators to understand the composition of the Medical Council. The council is a body of 25 people constituted under statute. We are the only medical regulatory authority in the world with a lay majority. Of the group of 25 people, 12 are doctors and 13 are laypersons. We very carefully consider these issues. Our primary role is to protect the public and this guides all the work we do. We take the publication of our guidance extremely seriously. We want it to be fit for purpose to ensure that doctors understand what they need in terms of how they should work. It is also important for patients to understand the standards we expect of our doctors and they should expect of their doctors. As I stated, I regret that Senator Mullen does not share the collective view of the Medical Council.

Senator Rónán Mullen:

I asked a question rather than expressed regret.

Professor Kieran Murphy:

Deputy Timmins also asked questions about our guidance. I hope I have addressed the issue of how the Medical Council constructs its guidance without having to go over it again.

To respond to Deputy Mathews, as I indicated earlier, it is extremely important, as the Taoiseach has said on numerous occasions and the Minister of Health agreed, that doctors have legal clarity when making clinical decisions. The role of legislators, I submit, is to ensure that they can provide doctors with that legal clarity. Once that legal clarity has been established, it will be up to professional bodies, including the Medical Council, to draft guidance that will assist in the implementation of this new legislation.

Dr. Matthew Sadlier:

I will respond to three general questions asked by a number of speakers. On the issue of guidelines and legislation, we are more in favour of guidelines than legislation on technical-medical issues because, as has been noted before, medical evidence changes and guidelines will change more quicker than legislation. We do not want to end up in a position where medical evidence or procedures make something feasible but the law makes it illegal. That is the reason we would prefer guidelines to be developed by professional expert bodies, rather than having legislation in specific medical instances. This view is shared across all specialties.

Two speakers asked questions on the official position of the Irish Medical Organisation. At our recent annual general meeting, there was no change in the policy of the Irish Medical Organisation. A number of motions were proposed, all of which were defeated. As such, the policy remains as it has been since the last time a motion on this issue was approved. That motion, which was approved in 1993, states that the IMO endorses the principle of respect for all human life, born and unborn, and rejects abortion. That answers the question.

Notwithstanding that, we are aware that we are democratic organisation operating in a democratic society. The laws of the land are made by referendum, the people and the Oireachtas and it is our job to represent our members within that legal framework. We will, therefore, engage on issues notwithstanding our own policy.

We welcome the fact that there is a provision for conscientious objectors and that doctors can object to engaging in this process and are not being forced to engage in a process to which they object, notwithstanding their obligations under the Medical Council ethical guidelines which Professor Murphy alluded to previously. If they agree to participate in this process, whatever morals and ethics they use to inform their decisions is a matter for them. Obviously, they are guided by the Medical Council guidelines and those of their own colleges and specialised information.

Chairman:

Members should have received the submissions. That was agreed at the committee. If they have not received them, I will check it out afterwards. Deputy Tóibín said a question of his was not answered?

Deputy Peadar Tóibín:

Yes. I have a heavy cold so I probably asked the question very badly. My question was addressed to Professor McAuliffe. She predicted that there would be a very low number of individuals who would need this type of treatment in the cases of suicidality. We heard at similar hearings here in January that prediction accuracy for suicide is about 3%. Given that the legislation identifies that objective medical markers will not be available to the decision makers but that subjective analysis will be available and the fact that in every other jurisdiction where similar legislation has come through, the experience has been quite different and there has been a very large increase in the number of people accessing this service with similar types of symptoms, it is very difficult to make that prediction that the numbers will be very low. Professor McAuliffe said earlier that the legislation is not really a change in the *status quo*. Dr. Holohan mentioned this morning that this legislation was without precedent in that it meant that a third party would be damaged or would lose their life as a result of the treatment for suicidality.

Professor Fionnuala McAuliffe:

With regard to suicide, we would defer to our psychiatric colleagues regarding making an assessment. They are trained in assessing patients, as we all are as doctors in assessing medical risk. I understand the committee will have a full day on the psychiatric evidence on Monday so in terms of the prediction of suicide, we would defer to the specialists involved.

In respect of the numbers, limited termination of pregnancy is permitted in Northern Ireland where there is a lethal foetal abnormality, there is a risk of permanent damage to the health of the mother or there is a risk to the life of the mother. Northern Ireland has very small numbers of cases. There are approximately 40 cases every year in Northern Ireland so it has not seen huge numbers of cases or a big requirement for increasing capacity. I suspect that we would see very low numbers of cases as well.

Deputy Mattie McGrath:

Could I get an answer to my question?

Chairman:

This section is for non-members. The Deputy is a member of the committee.

Deputy Mattie McGrath:

It is a waste of time.

Chairman:

In respect of submissions, I will make it my business to talk to people afterwards to make sure submissions are given to members who were here this morning. We will now suspend until 2.45 p.m.

Sitting suspended at 2.15 p.m. and resumed at 2.45 p.m.

Obstetric Care Facilities - Larger Hospitals

Chairman:

I welcome everyone to this afternoon's session. Is it agreed that we begin in public session? Agreed.

I remind members of the committee, witnesses and those in the Visitors Gallery, be they members of the media or members of the public, to ensure their mobile telephones are switched off for the duration of the meeting as they interfere with the broadcasting equipment even when they are on silent mode. It is particularly unfair to members of staff who have to wear headphones.

Over 500 submissions were received by the committee prior to today's meeting. Not all of them could be given to members. However, the submission referred to earlier this morning has been e-mailed to members. Any documentation, if it is made available by a delegation the day before the hearings, will be given to members in advance.

I acknowledge the presence in the Visitors Gallery of former Deputy, Ms Geraldine Kennedy, and former Ministers, Ms Gemma Hussey and Ms Nora Owen. I also acknowledge the presence this morning of Ms Mary Banotti. I thank those watching these proceedings on UPC or the Oireachtas live feed. It is very much appreciated that people are taking time to watch the proceedings of this committee.

With that said, we are in our third session of hearings to discuss the heads of the protection of life during pregnancy Bill 2013. I welcome Dr. Peter Boylan, Dr. Sam Coulter-Smith and Dr. Rhona Mahony. Before we begin I wish to remind you of the position regarding privilege. Witnesses are protected by absolute privilege in respect of the evidence they are to give to the committee. However, if you are directed by the committee to cease giving evidence in respect of a particular matter and you continue to do so, you are entitled thereafter only to a qualified privilege in respect of your evidence. You are directed to give only evidence connected with the subject matter of these proceedings and you are asked to respect the parliamentary

practice to the effect that, where possible, you should not criticise or make charges against a person or persons or an entity by name or in such a way as to make him or her identifiable. Members are reminded of the long-standing parliamentary practice or ruling of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make him or her identifiable. I remind all members that the witnesses are here voluntarily to give of their time and I hope we will all show respect to them and to each other in our language and in the way we behave in the Chamber. We are now ready for opening statements. I call on Dr. Boylan to make his opening remarks.

Dr. Peter Boylan:

I have been a practising obstetrician and gynaecologist since 1975. Part of my training was undertaken in London and after I qualified I held an academic post in the United States for four years. Over many years I have been invited to give lectures and perform clinical practice reviews in the United Kingdom, the United States, Europe, Scandinavia, Singapore, Israel, Australia and New Zealand. All of this experience has given me wide opportunity to observe the practice of obstetrics as it relates to the issue under discussion, namely, the termination of pregnancy to save the life of the mother.

Ireland is in a unique position in that there is ready access to termination of pregnancy in the United Kingdom for residents of this State despite it being illegal here. It could be interpreted that the State has implicitly agreed to facilitate this access by way of the constitutional amendments of 1992 which guaranteed the right to access information regarding termination of pregnancy and guaranteed the right to travel to obtain a termination.

The situation in Ireland regarding termination of pregnancy where there is a real and substantial risk to the life of the mother remains unclear. As doctors, we are aware of the Supreme Court judgment in respect of the X case but we are left, in the absence of legislation and regulation, to attempt to interpret that judgment on an *ad hoc* basis when it comes to termination of pregnancy in order to save the life of the mother. Meanwhile, the Offences against the Person Act 1861 remains on the Statute Book. This is a wholly unsatisfactory and, I believe, unreasonable situation to expect doctors to operate in. It also places the woman in the highly unsatisfactory position whereby doctors caring for her are unsure about whether they may be breaking the law in cases where they believe they must intervene to save her life. For these reasons I welcome the intention to enact legislation to protect life in pregnancy.

Dr. Sam Coulter-Smith:

My name is Dr. Sam Coulter-Smith. I am master of the Rotunda Hospital in Dublin. My submission to the committee today is based on my views and the views of my consultant colleagues at the Rotunda Hospital following consideration of the draft heads of the Bill. I thank the Chairman and members of the Joint Committee on Health and Children for giving me the opportunity to present these views on this important draft legislation.

I will start by making some general comments. I acknowledge the work that was done on this extremely difficult and contentious document and I commend those who drafted the text for avoiding the word "abortion" in the terminology. This is a positive move and ensures that those women who have to have a pregnancy terminated in an emergency situation are not stigmatised in any way and this should be welcomed.

In terms of where a termination of pregnancy can occur, there are two factors that need to be considered. I welcome the fact that the legislation provides for termination of pregnancy in an emergency situation in any of the 19 maternity units in the country. However, there are occasions when it may be necessary to terminate a pregnancy outside these institutions, for example, in Mount Carmel Hospital, which is a private, non-HSE institution delivering maternity care.

In addition, in each of the big maternity hospitals in Dublin there is no provision for intensive care. Therefore, our sickest patients from these units, some of whom will have been transferred from other units around the country for care, will be looked after in intensive care units in hospitals such as the Mater Misericordiae University Hospital, St. Vincent's University Hospital, St. James's Hospital and others. There may be occasions, therefore, when it is necessary to provide this type of emergency care, which is provided for within this legislation, to patients in these intensive care units, which are currently outside the draft legislation.

I will turn my attention now to the clinical scenarios that the heads of the Bill cover. The document broadly covers three clinical scenarios. First, when a woman's life is acutely at risk in an emergency situation due to a complication of pregnancy. Second, when the acuity of the situation may be less urgent but the severity of the situation relates to a co-morbidity such as cancer, significant heart disease or other illness. The third clinical scenario is where there is imminent risk of death from suicide or self-destruction.

In respect of the first two scenarios, the heads of the Bill provide clarity and appropriate protection for those giving care to pregnant women. This, in turn, should provide clarity and reassurance for all professionals, including medical, midwifery and nursing professionals, that their actions in giving best care to the mother are covered under the law. It should also provide reassurance for women and their families that the medical profession can act in their best interests during difficult, life-threatening situations, and this is to be welcomed. It is also important to note that there is no gestational limit applied to either of the first two scenarios and this, in my view, is appropriate. It is also important to note, and it is confirmed and reiterated in several areas within the draft document, that doctors must have regard to the protection and preservation of the unborn human life where practicable. This should provide appropriate reassurance for patients and their families in very difficult and distressing situations.

In respect of the first scenario where a woman's life is at risk in an acute emergency situation, it is now acceptable for one obstetrician to decide whether a termination of pregnancy is required to save a woman's life. It is good practice for an obstetrician in this situation to seek a second opinion from a colleague if it is possible to do so. However, in these difficult situations there will often be other consultants involved, such as a haematologist in the case of haemorrhage or a microbiologist in the case of infection. It is also likely that a consultant anaesthetist will be available and it would be appropriate for the consultant obstetrician to seek advice and to discuss the decision-making process with these colleagues.

In respect of loss of life from self-destruction there are a number of issues that need to be raised. First, this is an extraordinarily rare situation with the incidence of suicide in pregnancy of the order of one in 500,000 pregnancies as per United Kingdom figures. Second, our psychiatric colleagues tell us that there is currently no available evidence to

show that termination of pregnancy is a treatment for suicidal ideation or intent and, as obstetricians, we are required to provide and practice evidence-based treatment.

Deputy Peter Mathews:

Hear, hear.

Dr. Sam Coulter-Smith:

It, therefore, creates an ethical dilemma for any obstetrician who has requested to perform a termination of pregnancy for the treatment of someone with either suicidal ideation or intent. Third, this legislation, I am sure, is designed to create clarity and reassurance for both health professionals and patients alike.

The fact that there is no gestational limit in respect of the third scenario relating to suicidality is a major ethical issue for obstetricians. I will illustrate this with two scenarios. First, let us consider the case of a patient who is 25 weeks' gestation. If she is deemed to be sufficiently suicidal to require a termination of pregnancy by one or more psychiatric colleagues, an obstetrician who is tasked with dealing with this situation is faced with an enormous ethical dilemma. Delivering a baby at 25 weeks' gestation could lead to death, due to extreme prematurity or it could lead to a child with cerebral palsy or with other significant developmental issues for the future. This outcome would be entirely iatrogenic and the responsibility of those clinicians who have agreed to be involved in the process. This is a source of serious concern for myself and my colleagues.

Another clinical scenario which provides a difficult ethical dilemma is a situation whereby at a woman's 20 week anatomy scan a significant but non-lethal malformation is discovered. The patient, for a variety of reasons, may decide that she cannot continue with the pregnancy and it is causing her significant mental health issues with risk of suicide. The obstetrician is left in the unenviable position of, by law, having to look after the best interests of the baby but also the understanding of the mother's issues. It would, therefore, seem appropriate in a case where there is a risk of self-destruction that there is no gestational limit applied in this situation as this creates a major ethical dilemma for us.

My overriding concern, however, in relation to the whole area of self-destruction and termination of pregnancy to prevent same, relates to the lack of evidence to show that termination is of any assistance in this scenario and that we as obstetricians and gynaecologists must be able to stand over the decisions we make as being based on good medical evidence.

In relation to the infrastructure and resources it is my view, and that of many of my colleagues, that the inclusion of suicidality within the legislation may, and I stress may, in the long term lead to an increased demand for termination in this country. We currently do not have any real understanding of how big that demand may be. Currently in excess of 5,000 women a year go from Ireland to the UK to have termination procedures performed. We cannot be certain how many of these women would decide to use this current legislation as a means of obtaining a termination in this country and even if unsuccessful in obtaining a termination in this country, a huge amount of time and resources will be spent on the assessment of these patients.

We currently have three sub-specialist psychiatrists with a special interest in mental health issues in pregnancy. These are part-time posts attached to each of the three Dublin maternity hospitals. Mental health issues in pregnancy are among the most common complications we see, affecting between 10% and 15% of our pregnant population. The impact of this very high incidence of mental health complications means that these services are overstretched and find it difficult to cope with their existing workload. Any increase in the workload of these services could put huge strain on the system and take it beyond breaking point.

Each of our Dublin maternity hospitals delivers approximately 9,000 women per year. The midwife to patient ratio is approximately half of what it should be, the consultant to patient ratio is also half of what it should be. We have seen an increase in the delivery rate in Dublin of about 30% over the past six years and this has put an enormous strain on the infrastructure of our hospitals. The increase in the number of women delivered is now leading to a huge increase in the demand for gynaecology services to the extent that waiting lists for routine gynaecology outpatient clinics are currently well over a year and growing. The combination of these factors means that it would be extremely difficult for us in the maternity hospitals to take on any additional service which would require input from staff in an outpatient setting in terms of assessment or in theatre time to cope with an increase in the number of termination procedures.

In conclusion, I welcome this draft legislation, particularly in the area of real and substantial risk to the life of the mother which pertains to physical illness. I think, however, that there are significant concerns in all areas of the medical profession in relation to this Bill when it comes to suicidality. Our overriding concern relates to the lack of evidence to show that termination of pregnancy is an appropriate treatment for women who are deemed to be at risk of suicide. As obstetricians we are expected to practise evidence-based interventions and first and foremost to do no harm. This legislation should help in providing clarity and reassurance to professionals and patients alike. To enact and underpin the idea that termination of pregnancy is a solution or a treatment for a patient at risk of committing suicide when there is no evidence to support that intervention creates an ethical dilemma for our profession.

To make matters a little more difficult there is no gestational limit mentioned in the draft at which this termination might happen. This opens the possibility for iatrogenic prematurity with all the risks of infant morbidity and mortality. Who will be responsible for these interventions? I also confirm to the committee that we as a profession, and particularly in my hospital, have concerns about the potential for increased demand for termination services in this country as this may be an unintended consequence of this legislation in its current form.

Dr. Rhona Mahony:

Chairman and members of the committee, I thank you for the opportunity to comment on the draft heads of the protection of life during pregnancy Bill. I am the master of the National Maternity Hospital. I am a practising obstetrician, having practised for 17 years, and am a specialist in foetal and maternal medicine. I have practised as a consultant at the National Maternity Hospital since 2008.

This Bill is about saving women's lives. Women sometimes die during pregnancy and it is my belief that everything possible must be done to prevent such a tragic outcome. Where there is a substantial risk to a woman's life during pregnancy there should be no hesitation to save her life. If she dies her baby will die too. Despite this fundamental imperative there remains

today in Ireland a lack of clarity surrounding when termination of pregnancy is legally permissible. It could be argued that the State has gone to great lengths to avoid legislating for this reality, the reality of maternal death as a consequence of pregnancy. This is inexcusable.

Provision has been made in Ireland for women to access termination of pregnancy outside of this jurisdiction despite the fact that it remains a criminal offence in Ireland. I believe this Bill, which is restricted to circumstances where a pregnant woman is at risk of dying, sets out to provide clarity in a number of key areas which directly affect clinical obstetric practice. Despite the Supreme Court judgment in the X case which provides for termination of pregnancy when there is a real and substantial risk to a pregnant woman's life which may be ended or removed by ending the pregnancy, there remains today no legal framework through which this risk can be determined. This leaves doctors and their patients, women at risk of dying, legally vulnerable. This Bill addresses this issue.

The Offences Against the Person Act 1861, sections 58 and 59, means that abortion, termination of pregnancy, is a criminal offence in this country. This is addressed also by the Bill and provision is made to remove this which is necessary. At present there is no formal process through which a woman who perceives that she is at risk of dying can access opinion on whether termination of pregnancy is appropriate. I believe women deserve that consideration and this Bill addresses that issue. I therefore commend the Government on the decision to provide legal protection for women and their doctors in this very difficult, rare and complex circumstance when termination of pregnancy is necessary to save a woman's life.

Most importantly, I understand that according to this Bill the constitutional protection of the unborn is preserved where practicable. We must vindicate the life of the foetus where it is practicable. This obligation has underpinned my clinical practice over 17 years and will continue to do so. In current practice all efforts are exhausted within the medical margins of safety to prolong pregnancy in the foetal interest. When a foetus has reached a gestation where survival is possible, every effort is made to optimise that survival. This is regardless of the indication for termination of pregnancy which in this context will be to save a woman's life. In practical terms with current neonatal intensive care, neonatal survival is now possible from as early as 23 weeks' gestation. Every year in Holles Street we look after at least 20 babies who were born somewhere between 23 and 26 weeks' gestation. This is not strange to us.

I want to leave the committee in no doubt of the following: we do not destroy or kill foetuses. We deliver them and on occasion delivery in order to save a woman's life is required at gestation so early that very sadly foetal survival is not possible. In this context if a pregnant woman dies her baby will die too. It is my experience - and I am experienced in this area, I specialise in foetal and maternal medicine - the majority of women do not wish to lose their babies but they do not want to die. The indications for termination of pregnancy prior to foetal viability include situations such as infection, choreoamnionitis, blood pressure that we are unable to control, haemorrhage, treatment for some cancers and management of severe medical disorders in pregnancy such as heart disease. These situations are very complex and very rare. At the National Maternity Hospital, which is one of the busiest maternity hospitals in Europe, we have annually up to five cases.

Following the months of debate regarding the draft heads of this Bill one could be forgiven for thinking that this Bill is about the risk of suicide in pregnancy.

It is not. It is about saving a woman's life regardless of whether that risk to life is physical or mental. Suicide is death just the same as death from infection chorioamnionitis; women are dead. A woman who is intent on suicide is indeed at risk of dying. She needs to be assessed appropriately, she needs to be believed and she needs expert psychiatric care.

The committee has already obtained my written submission in regard to each of the heads of the Bill and all my comments on those are set out in it. I think some practical amendments to them will need to be included. For example, in respect of the person carrying out the termination and the definition of obstetrician-gynaecologist, not all obstetricians and gynaecologists are on the specialist register. It is a technical point but it would be more pragmatic to refer to the term "obstetrician-gynaecologist".

The issue of location is also very important. We are a stand-alone maternity hospital in Dublin. When women become very ill we are often required to transfer our patients to a hospital that has a broader medical network where women can access a variety of areas of specialist care. Therefore, provision should be made to include all Government approved hospitals in the Bill.

I am pleased to note that conscientious objection is addressed in the Bill. I am also pleased to note that provision is made to remove the Offences Against the Person Act 1861.

Chairman:

I thank Dr. Mahony. I call Deputy Kelleher.

Deputy Billy Kelleher:

I welcome the three witnesses. There there are varying views in their three presentations. Large parts of legislation are quite agreeable to the vast majority of professionals and the broader public but the issue of self-destruction is something that divides Irish society. I wanted to get the varying views of our three witnesses on this. First and foremost, if there was no constitutional obligation because of the X case to bring forward legislation on self-destruction, should it be included in any event if one were introducing legislation in this area? In other words, do the witnesses believe there is the potential of a threat to one's life because of suicide and should it be legislated for, even if the X case was never heard in the first place?

The Irish Medical Council's guidelines of 2009 include suicide as a ground for a termination. I get the impression from Dr. Coulter-Smith that he believes there is never a reason to terminate a pregnancy because of the threat of self-destruction. I want to get clarity on that point.

In the broader context, what we are trying to do here, as Dr. Mahony has pointed out, is to bring forward legislation that saves the lives of women and gives clarity to the professionals who are dealing with them. There are varying views on how that should be done but the Government has decided to legislate. In that context, are the witnesses satisfied with the legislation before them in the practical terms in respect off making interventions to save the life of a woman and that it will not inhibit them in doing that and that it will give them protection? Are they satisfied it will not inhibit them in dealing with an emergency case, a non-emergency case or a case of self-destruction?

I wish to ask the witnesses a question that I have asked the previous witnesses and it is about an issue to which Dr. Mahony has referred. We need to get clarity on this issue, which I have already got, but I raise it for the benefit of the broader public who may be following the proceedings and others who have an interest in this matter. It is the area of foetal viability and when the foetus is on the cusp of viability. Obviously in emergency situations, a decision must be made there and then but in non-emergency situations or in a case of self-destruction, do obstetricians in the course of their duty in trying to save the life of the woman look at the viability of a foetus and believe that if they could extend the time of intervention it would give the foetus greater viability?

People have asked me to raise the issue of how a termination of a pregnancy is performed. It has been described as an interruption of pregnancy. In Britain there is an intention to destruct the foetus whereas the opposite is the case here. Every effort is made to save the foetus, regardless of gestational age. I would like to get clarity on that. Is a pregnancy terminated normally through inducement or caesarian section? I understand they would be the normal ways of inducing early pregnancy. I would like clarity on that issue. I met many members of the public in recent weeks and these are issues on which they would like certainty and the witnesses are the people best placed to give it to us.

Deputy Caoimhghín Ó Caoláin:

I join the Chairman in welcoming our three guests. In relation to Dr. Peter Boylan's contribution, it should not strike one as strange that I would not have known that intensive care units did not exist in any of the three maternity hospitals in Dublin but it has come as a shock or certainly a surprise. It poses the question of whether these entities, as they are currently resourced and configured, have the capacity to provide for all situations that could present. It is not just about legislation; it is like all legislation here, it must be resourced. I take the opportunity to welcome Dr. Boylan's exposure of that deficiency, which I expect may have presented difficulties in the past, not only in the context of for what we are currently legislating.

A number of the contributions made this morning would complement and echo Dr. Boylan's points regarding a wider number of approved locations, other than the 19 designed, extending it to the general hospitals and he also made a case for the approved private hospital scenarios.

Dr. Boylan and Dr. Mahony referred to limitations regarding only obstetricians and gynaecologists who are in the specialist division. There is a number, whatever number that would be but it is an significant and important number, who would not be on the specialist register but on the general register of the Irish Medical Council. We welcome all these points and that light has been thrown on these because these are elements that can and hopefully will be addressed during the Bill's passage through Committee, Report and Final Stages.

I do not want to go over the area covered by my colleague, Deputy Kelleher. I note in Dr. Mahony's contribution her commendation of the Government for bringing forward the Bill. I presume the subtext of that is that she accepts that the five obligations of the State, as set out in the expert group report, are addressed here. She might elaborate on whether they are addressed to her satisfaction. I recall very well her stated concerns back in January regarding the Offences Against Person Act and sections 58 and 59 and we all join in welcoming the fact that this is now being addressed. I asked Dr. Holohan this morning if in is view, as chief medical officer, this complies with the obligations of the State, as set out in the expert group

report. From her practitioner perspective, I would like Dr. Mahony's confirmation that is also her view.

Deputy Mattie McGrath:

I welcome our guests. At the hearings of the committee in January Dr. Mahony dismissed the notion of performing late-term abortions in Irish hospitals. However, this Bill contains no term limits. While she told *The Irish Times* that babies who were viable would be kept alive, there seems to be a legal question about a potential liability which arises for doctors who deliberately induce a physically healthy child who was being carried by a physically healthy mother. Even if viability becomes a term limit for abortions, I would like an answer to the following scenario. A woman presents in the 20th week of her pregnancy. She is suicidal and requests an abortion and this is granted. The 20-week old baby is not viable outside the womb but the baby has been fully formed for many weeks. The baby is quite big, perhaps up to 10 inches long, reacts to her mother's voice, can feel pain and the mother can feel movement. What I would like to know is what procedure Dr. Mahony or any Irish doctor operating under this proposal undertakes at this point to end the life of the child?

In the United Kingdom there are two methods used. Either a D and C is performed where the unborn baby is dismembered or the unborn baby is given an injection into the heart which causes it to have a fatal attack. Will either of these procedures be used in Irish hospitals? Are doctors in this country trained to perform these procedures?

I believe Dr. Sam Coulter-Smith made the point at the Medical Council recently that he had been forced to react to an *Irish Independent* headline in which he had been misquoted. I understand he has issues with the media.

Chairman:

I am sorry, Deputy, but we are discussing the heads of the Bill. We are not discussing the *Irish Independent* , the *Irish Examiner* or *The Irish Times*. On the heads of the Bill, please.

Deputy Mattie McGrath:

I believe Dr. Coulter-Smith has an issue with the media. Does he believe some elements of the media are covering the issue fairly?

Chairman:

That is not relevant to our business today.

Deputy Mattie McGrath:

It is all relevant, as far as I am concerned.

Chairman:

It is not; we are dealing with the heads of the Bill.

Deputy Mattie McGrath:

I have questions for Dr. Peter Boylan and Dr. Mahony. I understand they are related through marriage-----

Deputy Ciara Conway:

On a point of order-----

Chairman:

Thank you, Deputy; I am chairing the meeting.

Deputy Mattie McGrath:

Good man.

Chairman:

I am sorry, Deputy, but I ask you to withdraw that last remark.

Deputy Mattie McGrath:

I have no intention of withdrawing it. I am concerned that-----

Chairman:

As Chairman, I want to be fair to everyone.

(Interruptions).

Chairman:

I want to be reasonable, objective and impartial. The Deputy's commentary has no relevance to the heads of the Bill.

Deputy Mattie McGrath:

The disappearance of the Minister this morning had as much relevance as what I said.

Chairman:

Please, Deputy.

Deputy Mattie McGrath:

Given that the two doctors are leading advisers among the physicians in favour of the proposals made, is there a danger of group-think?

Dr. Peter Boylan:

We are related by marriage but not that closely.

Deputy Robert Dowds:

The experts only answer the questions to do with the heads of the Bill.

Chairman:

They are well able to do so.

Dr. Peter Boylan:

Deputy Billy Kelleher raised the issue of self-destruction or suicide in pregnancy. My expertise and that of obstetricians is in the area of obstetrics, not psychiatry. I understand the council of the College of Psychiatrists of Ireland has made a submission. It is the representative body of the more than 800 psychiatrists in the country. As an obstetrician, I am happy to defer to their expert opinion. If a woman is referred to me by a psychiatrist whose opinion I respect - an opinion which is not driven by ideology but by care for the woman, taking everything into account - and if that psychiatrist believes the only way she will be prevented from killing herself - it is her life I am talking about - is by terminating that pregnancy and if I trust the psychiatrist's opinion, I will terminate the pregnancy. If the mother dies through suicide, so too does the baby. This is about the protection of life in pregnancy. That is my comment in that regard.

I advise the committee that it should not really give much credence to evidence which is not expert in this area. I also advise it and perhaps the broader public and the Government in general not to be misled by bad science. Medicine and society are littered with examples of the damage bad science can cause. One of the most recent examples which will be fresh in people's minds is the evidence from the United Kingdom of the bad science about vaccination and a link with autism in children. The consequence of that bad science has been many children dying and many ending up mentally handicapped. If the committee plans to interpret scientific studies, I advise that members should make sure they are from a good reputable source and that they have been properly conducted. That is all I wish to say about suicide.

Dr. Sam Coulter-Smith will deal with the point raised about the Medical Council. I am very satisfied with the legislation proposed. I did not go through my commentary on the various heads of the Bill because I did not understand that was part of my opening presentation but, no doubt, it will arise during the course of the discussion. I am happy to deal with the individual heads, if the committee wishes and there is time to do so.

Foetal viability is considered in all of our clinical decisions. This arises, for example, in the case of women with extremely severe hypertension. In that case if a mother has seizures, she may well die or she may effectively become brain dead or blind if we do not deliver the baby. We will deliver a baby at 23 weeks in order to save a mother's life. As I said, we cannot allow a woman who is pregnant to die in front of our eyes. We cannot allow her to get to a situation where she may kill herself. If she kills herself or she dies, the baby dies too.

Deputy Mattie McGrath and others asked about the method of termination. The majority of terminations of pregnancy will be done medically by induction of labour, certainly in the early stages of pregnancy. We do not at any stage set out to destroy life. The Bill is about the protection of life in pregnancy; it is not about the destruction of life in pregnancy. The concept that Irish obstetricians would involve themselves in dismemberment of a living

foetus is, frankly, on the extreme end of I am not sure what, but it is on a very extreme edge of opinion and not one that would be shared by us.

In reply to Deputy Caoimhghín Ó Caoláin, there are no intensive care units in the three Dublin maternity hospitals. That is one of the reasons we need relocation in order to be located close to general hospitals with intensive care facilities. Despite this, we have very good working relationships with the general hospitals. Holles Street Hospital has a very good relationship with St. Vincent's Hospital. We transfer women to St. Vincent's Hospital when they are very ill and require intensive care. It is not entirely satisfactory because they have to be put in an ambulance, sometimes on a ventilator, and transported. We deliver babies in St. Vincent's Hospital on occasion when we believe the mother will be at risk, particularly in a case of a severe form of placenta previa where there can be dangerous bleeding. There is that precedent, but it would be much better if we were co-located. When the Deputy is in government, no doubt he will accelerate that process.

On the question about designated hospitals, I make the point in my submission that because of the way things will happen in emergencies all Government-approved hospitals in the State should be designated rather than just the maternity hospitals or maternity units in general hospitals. Things can happen very fast. One cannot have a situation in Mount Carmel Hospital, for example, where a woman is going to die if she does not have a termination of pregnancy, but she is put in an ambulance and dies on the way to a designated hospital. It is a minor point, but it should be considered by the committee when reviewing the Bill.

On the specialist register question, some of the more senior colleagues are not on the specialist register, even though they have been consultant obstetricians for many years. This is a result of historical reasons because a specialist register was introduced by the Medical Council in 2005 and some specialists have not bothered to put themselves on the register. That is a minor matter.

Everyone in this room will be aware of the relative shortage of specialists in the country. We have the lowest ratio of specialists per head of population in the European Union. On occasions such as at weekends and holiday times, particularly in smaller hospitals around the country, there is a dependence on locum consultants who may be registrars and who are in an acting up capacity. They are not on the specialist register. That point needs to be taken into account when the committee is considering alterations to the Bill.

Dr. Mahony will answer the question about the expert group. I think I have dealt with all the questions raised.

Dr. Sam Coulter-Smith:

On the question of whether we should legislate for suicide, even in the absence of the X case, my view is that this legislation is required to protect doctors and give reassurance to mothers and their families that when a woman's life is at risk for whatever reason, doctors are duty bound to look after the baby, if at all practicable.

When there is no option but to terminate a pregnancy, then that is what they should be covered to do.

We are not mentioning cancer or heart disease; I am not sure whether we should be mentioning suicide. I think there is an issue there. It widens the problem by including suicidality - risk of self-destruction - but my understanding is that we have been told by the European court that this is what we must do. I suppose what I am trying to do here is trying to point out the issues for obstetricians if suicidality is included in its present form.

In regard to whether we look at the viability of the baby, of course we do. If we are lucky enough to be in a situation where a woman who becomes unwell is 37 or 38 weeks pregnant, then we terminate the pregnancy by induction of labour or by caesarian section, depending on the situation. If bringing her pregnancy to a conclusion happens at 27 or 28 weeks, then those babies have a very good chance of survival given the standard of intensive care we have for those babies in this country. As Dr. Mahony rightly said, we have babies surviving in all our maternity hospitals from 23 weeks on but before 23 weeks, these babies unfortunately do not survive. I am not sure if that answers the question in totality.

Dr. Boylan mentioned methods of termination and I would be entirely in agreement with him. I am glad the committee has picked up on the fact that none of three biggest maternity hospitals in the country have access to intensive care on-site. This is a big issue for us. We transfer patients not on a daily basis but certainly on a weekly and a monthly basis to our sister hospitals. These are our sickest patients and we should have access to intensive care facilities on-site - not five minutes away by ambulance but actually plugged in and in the right way, and in hospitals designed in the right way so that we can look after our sickest patients appropriately.

There was a question about what does one do with a patient who is suicidal at 20 weeks. I think one gets a psychiatrist to see her. The psychiatrist will take a view on the best method to manage that. If, in extremely rare circumstances, termination of pregnancy is what is required in that situation, then a discussion will have to be had with obstetric colleagues as to how that should be best achieved. I echo the comments Dr. Mahony and Dr. Boylan made in regard to the specialist register. That is an important area which needs to be covered in this legislation.

Dr. Rhona Mahony:

I will answer the questions Deputy Kelleher raised. If the X case did not exist, would we still legislate for suicide? Suicide is death. We are legislating here for the substantial risk to life. If one commits suicide, one dies so, inherently, when someone plans to take their life, they are at risk of dying. I make no distinction between medical and physical risk to life. I am not talking about mental health disorder but about the intent to commit suicide which can occur without a history of mental disorder.

In terms of suicide and all the evidence we talk about, the incidence of suicide is about one in 500,000. There is no evidence. When a condition is that rare, it is impossible to perform adequate research or studies which inform one because the condition and the outcome are so rare. If one was to truly examine the issue of suicide, one would have to take a group of women who planned to kill themselves and randomise them to termination of pregnancy to prevent them from killing themselves or to not being allowed have termination of pregnancy. I suggest that studies should never be done. What we do instead is we defer to our psychiatric colleagues who are expert in the assessment of suicide ideation and they use their clinical experience and acumen.

Does the legislation do what we wish and does it give us clarity? I think it does in a number of key areas. It now gives us a framework in which we can define a substantial risk to life. That is supported by the law and that is one of the key issues. It also addresses the issue of the 1861 Offences Against the Person Act which hangs over us with that chilling effect. In addition, and very importantly, it gives women, if they feel they are going to die or are at risk of dying, a process through which they can determine whether termination of pregnancy is appropriate. That is very important.

I have said a lot already about the threshold of viability and I am concerned that this message still does not seem to be getting across. When we deliver babies, we do our utmost to protect and vindicate that baby's life. We are mandated to do that; we must do that and we wish to do it. I have no desire to see late termination of pregnancy coming into this country. That would be an affront to me. I spend a great deal of time in my own medical practice trying to look after both the mother and the baby but I am aware that if a mother dies, her baby dies too and we must prevent the unnecessary death of two people. Therefore, we will do our best to prolong the pregnancy until a baby is viable and again if a baby is born at that threshold of viability, every effort is exhausted to optimise that baby's chances of survival but one simply cannot allow a woman to die.

In terms of the scenario of delivering the 20-week old baby at the threshold of viability of a woman who has suicidal intent, that woman requires assessment by an experienced psychiatrist. In terms of the method, we do not kill babies; we do not destroy babies. We induce babies medically. Dilation and extraction at 18 to 20 weeks is a very dangerous procedure. We are not trying to kill women; we are trying to save their lives and so they will be induced medically - a medical induction of labour where, as Dr. Coulter-Smith has said, after viability is achieved and by whatever method is practicable.

I will address Deputy Ó Caoláin's issue. Again, I am echoing my colleagues on the whole issue of intensive care. The three Dublin maternity hospitals are quite unusual and unique in terms of obstetric care in that they stand-alone. This is not normal for an obstetric hospital and it means that not only are we deprived of intensive care facilities but we are deprived of a whole range of on-site medical facilities that would be very useful to us. For example, we transfer our tiny babies to access an MRI scanner because we do not have one on our site. We must transfer patients everyday for simple scans to see if they have a deep venous cloth in their legs. There is no doubt that co-location with an adult hospital is the way to go. It is not just me saying this, that is supported by an independent international recommendation in the KPMG report.

I refer to the technical issue on the wider number of hospitals. Sometimes we elect to deliver women in a general hospital because of the concurrent medical difficulty she might have. In addition, in an emergency, we cannot have a situation where we have to require to transfer a patient to an obstetric unit for determination of pregnancy. Therefore, it is very important that we include all Government-approved hospitals in this legislation.

Again, Dr. Boylan has covered the issue of specialist omission. This is a historic omission. Some doctors have simply not put themselves on to the specialist register, which began in 2005, so perhaps for the sake of safety we should use the term "obstetrician-gynaecologist". This again would cover the situation of locums.

I was asked about the recommendation of the European court in the case of A, B and C *v.* Ireland. Central to that is that we are now obliged to find a process for women through which they can see if they qualify for termination of pregnancy and, when that happens, whether they are able to access termination of pregnancy when their lives are at risk. Today all of this is restricted to when a woman is at risk of dying.

Again, I would say that this legislation gives us the protection we need to allow this happen. It addresses the issue of providing a process. It allows us to establish substantial risk in a way that is supported by the law and it gives a woman a process through which she can explore this risk when she perceives herself to be at risk of dying. In terms of suicidal intent, it is always a psychiatric assessment and we defer to our psychiatric colleagues in this.

Deputy Ciara Conway:

I thank the witnesses for their presentations. I would like to ask Dr. Coulter-Smith about the point he raised in regard to the difficulties he and maybe some of his colleagues in his hospital face on the suicide issue.

As I understand it, suicide is still among the top four causes of maternal death. Is that true? If it poses such a high risk, how could we fail to legislate for it? Suicidaility, particularly in a crisis pregnancy, tends to peak in the third month, and an unwanted pregnancy is a relevant risk factor. Risk management requires access to services. If we were to fail to legislate for that issue, we would be limiting access for those women who are suicidal. I have a simple question, which I put to each of the witnesses. Will the legislation save lives?

Deputy Peter Fitzpatrick:

I thank the witnesses for making themselves available. My first question is for Dr. Boylan and Dr. Mahony. Will every effort be made to save a baby's life in every case where a pregnancy is terminated post-viability? Can Dr. Coulter-Smith explain the difference between abortion and necessary medical treatment which may result in the death of the baby? Are all three doctors satisfied that the proposed legislation will provide for mandatory care of newly born children resulting from later stage termination in order to vindicate the equal right to life?

Deputy Regina Doherty:

I thank the three witnesses for attending. My questions are primarily for Dr. Sam Coulter-Smith. He referred earlier to the ethical dilemma with regard to suicidal intent. Does that ethical dilemma still exist personally or professionally if a patient in his hospital is prescribed a termination of pregnancy by her psychiatrist?

Dr. Coulter-Smith referred also to the ethical dilemma he would have about delivering very premature babies and the conditions which might arise thereafter. Who is currently responsible for delivering premature babies in circumstances, for example, of severe pre-eclampsia or other, what might be termed, medical conditions which give rise to a medical intervention?

I apologise if I am wrong, but I think Dr. Coulter-Smith mentioned in his presentation that he feels the introduction of the legislation could lead to an increase in abortions. Can he explain how and why he feels that?

Senator Colm Burke:

I thank all of the witnesses for their contributions today. I want to raise an issue in relation to the submission by the Irish Medical Council this morning. The IMC is at variance with a proposal in the heads of the Bill. Its proposal is that the text in head 4(1)(*b*) should be amended to read:

> two psychiatrists, have, in accordance with this head, jointly certified in good faith that-
>
> > (i) there is a real and substantial risk of loss of the pregnant woman's life by way of self-destruction, and
> > (ii) in their reasonable opinion this risk can be averted only by that medical procedure.

The IMC is saying two psychiatrists should sign off on that and then there would be a consultation with an obstetrician. What is the view of the witnesses about that?

Do the witnesses feel that there is adequate protection in the heads of the Bill in relation to the decisions they have to make on a day-to-day basis, particularly where decisions are being made in respect of a person who is under 18 years of age?

One of the witnesses referred to the consultant-patient ratio in this country compared with others. It would be helpful if we could be given the figures comparing Ireland with one or two other countries. It is important to get that information out there given that we have a very high number of patients per consultant compared with other countries.

Deputy Denis Naughten:

All three speakers this afternoon have said they do not destroy the foetus in the termination of a pregnancy. The legislation as proposed is silent on the issue, however. Do the witnesses believe there should be clarity regarding the procedure used to terminate the pregnancy? I do not mean that it should specify the means but rather that it might refer to destruction versus induction. It seems that induction is what we are talking about here whereas the legislation is silent on the matter.

Dr. Mahony in her evidence last January said that there was no definition of substantial risk to life during pregnancy in terms of whether it meant a 1%, 10%, 50% or 80% chance of dying. Is she satisfied that she has clarity in relation to that in the heads of the Bill before us?

Dr. Tony Holohan gave evidence this morning that there may have been women who have had early deliveries due to suicidal ideation. Can each of the witnesses say whether they are aware of women falling into that category in their three hospitals? If so, what numbers have been involved?

It is clear from the heads of the Bill that for a facility to provide services under the legislation, it must be a maternity hospital, it must have psychiatric support and it must have

neonatal facilities. Few if any of those facilities exist in any location currently. Can the witnesses clarify whether such facilities exist or state what challenges there are to compliance with the legislation as it is proposed to be drafted? Do they believe psychiatric support should be perinatal or simply involve a psychiatrist?

Dr. Boylan mentioned quite correctly the issue of bad science. It is vital we have clarity on that. He might comment on the reports by Professor David Fergusson who has reviewed the evidence in this area and said there is no evidence to show that a termination on a mental health basis improves the quality of the mental health of the individual.

Dr. Rhona Mahony:

Deputy Conway said suicide was among the top four causes of maternal death. It is very difficult to estimate the incidence of suicide. Occasionally, that verdict can be returned as an open verdict. According to the triennial report on all deaths in Ireland between 2009 and 2011, there were two cases of suicide and I understand there was an antenatal case of suicide last year. Suicide is extremely rare and the numbers can be difficult to estimate.

I was asked if legislation will save lives. Legislation will provide legal protection and flexibility for doctors to do their job. I believe it will give doctors some peace and prevent hesitation where doctors are uncertain about whether they may act. Doctors will always try to save a life but at the moment what is wrong is that they do not have the necessary legal protection. That is really what the Bill is providing.

In terms of mandatory care for a late delivery, we care for all babies. I have to keep saying this. Once a baby is viable, we give that baby every support to survive, regardless of why the baby is born. If the baby requires support to survive, we do that. We will always vindicate the life of the foetus. That is not at issue.

I will allow Dr. Coulter-Smith to address the ethical dilemmas surrounding suicidal intent. In terms of the Irish Medical Council's proposal on head 4 and whether or not there are two psychiatrists, we must be clear that obstetricians and psychiatrists have very different roles. I am not qualified to assess suicidal intent or ideation. However, in a patient who may require termination of pregnancy because an expert psychiatrist feels she will kill herself, there are obstetrical considerations and, therefore, there must be a team involved. We work as a team, generally. These are rare, complex cases and it is very much our culture that we function as a team and include a broad range of disciplines. It was interesting that Senator Burke asked about the patient who is under 18 years of age. Of course, she is X. I interpret this head of Bill as legislating for the X case and would argue that it is X who is very vulnerable and who needs to be protected by the State.

Let me just remind members about X - she is a 14 year old child who has been abused and raped and who is pregnant and wants to kill herself as a result of that pregnancy. She needs to be listened to, believed and protected.

I was asked about something I said when I presented in January about defining risk at 1%, 5% or 20%. The point is that two qualified specialist doctors in whatever field, such as an obstetrician and a cardiologist, an obstetrician and a liver doctor, or two obstetricians in the case of an obstetric intervention, can assess the patient's clinical case in its entirety and can come to a conclusion in a way that is supported, or will be supported, by law. It will be

impossible to draw up a list of the reasons we can terminate a pregnancy because, invariably, that is impossible. Now we have a process supported by law, and I welcome that.

In terms of the legislation being silent, and the comment that there is no upper limit and that we can destroy foetuses, at the risk of repeating myself time and again, I understand that Article 40.3.3° still stands. Perhaps this needs to be clarified when the lawyers appear before the committee. I understand the 25th amendment still stands and I understand that, according to these provisions, where it is practicable, I am obliged to vindicate the life of the foetus. I have always practised in this way and I always will. I have no wish to kill babies but I want to make sure no woman under my care dies. If she dies, her baby will die too.

All 19 units are able to cope with routine obstetric emergencies and they are all able to give that comprehensive cover. In an emergency setting, all units are equipped to deal with that. When it comes to complicated medical cases, not all 19 units have that medical expertise. Indeed, the National Maternity Hospital, which is one of the busiest maternity hospitals in Europe, will often refer patients to St. Vincent's Hospital, for example, because of medical complications. We are well used to networking and it is normal medical practice to refer patients for opinion. We can obtain opinions over the phone and it is our culture to practise obtaining as much opinion as we can about the patient. We discuss patients quite often and we get as many opinions as we think we need. We are caring for women and we will obtain the opinions we need. We are well used to networking. This goes on all the time, day in, day out, in terms of psychiatric practice.

I am not a psychiatrist, but with regard to this business that there is no evidence that termination of pregnancy is a treatment for suicide, we are not talking about treating - we are talking about the risk to life. If members want to remove suicide from the legislation, in the X case, involving a 14 year old girl, is everyone in the room absolutely certain there was no way that X would kill herself and no way that she would die? In the case of a woman who does not want to be pregnant and who is so distressed by her pregnancy that she tells us that she wants to kill herself, can we all sit here and say we are absolutely certain she will not kill herself? I cannot.

Dr. Sam Coulter-Smith:

I thank the Chairman. With regard to suicide and where it ranks in terms of maternal mortality, suicide is extremely rare in pregnancy. According to the UK figures, it is around one in 500,000. It is extremely unusual and there are much more common causes of maternal death. This is really more a question for psychiatrists. From my discussion with psychiatrists, particularly in our hospital, it can be extremely difficult to decide how suicidal a woman is and how to rate it. Our psychiatric colleagues tell us that, in pregnancy, if a patient's mental state is so altered that she has suicidal ideation or suicidal intent, she needs psychiatric treatment. If the psychiatrists tell us the only way the woman's life can be saved is through a termination of pregnancy, it will require a number of psychiatrists to agree with that view. If that is the case, following a multidisciplinary meeting about the case, that is what we will do. The legislation confirms, reassures and provides clarity, certainty and protection for the doctors involved in the treatment of pregnant women in these very difficult situations. It also provides clarity, reassurance, certainty and protection for the mothers and their families. With regard to the protection of the baby, I totally agree with what Dr. Mahony has said. In every situation where intervention must be made in order to save the mother's life, we do our utmost to prolong the pregnancy as long as we possibly can to give the baby every chance of

survival. Intervention is only made at the point at which we feel that if we do not intervene the mother may die.

With regard to the Medical Council recommendation on the number of psychiatrists and obstetricians involved in the decision, it is a resource issue for our professions. I will allow the psychiatrists to answer the question about their specialty. If we get an increase in the number of women seeking to avail of termination of pregnancy in this country based on the legislation, there will be resource issues for our obstetric personnel, our psychiatric personnel and our hospitals.

On the question of the legislation being prescriptive or silent on the methods of termination, I do not think the legislation should be prescriptive in any way. The decision on how a pregnancy needs to be brought to a conclusion is based on a large number of factors. The method used will be one that is the safest for the mother in any particular situation.

On the question of whether the scheme of the Bill provides adequate protection for us as doctors, I think it does. It goes a long way towards bringing forward legislation that sits well with the Medical Council guidelines, which is good. In the case of a minor - someone under the age of 18 years - there are appropriate services that need to be put in place to deal with younger women. Professionals in mental health care need to be made available to allow the appropriate care to be given. The same multidisciplinary team involvement will be required in any major decision-making for patients who are minors and for older women.

Dr. Peter Boylan:

A number of points have been raised. The issue of suicide has come up again, as has the incidence of suicide in pregnancy. Until recently, the CSO did not stipulate that it had to be included on a death certificate whether a woman was pregnant in the recent past. We will never know the incidence of suicide among women in the early stages of pregnancy. From time to time, coroners have issued verdicts that avoided the use of the word suicide out of sensitivity to the families involved. It is understandable but perhaps not helpful in other contexts. I will say no more about suicide; it is a matter for the psychiatrists, but it is important that members understand that we just do not know. A question was directed to me about Professor Ferguson's paper and bad science. I defer to the College of Psychiatrists of Ireland, which will deal with this in evidence on Monday. I am not a psychiatrist and, as I emphasised before, we should be wary of people interpreting articles, information or papers in a field in which they are not practising on a daily basis and in a field in which they are not expert.

I would not give an opinion on an orthopaedic problem to somebody who might need a hip replacement. I would not dare give that opinion. Similarly, I would not give an opinion in regard to psychiatric problems. I am not trained for that and I have no experience in it. We will always strive to save the life of the baby. We make those decisions on a daily basis. There are ethical issues involved and we deal with those on a daily basis as well. That is what we do in our practice so there is no big problem in respect of that.

Under the heading of reasonable opinion in my statement, I said that I welcome the confirmation that the constitutional protection to the right to life of the unborn child is retained at all times where practicable. Some campaigners are attempting to suggest that late terminations will be performed in Irish hospitals if this legislation is passed, implying that

doctors would deliberately kill an unborn baby who is capable of existence outside the uterus. Some of the more extreme groups are suggesting that newborn babies might be killed if this legislation is passed. These views are clearly extremist, have no basis in fact and are, quite frankly, insulting. There should be no suggestion that obstetricians and neonatologists would ever fail to make every effort to maintain the life of a baby once the threshold of viability is reached.

I refer to the issue of how we assess the risk. The legislation reflects the judgment in the X case by saying it is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate, as this approach insufficiently vindicates the pregnant woman's right to life. We are talking here about the right to life of a woman and we need to remember this in discussing this entire issue. It is interesting, though, that no figures are available for what percentage risk of death is acceptable and I hope that, in the future when the legislation is passed, that we, as obstetricians, will be able to take into account a woman's point of view as to the degree of risk she is willing to accept. Some women are willing to accept an extreme risk and are willing to die in order to hope that they might have a child; other women decide that the risk is too great for them and, in these circumstances, when the outlook is utterly hopeless they prefer to have a termination of pregnancy and perhaps try again. I need not elaborate on that anymore. We have to be careful about trying to quantify risk that is unquantifiable.

The question of consultant numbers and ratios has come up and the committee would like some figures. The figure in our maternity hospitals is approximately one consultant per 1,000 deliveries. The ratio in the UK, with which we are frequently compared in all sorts of ways, is less than one in 500. We are one in more than 1,000. Those of working in the National Maternity Hospital recently visited a hospital in Malmo, Sweden, which is of similar size to our hospital. There were 30 consultants on the staff there; we have eight. I hope that answers the question. It means that obstetricians working in this country have no shortage of experience in dealing with complicated obstetrical cases and are well able to make decisions in the best interests of both patients for whom they are caring.

Have I left anything out?

Chairman:

No. Deputy Doherty had a question for Dr. Coulter-Smith.

Deputy Regina Doherty:

The only reason I asked the question again is because his opinion is so highly regarded, I would not like it to be misconstrued by people. He said if we introduced this legislation, it could lead to an increase in abortions. How and why?

Dr. Sam Coulter-Smith:

I said in my statement that it may lead to an increased number of requests for termination of pregnancy in this country. The reason I say that is I do not have any understanding - I do not think anybody has any understanding - of the numbers that could try to avail of the service in this country if it is passed into legislation. Currently, approximately 5,000 women a year and probably more go from Ireland to the UK for termination of pregnancy. They never cross the

threshold of our maternity services. We do not know who they are and we do not have any understanding of the issues they have. Some of them are crisis pregnancies and some are a result of rape and incest. It is unfortunate that those areas are not covered in this legislation but that is a conversation for another day. Because we do not know who these women are and what their issues are, we do not know how many of them may try to use this legislation to get a termination in this country. If they do, then the point I was making is that we do not have the infrastructure, resources or the staff available to deal with that issue if it arises.

Chairman:

Deputy Fitzpatrick indicated that his question was not answered.

Deputy Peter Fitzpatrick:

I asked Dr. Coulter-Smith to explain the difference between abortion and necessary medical treatment which may result in the death of the baby.

Dr. Sam Coulter-Smith:

An abortion and a termination of pregnancy is when a pregnancy is brought to an end. Most people's understanding of that terminology would be when that process occurs early in pregnancy. In most situations, terminations or abortions are performed before 12 to 14 weeks. What was the second part of the question?

Deputy Peter Fitzpatrick:

It related to the necessary medical treatment for the mother, which could cause an abortion.

Dr. Sam Coulter-Smith:

Is the Deputy talking about a situation where a woman may have cancer of her womb?

Deputy Peter Fitzpatrick:

No, I refer to where a woman is undergoing medical treatment and she gets medication, which would cause the death of the unborn child. What is the difference in this regard? Does that happen much?

Dr. Sam Coulter-Smith:

The sort of thing the Deputy is probably talking about is in the realms of oncology where a woman has some form of cancer that requires treatment, which may be harmful to the baby and result in the death of the baby. Is the question what is the difference between the two?

Deputy Peter Fitzpatrick:

Yes.

Dr. Sam Coulter-Smith:

Both will lead to the termination or the end of the pregnancy.

Deputy Denis Naughten:

Dr. Tony Holohan made the point earlier that there may have been early deliveries on the basis of suicidal ideation. Was there any experience of this in any of three hospitals? When the witnesses reply later, they might respond to that.

Senator Ivana Bacik:

I thank the three witnesses for bringing their expertise for our benefit. I thank Dr. Mahony, in particular, for reminding us so powerfully of the facts of the X case and of the evidence of the suicidal intent of that unfortunate young woman. We have heard useful evidence about the lack of access to intensive care units in the maternity hospitals. All three witnesses have suggested that the definition of "appropriate location" under head 1 should be broadened to include Government approved hospitals. Related to this, under head 4, it is required that one of the two psychiatrists would be attached to an appropriate location, that is, to a maternity unit. As Dr. Coulter-Smith pointed out, currently only three sub specialist psychiatrists are attached to the three large Dublin maternity hospitals. Does that mean in Dublin if a woman is seeking to access the procedure under head 4, there are only there psychiatrists from whom one psychiatrist can be drawn? That is a restrictive pool. We heard earlier from the medical bodies that this restriction might not be practicable. It might be too restrictive and it might be better to require that a psychiatrist be defined more broadly because many of the women will be young girls, in respect of whom a child or adolescent psychologist might be more appropriate.

Dr. Boylan, in his submission, pointed out the time limits for the review process under head 6. He pointed out very helpfully that the time limit would currently allow for 14 days before the clinical review could take place, which would lead to undue delay for a woman in accessing her constitutional right to life. What sort of time limit would be practicable?

With regard to the finding on the criminal offence and the chilling effect currently provided in the 1861 Act, is the new wording in head 19 sufficiently tightly drawn to ensure the chilling effect will be reduced or removed? In particular, should the woman herself be criminalised? The head refers specifically to the Criminal Law (Suicide) Act 1993 as a model. Under that Act, the person who attempts suicide is not himself or herself criminalised, only those who aid and abet the person.

Chairman:

I call Deputy Mary Mitchell O'Connor.

Deputy Mary Mitchell O'Connor:

The master of Holles Street hospital has answered my question very comprehensively.

Senator Jim Walsh:

My first question is for Dr. Boylan. In respect of head 3, he states consideration should be given to the possibility that termination might need to be carried out in a private institution. Could that include Marie Stopes?

With regard to head 6 and the point made by Senator Bacik, when the psychiatric personnel were before us they actually made the point that the appropriate treatment for somebody who is suicidal would be to take them into care for a minimum of a couple of weeks, in which period they would be observed and treated, before determining what should happen next. Dr. Boylan seems to be ruling that out as a possibility.

Dr. Mahony laid heavy emphasis on the lack of clarity over when interventions can be made at present. I remember when she was here on the last occasion. Was there any occasion on which she was unable to intervene, leading to the death of a mother under the current legal position? Dr. Mahony mentioned Ms X and stated she should be listened to. I do not disagree with her. She will know that Ms X did not have an abortion. In 1997, Ms C was brought to Britain unaware of the fact that she was going to have an abortion. She was subsequently suicidal. She was in this House two days ago talking to Members. Should Ms C and women who have had abortions and who have suffered from serious trauma subsequently, sometimes for 20 and 30 years, not need to be listened to also?

I thank Dr. Coulter-Smith for the clarity of his presentation. He mentioned something that struck me. It was stated that if one carries out an induction of a baby of 25 weeks, there is a risk of death or disability and cerebral palsy. That was not mentioned by Dr. Boylan or Dr. Mahony. Does Dr. Coulter-Smith agree it is a possibility? I have been told by an obstetrician that there could be a 50% chance of cerebral palsy for that early delivery. Do Dr. Boylan and Dr. Mahony agree that we should operate on the basis of evidence-based medicine and, above all, do no harm? Can they point to any evidence that will actually vindicate the position that abortion is a treatment for suicidality? I acknowledge that is outside their range.

The spectre is being raised that this, perhaps, is a very restricted regime. I suggest that the doctors examine California's Therapeutic Abortion Act 1967. Within three years of enactment, the number of abortions grew from hundreds to 61,000. An expert and constitutional scholar in the Visitors Gallery, Mr. Linton, will be able to fill in the witnesses on precisely what happened in that area. The committee chose not to hear him but I am sure he will talk to the witnesses privately and advise them on the challenges facing us because of the opening of the suicidality issue.

Senator John Crown:

Hearing politicians lecturing specialist doctors about following evidence-based guidelines was one of the most eye-rubbing, incomprehensible moments I have experienced since I came to Leinster House.

Chairman:

If the Senator does not mind, he should speak to the heads of the Bill.

Senator John Crown:

I am sorry about that.

Let me point to a little bit of evidence to which, I am glad, my friend and colleague, Dr. Boylan, has already alluded. The figures are that Ireland has 2.4 obstetricians per hundred thousand members of the population while the figure for the second lowest-rated country in Europe, the Netherlands, is four, which is twice as high. The Netherlands has a birth rate of approximately two thirds that in Ireland. Our proportion of obstetricians to members of the population is one third the European average, and we have one of the highest birth rates in Europe. None of the hospitals in our network can provide comprehensive care to a woman who becomes seriously ill in pregnancy. Most of our maternity care is being given in small units or specialist stand-alone hospitals that do not have adequate backup. My profession, our medical schools and hospitals bear some responsibility for this; the fault is not entirely that of politicians, but let us at least leave this Chamber after these three days of debate having put firmly on the public agenda the need to reform the way in which we deliver obstetrical care in this country. We need to reform it urgently.

Let me get down to the business of the moment, the endless tendentious questioning about the suicidality issue. All of the doctors who have been here will have been here because we follow evidence. There is extremely close agreement that it will nearly never happen that a doctor will be confronted with somebody who requires an abortion on grounds of suicidality. Some believe it will actually never happen while most agree it will, at most, happen very rarely. With regard to people's concerns, I fear that Dr. Coulter-Smith may have been misquoted in the national media, and that his concerns may have been misinterpreted today. I ask him to clarify this. He alluded today to the possibility that obstetricians in general might be forced to carry out a medically unnecessary abortion because a psychiatrist indicates an abortion is necessary, and obstetricians know that the evidence base suggests it never is. For the benefit of those present, could the doctor clarify that the people who would make that decision-----

Senator Jim Walsh:

I have here-----

Chairman:

One speaker, please, Senator Walsh. Senator Crown's time is up.

Senator John Crown:

I have been very careful about not interrupting. I am desperately fond of Senator Walsh as a person but his behaviour today has not been edifying. I am sorry to have to say that. He has been repeatedly rude today.

Chairman:

Could we speak through the Chair on the heads of the Bill?

Senator John Crown:

I ask Dr. Coulter-Smith and my other colleagues to clarify that they are satisfied that in the very rare and probably never-to-arise event of an abortion being recommended on grounds of

suicidality, it would be done by people who are actually aware of the evidence base of medicine and who would assess the matter and reach a unanimous consensus.

Chairman:

There are four members who want to speak. We are to conclude this section of the hearings at 4.35 p.m.

Dr. Rhona Mahony:

On Senator Bacik's point, we have already covered the lack of intensive care. I will come to Dr. Crown's comments presently. I passionately believe that the maternity hospitals should be co-located and that they require a great deal of further resources to carry out their day-to-day work.

I appreciate the comments on psychiatrists. The additional resources needed in psychiatry comprise a question best posed to the psychiatrists.

I am interested in the Senator's comments on head 19. She is absolutely correct. If a doctor has made an error in judgment or has not acted according to the law, I do not believe a woman could then be at risk of finding herself in breach of the law. If it were the case, it would not be wise law, I would argue.

The question of time limits is more related to Dr. Boylan. I agree, however, that we must be very careful that the appeal time not be too long. The appeal time must be appropriate to the urgency of the medical condition that is unfolding.

With regard to head 3, on the termination of pregnancy in private institutions, the concern must, of course, be addressed. I refer to the idea that one could set up a clinic and perform terminations of pregnancies. I think we can assume that Government-approved hospitals would get around that so it would not be possible to set up a clinic. That is not what we are suggesting here. Practically, it is very unlikely that a Marie Stopes or termination-of-pregnancy clinic would be dealing with very sick women at risk of dying. That is simply very unlikely. Most of the women would be in hospital because they would be very ill.

With regard to head 6, it seems to be a matter for the psychiatrist. There is a hint and a suggestion that we should be locking women up. I would always not concur with that, but that is a matter for the psychiatrists.

With regard to the effect, I have no doubt that the termination of pregnancy can be really harmful for a woman's health, and the circumstances surrounding it can be really harmful. I also believe that, on very rare occasions, it could save a life. That is my only comment on that. Psychiatry is not my area of expertise. With regard to delivery at the threshold of viability, I practice in foetal and maternal medicine and believe that there is no doubt that where we deliver babies at a very early gestations, there is a risk of cerebral palsy.

To give an example, the survival we expect now in Ireland at approximately 24 weeks is approximately 50%, and of those survivors we might anticipate that up to 50% of those babies will have cerebral palsy. These are enormous considerations and we spend much time, if we have time, talking to parents, counselling them and making them aware of this.

However, what we are talking about here is saving women's lives and we are making the assumption that if we do not carry out this termination or interruption of pregnancy, even if it is at 24 weeks and with all the risk of cerebral palsy, the woman will die and her baby dies too. It should be noted that medical obstetrics is extremely complex, as are these decisions. That reflects the complexity of what we do.

In response to Senator Crown, I am glad to have the opportunity again to talk about figures, because I missed that opportunity in the last round. I note the presence of Paul Cullen in the Press Gallery. He wrote a very nice article two weeks ago in which he looked at comparisons between here and the UK. He said Scotland has 121%, England 81% and Wales 63% more obstetricians than Ireland. I might be misquoting the figures, but it was clear there is a big disparity in the number of obstetricians here. Dr. Boylan says we have about eight obstetricians. It is actually fewer than that when talking in whole-time equivalents. The majority of consultants in our hospitals work between two areas, so when we look at the numbers ratios, we must look at whole-time equivalents. Dr. Boylan is correct that it is about eight whole-time equivalents. There are approximately 15 consultants on the staff but it is about eight whole-time equivalents. The same applies to neonatologists. We have just under four whole-time equivalent neonatologists looking after more than 9,000 babies.

There are huge resource issues that must be addressed, and addressed urgently in obstetrics. However, that is not a matter for this Bill. We must be very careful. The resource issues need to be addressed, but we drafting this legislation in the context of women who might die, so we must not let resource issues influence this important legislation which will last into the future.

What can we say about the rarity of suicide? It is extremely rare. I agree it is unlikely we will see it. We just do not see it because it is a rare condition which is best dealt with by psychiatrists. This Bill is not about legislating for suicide intent in pregnancy; it is not about suicide. It is about the risk of a woman dying, whether that is for mental or physical reasons. This Bill will largely cater for women who might die either because of direct complications of pregnancy or because of a medical disorder such as cardiac disease. We might never see a woman presenting through this process with suicide intent. She will likely go to England.

Dr. Sam Coulter-Smith:

With regard to the lack of intensive care facilities, I agree that head 1 must be broadened to include the general hospitals as some of our sickest patients will be in those institutions. It is absolutely correct that there are three specialist perinatal psychiatrists, all of them based in Dublin. This is a very restricted pool of professionals in this area. Not only are we under-resourced from a maternity services point of view, the mental health support of those maternity services is also under-resourced. It is something that must be addressed.

I have nothing to add to what Dr. Mahony said about decriminalisation in head 19.

To return to a question I missed earlier, I was asked if I was aware of any intervention in a case of suicidality. I am not.

There was reference to the Californian experience. I do not have any knowledge of that or of what legislation was introduced which might have led to that change.

We have talked in detail about the consultant-patient ratio. Our midwife-patient ratio is also approximately half of what it should be. The internationally recognised appropriate ratio of midwives to patients should be between 1:25 and 1:30. In our hospital at present it is approximately 1:50. That is in a situation where, at our peak levels of activity, there were 42 deliveries in a 24-hour period last December. That was delivered from nine labour ward rooms. One cannot imagine the level of activity and the risk associated with trying to put that level of activity through an extraordinarily busy labour ward. It is not a matter for this setting, but I should point out that the safety of the services we provide is down to the skill, dedication, hard work, missing meals and missing breaks of our extraordinarily talented and gifted midwives. We owe a huge debt of gratitude to that group, mainly women although there are some men.

In terms of Professor Crown's point about how often this situation occurs, I agree that suicidality in pregnancy is extraordinarily rare. Most obstetricians will go through their entire working life and not encounter this situation. However, it is important that if a woman's life is deemed to be at risk, she has access to the appropriate psychiatric care. If termination of pregnancy is deemed to be appropriate in that situation, that is fine. We will get involved and we will do that. However, it is important that gestation is not covered by that element of the legislation, and that leaves this open.

Dr. Peter Boylan:

With regard to Senator Bacik's points, the issue of head 1 being broadened has been dealt with adequately. I support everything that was said. As to whether a perinatal psychiatrist should be involved, we do not have three. We have one and a half. As Dr. Mahony said, these are whole-time equivalents, so we have 1.5 perinatal psychiatrists for 75,000 pregnant women per year. It is approximately 100,000 if one includes miscarriage. That is questionable.

Regarding the time for the medical review procedures, seven days is too long to initiate the process, with another seven days for the review team to give an opinion. These women are at risk of death and a fortnight is probably too long to wait in those circumstances. The circumstances will vary from one woman to another. We need to be able to individualise. My personal opinion is that seven days is too long.

On head 19, I have difficulty with the proposal that a pregnant woman who undergoes a termination will potentially face 14 years in prison. If a woman is subject to medical opinion and if that opinion, even if erroneously, concludes that termination is necessary to save her life, it is entirely unreasonable to expect her to second-guess a doctor's opinion in this respect. It would appear somewhat bizarre and contradictory to propose that a woman be sentenced to 14 years imprisonment on foot of accepting medical advice in this State, whereas should she travel to the UK and have a termination there, she is protected under the constitutional amendments of 1992. That does not seem to make sense.

There were several other questions relating to the Marie Stopes clinic and private institutions. The end of the sentence was omitted by Senator Walsh, that is, in emergencies. Women in emergencies will not be attending the Marie Stopes clinic and I doubt very much that the Minister would approve that the Marie Stopes clinic terminate pregnancies.

Head 6 is a matter for comment by the psychiatrist. In my practice I have not come across an instance where a woman has died because we have not terminated her pregnancy. I have come across it in other circumstances in the recent past.

Should women who have had an abortion be heard? Absolutely. Women who have had all experiences should be heard. However, the climate in which women have terminations in this country, albeit they have them abroad, is quite hostile. We should, perhaps, carry out some research on the influence of hostility, antagonism, guilt and so forth that these women experience and the inability, in particular for women who have foetal abnormalities and who go abroad for a termination, to grieve for the loss of that child. They grieve for them; these are very much wanted children.

Very often women who have terminations for apparent social reasons or mental distress very much want the child but cannot cope with the prospect. We need to listen to these women. It is not within the remit of this Bill. Of course we need to listen to women; that is what we are about.

Very premature babies have a risk of brain damage. Their brains are very fragile, they are exposed to lack of oxygen, they can have bleeds on the brain and, in effect, strokes, and end up with cerebral palsy, blindness, brain damage, etc. However, if the mother dies, the baby dies too. We have to make balanced decisions based on the best evidence of the woman in front of us, taking all things into account. We do not want to have two deaths on our hands. I think one should respect the professional opinion of professionals who are making these decisions.

There was a question about evidence-based medicine in the context of suicide. I will leave that to the psychiatrists. I am not an expert in that area.

The Californian experience was referred to. It might be useful - and I am sure the committee has done so already - to look at the experience in Northern Ireland where, as I understand it, termination is allowed for foetal abnormality incompatible with life and not just a threat to the life of a woman. There are about 40 terminations a year in Northern Ireland out of 25,000 births. If one extrapolates from that, there will probably be about 60 for 75,000 births in Ireland. That is a guesstimate, but it is certainly not thousands upon thousands. It is a small number. I thank Senator Crown.

Chairman:

There are four minutes remaining in this section and three members have indicated, two of whom have not yet spoken. I will call Deputies Maloney, Healy and Troy, and ask them to be brief.

Deputy Eamonn Maloney:

I welcome the witnesses, as others have done, and thank them for their contributions. I have long held the view that the relationship between all of us and our doctors is very special, and I think most people would hold that view. The relationship between a pregnant woman and her doctor is unique, based on care, trust and so on. I have always been uncomfortable with the idea of legislators - that is, people like myself - interfering in that relationship between a woman and her doctor in pregnancy and childbirth.

To use that awful phrase, "We are where we are." We are dealing with a Bill which is extremely restrictive and deals with only one item - namely, pregnant women whose lives are at risk by suicide. We are not dealing with women who are raped and conceive; I wish we were. We are not dealing with fatal foetal abnormalities. If we were brave enough as legislators we would be, but we are not.

We have to try to be honest about pregnancy and the law. It is the height of hypocrisy that the law of our land allows for information to be given to women who wish to avail of abortion. It goes even further, allowing free travel if one wants to have an abortion. However, when it comes to a very restrictive piece of legislation to show some care towards what have been described as rare cases, we wrestle with ourselves about doing so. We have to get to a stage where we as legislators will introduce legislation that will not even be availed of.

Chairman:

I ask Deputy Healy to be brief.

Deputy Seamus Healy:

It is important that we remember that the backdrop to the Bill we are discussing is the constitutional protection of the life of the mother and the unborn in Article 40.3.3°. It is also the background to the X case, which refers to the real and substantial risk to the life, as distinct from the health, of the mother, which can only be averted by a termination. We are talking about a situation in which there will be very strict and onerous access procedures in the Bill.

I have some brief questions for the medical witnesses. Are they happy that there is now legal clarity for medical practice as a result of the Bill? Are they satisfied that there is protection for medical and nursing personnel involved in these areas? Are they satisfied that the question of adequate access to terminations where they are medically necessary, which was referred to specifically in the European case, is provided for in the heads of the Bill?

Deputy Robert Troy:

I understood the purpose of these hearings was that those of us with no expertise in this area could be informed in order that we would be able to make an informed decision when we eventually come to legislate. That is why we are all here as legislators. The Supreme Court in the X case held that the correct test was that the termination of pregnancy was permissible if it was established as a matter of probability that there was a real and substantial risk to the life of the mother and that this risk could only be averted by the termination of her pregnancy.

The expert group said, regarding the application of the test, that although medical decisions may be difficult in particular cases, the complexities will not arise from the words of the test but from diagnostic and treatment issues, and that implementing the decision does not, therefore, require another definition of the test. Why do the witnesses think there is a need to separate physical illness and self-destruction? Should it not be left to medical professionals to determine what the real and substantial risk is? On the creation of a separate head on self-destruction, do the witnesses feel this will create a rebuttable presumption in this regard?

Chairman:

I ask Dr. Mahony to respond.

Dr. Rhona Mahony:

I note Deputy Maloney's comments. It is quite extraordinary that in Ireland the 1861 Act stands and we have not legislated for the X case, yet we have gone to great lengths, as I said earlier, to avoid addressing the reality of maternal death during pregnancy. Therefore, women are allowed to travel from this jurisdiction despite the fact that termination of pregnancy remains a criminal offence in Ireland. That is, of course, extraordinary.

Deputy Healy asked number of questions, some of which might best be addressed to the lawyers. When we talk about legal clarity and whether I am happy that the provisions in the Bill give us what we are looking for, there is provision to remove the 1861 legislation, which I favour. There is provision in the Bill to have doctors protected by the law in making their opinions, and where they perceive there is a substantial risk to life I believe, under this Bill, they will be protected in that regard, which is very important.

On whether there is adequate access, there are number of issues. In terms of emergencies, all of the 19 units in this country have comprehensive cover. For example, in the case of haemorrhage or fulminating blood pressure, all units in Ireland are capable of carrying out those procedures. If they are not, they should not be open for business, because if one is running an obstetric institution one must be able to take on obstetric emergencies.

In terms of access for more complicated medical disorders, as I said, we have a great network. We cannot have every single medical discipline in every single hospital. We do network for expert opinion and can pick up the phone and talk to each other. We all know each other quite well. We are used to working together. We have a culture of working together and of seeking other opinions.

On the specific area of access - namely, the question of seven days to make a submission and seven days for appeal - I agree with Dr. Boylan. We have to be very careful. There is a medical problem at stake and how imminent the risk of death is will determine the procedure.

Compared with many other specialties, obstetricians are well used to dealing with emergencies. In fact, a great deal of our business is emergency and unplanned in nature. If ever there was a specialty suited to delivering in this role, it is us.

An interesting question was posed in regard to midwives. If there is a liability, it lies with doctors who are the ones who assess the women and make the judgment. Such is the case in many instances in medicine. Where I make a decision to do an operation, I am responsible and accountable. That is how I practise.

The Supreme Court judgment is truly an interesting one. I will begin by saying, as I have many times, that I do not distinguish between physical and mental risk to life. We are talking about whether a woman will die. If she commits suicide, she is dead, in the same way that a woman might die from pre-eclampsia, haemorrhage or whatever else. I do not make that distinction. I am not a lawyer, but what is central to the whole judgment is the interpretation of Article 40.3.3°. Clearly, prior to any prospect of a baby surviving, because of prematurity, it cannot be about a balance of rights. That does not make sense. It can only be about the substantial risk to the life of the mother because if she dies, her baby dies too. That is central

to and the core of this whole issue. We must seek to prevent two unnecessary deaths and save women's lives. We cannot simply balance rights at 15 weeks gestation because then one will find against termination of pregnancy and I am afraid some women will die.

Dr. Sam Coulter-Smith:

Senator Marie Moloney referred to rape and lethal foetal malformations as grounds for termination. I agree that it is unfortunate these two issues are not covered in the legislation because they are serious and real problems for a certain number of patients.

In terms of legal clarity and protection for the medical profession, including the nursing profession and other health care professionals involved in such cases, the legislation goes a long way to providing the clarity, protection and reassurance they require in dealing with these extremely difficult cases.

In regard to the X case and the fact that suicidality is included in the provisions, the legislation should be all about protecting doctors in situations where they have to act in order to terminate a pregnancy to save a mother's life. It should not matter what the issue is, whether it be suicidality, cancer, heart disease, complications of pregnancy and so on. What we, as a profession, are seeking is the reassurance, clarification and protection we require under the law to enable us to act in the best interests of a mother, while, at the same time, always doing our very best to save the baby in these very difficult circumstances.

Dr. Peter Boylan:

I do not propose to say a great deal in response to the comments on hypocrisy and so on in this country because that is not relevant to our discussion on the heads of the Bill. I am happy that the Bill, if enacted with the alterations we are suggesting, will introduce legal clarity and provide protection for doctors, midwives and so on.

The question was raised about access in respect of the decision as to whether a woman is entitled to a termination. There is also the question of access in the case where the decision is that she should have a termination to save her life. We have discussed the issues relating to which hospital and so on and doctors' definition of a specialist register, etc.

Deputy Robert Troy asked why we should separate medical from psychiatric illnesses. I have always felt, like my colleagues Dr. Mahony and Dr. Coulter-Smith, that if a particular procedure is required to save the life of a mother, the reason the procedure is required should not depend on whether the risk to her life is a consequence of a medical condition such as a congenital or complex heart disease or the consequence of an imminent danger that she will kill herself.

An issue we have not covered in great depth is that of conscientious objection, which I propose to deal with briefly. It is important to note that this issue also applies to the mother. We, as doctors, may make a decision that a mother is very likely to die, unless there is a termination of pregnancy, but the woman herself may refuse that termination because she is willing to take the risk or she has a conscientious objection to undergoing a termination of pregnancy. As doctors, we will respect that wish. Likewise, the wishes of doctors and midwives who have a conscientious objection to being involved in a termination of pregnancy will be accommodated. Those of us who have trained abroad, in the United

Kingdom and elsewhere, have personal experience of this and not faced any difficulty when it has come to performing terminations of pregnancy, primarily for social reasons in the United Kingdom. There is no problem with this and no need for people to be afraid. Nobody will be forced under this legislation to do anything against his or her conscience. Everybody should be reassured about this. We are adult, professional people.

Chairman:

As we are talking about new life, I take the opportunity to congratulate Deputy Damien English and his wife Laura on the birth of their twin baby girls this morning.

We have completed the slot for members' questions and will now move on to questions from non-members, for which half an hour is allocated. Unfortunately, there will not be sufficient time to accommodate all ten non-members who have indicated. I will begin by calling Deputies Peter Mathews and Terence Flanagan and Senator Paul Bradford in that order.

Deputy Peter Mathews:

I thank all three doctors for attending. Dr. Rhona Mahony left us with a huge silence and a question in regard to the X case. The five women who had had abortions, some of them many years ago, who came to speak to us are left with deep scars in the same way that a physical injury leaves physical scars. Their scars have faded, but they have a lot of the answers which this legislation is trying to address, yet their request to attend the discussion on the Bill was declined. That is a screaming silence which more than matches the question from Dr. Mahony that left us with a stunning silence.

I say, "Thank you from my heart," on my own behalf and that of my family to all the doctors, obstetricians, gynaecologists, general practitioners, surgeons, nurses and midwives who assisted in the births of my children. I had the honour of attending all four births, each of which was a wonderful miracle. I hope the witnesses ask themselves from time to time the question of when they believe life begins. The sanctity and miracle of life, whether in plants or animals or human beings, are utterly important. Is Dr. Peter Boylan aware, to go with the bad science point, that it is now legal in Britain to mix hybrids of humans and animals? Scientists are allowed to work on these in laboratories until the hybrids reach 14 days gestation, at which point they must be destroyed. That is bad science.

Chairman:

Does the Deputy have a question on the heads of the Bill?

Deputy Peter Mathews:

This is a chance to discuss the core of the issue-----

(Interruptions).

Chairman:

No, we are discussing the heads of the Bill.

Deputy Peter Mathews:

The bad science in Britain has allowed approximately 7 million abortions. That is very bad science, irrespective of Professor Ferguson's research papers. We are talking about the deaths of 7 million people, more than in the Holocaust. In America 55 million lives have been lost.

I thank the witnesses for all the work they do to look after people. My wife was very important to me when she was pregnant. Equally important are my daughters, my sisters, three of whom are nurses, and my brothers, two of whom are doctors and may be known to the witnesses. This country has to keep foremost the value of life in everyday life.

Chairman:

The Deputy's time is up.

Deputy Peter Mathews:

I have a question. We have heard about mothers and women, death during pregnancy and the need to preserve all life. Of course, it should be so, at all times. I will do anything that is necessary; I will stop my job here to help somebody in order to preserve a life. I mean that. Let us talk in the way we talk to our families across the dinner table.

Dr. Holohan has 30 letters behind his name, which is 1.15 alphabets in professional qualifications. We must respect the human, the spirit and the breath of life.

Chairman:

I thank the Deputy. Please keep the language temperate and refrain from straying.

Deputy Peter Mathews:

It is philosophy.

Deputy Terence Flanagan:

Dr. Mahony argued strongly before this committee in January that greater clarity is required in the law governing the termination of pregnancy, and that all the heads of Bill do is simply quote verbatim the X case test without offering any assistance in interpreting this, including what constitutes a real and substantial risk. How does this provide the clarity she said was needed?

I ask all the witnesses how the proposed legislation currently stands if two psychiatrists rule that a woman needs an abortion. Would an obstetrician feel comfortable overruling their professional opinions? How is the role of the obstetrician envisaged in that type of scenario? If a woman presents in the 20th week of a pregnancy with twins, states she is suicidal and requests an abortion for one twin - what is described as a "selective reduction" in the UK - would doctors be willing to carry out such a termination? If two psychiatrists told a doctor to abort a child at 20 weeks' gestation, would it be done, or could the doctor request that the termination be delayed in order to give the child a better chance of survival?

Senator Paul Bradford:

I welcome the witnesses. Dr. O'Mahony has stated a number of times this afternoon, as she did in January, that the legislation is all about woman's health. That has been echoed so often by the Taoiseach, the Minister for Health and many others that the message could go out that without this legislation, women's health would be at a profound disadvantage. In this room this morning we listened to other witnesses, and Professor McAuliffe reminded us - we should not need such reminding - that maternal health services in Ireland are among the very best in the world. She stated that "families should be reassured that they are receiving the very best of care during pregnancy", with Irish experience in this regard comparing "very well" with the UK and the rest of Europe.

There is the issue of a "chilling" factor, and we have allowed a myth to be created that is becoming a chilling factor. It postulates that Ireland is somehow a dangerous place for pregnant mothers and women. Will the witnesses comment on that and let us know if they agree with what we heard this morning about the superb current state of services in Ireland for pregnant women, with maternal health care in this country virtually second to none? Dr. O'Mahony expressed grave concern here in January about the current legislative position but when asked if she had ever been unable to intervene to save the life of a mother in her hospital because of the current legal position, I believe she stated she had not been unable to do so and had always been able to act. Will she comment on that?

I fully agree with Dr. O'Mahony's comment today that suicide is death, but I would invite her to agree with my statement that abortion is also death. All of us should try to ensure that with whatever legislative changes we enact, the medical changes that will be required, along with the investment spoken of by Senator Crown and others, must be addressed to ensure that the spectres of both suicide and abortion are removed as far as practicable from the landscape.

The witness indicated surprise at how the 1861 Act remains in force, but it is still operational in Britain, where we are exporting our problem. The 1861 Act in Britain is not stopping the huge abortion problem there. Perhaps we should take that fact on board as well.

Deputy Robert Dowds:

On a point of order, I understood, as a member of the committee, that we would be discussing the heads of the Bill today. I appreciate the Chairman has a very difficult job.

Chairman:

Will the Deputy allow me and help me to do it?

Deputy Robert Dowds:

Will the Chairman insist on people addressing the heads of the Bill?

Chairman:

I have done so on numerous occasions and I appeal to everybody to take a collective intake of breath, exhale and calm down. I am doing the best I can.

Dr. Rhona Mahony:

With regard to Deputy Mathews's comments, I agree that, undoubtedly, women can suffer very grave psychiatric trauma because of having to have a termination of pregnancy. That is not at issue. The issue here is the risk to life because of suicide and suicidal ideation. I remind the Deputy that if a woman commits suicide, she dies and her baby dies too. I have no doubt that women find termination of pregnancy very painful. The issue of when life begins is really not for discussion today. We are talking about the substantial risk to maternal life in pregnancy.

The Deputy commented on the number of terminations performed elsewhere in the world. That is disingenuous and does not add anything to today's debate. We are not talking about termination of pregnancy for any reason; we are discussing termination of pregnancy within a very narrow and confined context of risk to life, where terminations of pregnancy are performed to save a woman's life. These instances are rare. In my hospital, which is one of the busiest maternity hospitals in Europe, we perform approximately up to five of these procedures every year. Please do not confuse us with figures of 7 million or other large numbers. That is disingenuous.

Deputy Peter Mathews:

I am not confused. I am very clear.

Chairman:

I thank the Deputy, but he has already spoken well.

Deputy Peter Mathews:

I am not confused, in case the doctor believes I am.

Chairman:

We should have one speaker at a time.

Deputy Peter Mathews:

I am not being disingenuous.

Chairman:

When the Deputy was chairing the Dáil he did not interrupt speakers.

Dr. Rhona Mahony:

Senator Bradford agreed with my comment that suicide is death and indicated that termination of pregnancy is death. The point of this is to prevent two deaths. In other words, when faced with the possibility that if we do not terminate a pregnancy two people will die, I believe a woman has the right to have her life saved. We should not stand by and let two lives be lost unnecessarily. These are complicated situations.

I do not understand the legal position in Britain as I belong in this country and practice within Ireland's jurisdiction.

Dr. Sam Coulter-Smith:

I do not have anything further to add to Dr. O'Mahony's comments directed at Deputy Mathews. Deputy Terence Flanagan asked what is a real and substantial risk to the life of the mother, which is very difficult to identify. We should leave that up to our very competent doctors in obstetrics and gynaecology, oncology and cardiology and any other specialty dealing with very sick patients. We have a very high standard of medicine in this country and it is appropriate to put legislation in place to protect our doctors and let them do what they do best in treating women and all patients to the very best of their ability. We do not need to be prescriptive on those lines.

We were asked if an obstetrician would overrule a psychiatrist. We do not have the expertise and experience in the psychiatric area to overrule a psychiatrist, so I cannot see that happening. However, we do have conscientious objection to protect us in that regard.

We were given several scenarios and asked if we would perform a termination of pregnancy in such circumstances. It is very important to stress that the only position in which a pregnancy would be brought to a conclusion in this country as covered in the legislation would be if the woman's life is at risk and she will die if nothing is done. That is the important point that we are all here to stress. We are all here to look after women and babies. In a scenario in which the baby will die and we can save the mother's life, we need the freedom and protection to be able to act.

Reference was made to the safety of Irish health services, and this was also alluded to this morning.

Yes, our results are excellent and remarkable. I stressed earlier that this was down to the skill and dedication of our midwives and the excellent doctors who work from facilities that are absolutely not fit for purpose any longer. To tell the committee about the Rotunda Hospital, we have nine delivery rooms when we should have 16. Our public postnatal wards were built in 1757. The infection control risks we face on a day-to-day basis are ridiculous. It is absolutely crazy in this day and age that we are providing modern-day obstetric services out of a building which is no longer fit for purpose, but the results are fantastic. That is down to the staff.

When we are talking about saving mothers' lives, we should not use the terms "abortion" and "saving mothers' lives" in the same sentence, full stop. It is a dreadful reflection on anyone who would actually do that. This is about saving mothers' lives, preserving dignity and not stigmatising anybody. These are wanted pregnancies, loved pregnancies, and intervention has to be made to save the mother's life. To call it an abortion is wrong.

Dr. Peter Boylan:

The legislation is incredibly restrictive by international standards. Any suggestion this is a liberal legislative programme needs to be utterly rejected. Comparisons with the United Kingdom or any other country in Europe - in fact, any other country apart from Malta - are disingenuous and false. This is incredibly restrictive which everybody needs to recognise. I

have a fundamental problem with people abrogating the term "pro-life" to themselves and trying to paint me into a corner where I am held up as not being pro-life. Nothing could be further from the truth. As I have spent my entire professional career trying to care for and save lives, I have a fundamental personal objection to this.

Deputy Terence Flanagan asked about clarity regarding the law. This will clarify things for us as physicians practising on a daily basis. At the moment we are left to interpret the Constitution in our daily jobs. It does not happen very often, but it does happen when there is a risk to the life of the mother. We cannot be expected to interpret the Constitution; we are not constitutional lawyers. We are dependent on the members of the committee, the legislators, to do their job, for which they are paid, and legislate. It has taken a long time and I applaud the Government for initiating the process and, at last, legislating and standing up and doing what is required to protect the lives of mothers and give us the certainty that we can practise as we need to do.

An obstetrician feeling uncomfortable can invoke the conscientious objection clause. That is not an issue. Questions were asked about whether we would terminate a single twin if the mother asked for it. No, let us not go there, as that is getting into silly territory.

Senator Paul Bradford made reference to the health of the mother. This is about the life of the mother; not about her health. We are concerned that if a woman is not allowed to have a termination of pregnancy, she will die, not that she will be unhealthy. This is about death. Stop introducing the term "health" because it is irrelevant.

Ireland is not a chilling place. It is very good, but it is not because of the facilities available or anything else; it is in spite of what Dr. Coulter-Smith has very eloquently and repeatedly drawn attention to in terms of deficiencies in services.

I was asked if I had ever been unable to intervene because of the current legal situation, to carry out a termination of pregnancy and the woman had died. I have not, but I have personal, inside information and knowledge from the west of a woman who died last year because the doctors were unable to terminate the pregnancy because of the law.

Chairman:

There is an ongoing investigation in that regard, if Dr. Boylan could be careful in his remarks about it.

Dr. Peter Boylan:

That is my expert opinion.

Chairman:

Thank you.

Dr. Peter Boylan:

I also have personal experience as a junior doctor of a woman who died during pregnancy because she had a conscientious objection to termination of pregnancy. She was so desperate

to give birth to a child that she did and then she died. That happens too and we, obviously, respected her wish.

There was a question to the effect that suicide was death and so was abortion and an implication that the problem could be averted by investment. That is incorrect. If the mother dies, the baby dies. We are talking about the preservation of life. This is a preservation of life Bill. We are talking about the preservation of the life of the mother and if the mother dies, so too does the baby.

Chairman:

I apologise that we will not get to everybody. The three members in the next sequence are Deputies Liam Twomey and Michael Creed and Senator David Norris.

Deputy Liam Twomey:

Each of the witnesses might answer "Yes" or "No" to the following question. If the Houses of the Oireachtas passed legislation similar to the Bill before us, would it force any of the witnesses to do anything against best medical practice as we know it now? It is important to clarify this with a "Yes" or "No" answer for the committee.

My next question is about the heads on physical and mental illness and has as much to do with the legislation as with a medical ethos. A physical illness is very much about an objective diagnosis which one can clearly make very straightforwardly, whereas mental illness involves a more subjective diagnosis. Under the legislation as proposed, there is a reference to two psychiatrists and one obstetrician. Do the witnesses feel the obstetrician should have an informed opinion to add to those of the psychiatrists rather than an overall veto? This more or less goes back to what is a medical ethos and the relationship with the patient. Dr. Boylan has said the decision is the patient's because some patients want more and some want less, which is the basis of the relationship practitioners have with them. Perhaps we should approach it from that point of view in the legislation.

Since I qualified as a doctor 20 years ago, 100,000 women of child-bearing age have had terminations in other jurisdictions. I have treated and looked after some of these patients when they have returned and I would never paint their experiences in a uniform way. They have all experienced matters differently, both then and since, and we must be very humane about how we discuss their experiences.

Senator David Norris:

I commend the Chairman for his clear and decisive chairing and indicate to my colleagues that buffoonery almost invariably tends to discredit a viewpoint, however well intentioned.

Chairman:

On the heads of the Bill, please, Senator.

Senator David Norris:

It is very much welcome that the Title of the Bill includes the words "protection of life" as it provides space for the many of us in the Oireachtas who are strongly pro-life and also strongly pro-choice. It is a timid step and very little, very late. I regret that it does not deal with fatal foetal abnormality, incest, rape and the health of a woman. If it was the health of a man, there would quite a difference.

I was very concerned by a letter by the Archbishop of Dublin, Dr. Martin, which I took very seriously and raised as I was so concerned. I raise it again in the context of some of the comments made which I may have misinterpreted but which seem to constitute a general suggestion that as a result of the Bill a pregnancy might be terminated and the child or the foetus born left to die or deliberately killed. That horrified me and I raised the issue on the Order of Business. I have learned a lot today and would like to know if I would be correct to say the termination of a pregnancy does not automatically mean the termination of the life of the foetus or the child. I would like to be able to mention this next week in the Seanad. It is vitally important for the way the Bill is treated.

I address a question to Dr. Coulter-Smith who raised two interesting hypothetical questions - one on the delivery of a baby at 25 weeks and the second on delivery at 20 weeks and the consequences for the health of the child through cerebral palsy or whatever else. He raised this issue in the context of suicidality, but would it not also be the same ethical question if it occurred in the case of a sudden medical emergency, the worsening of a cancer or the onset of a dangerous heart condition?

Deputy Michael Creed:

I thank the witnesses for their contributions and preface my remarks by saying it is regrettable that we tend to elevate or diminish contributions depending on our own perspective. We are all trying to grapple with something that is enormously complex.

I preface my remarks by saying it is regrettable that we tend to elevate or diminish contributions depending on our perspective. We are trying to grapple with something enormously complex. I agree that the "pro-life" and "pro-choice" terms do an injustice to the complexity of the issue. We should be more tolerant of all contributions. To describe some contributions as buffoonery is to miss the point and the complexity of the issue.

In the contribution of Dr. Mahony today and in January, she made reference to the lack of clarity and the fear of going to jail for acting in a manner to protect women's lives and the lives of the patients. I have read the heads of the Bill. Where is the clarity in respect of vindicating that right to treatment that was not clear up to now? Perhaps it will emerge when the legislation proper is published but I do not see the clear referral pathway where a woman can access the service she requires. I would like the witnesses to take me through the heads of the Bill that provide that legal clarity. What does Dr. Mahony see that she can do today that she felt she may go to jail for in January?

Dr. Boylan made the point that this is conservative and does not deal with a host of issues we should deal with if we were more courageous. Many of us are fearful of the law of unintended consequences. The figure for suicidal tendencies during pregnancy is one in 500,000. If there are 100,000 pregnancies in the country per year, including miscarriages, it suggests that under head 4, which provides for suicidal women during pregnancy, we should be looking at one case every five years availing of legislation under head 4. If it emerges

during a review of the legislation that it is far more than that, will the three witnesses consider the legislation is flawed?

Head 19 has been referred to in the context of the chill factor and the consequences for doctors and women. I might have sympathy for the woman being subject to serious sanction but it is important to keep a chill factor in the legislation. Reference has been made to the 1861 Act. Without that provision, are we facilitating a more liberal regime than envisaged by law under the previous headings?

Chairman:

We have four speakers and our time expires at 5.20 p.m. I will call the remaining members before calling the witnesses. I ask Senators Mullen and Hayden and Deputies Timmins and Tóibín to be brief.

Senator Rónán Mullen:

I thank the Chairman for the job he is doing, which is difficult. Underpinning my questions is the fact that I would not like there to be a chilling effect on legislators or specialists doing their best to understand what the evidence says. That is a job we must all do. It is quite clear from Dr. Coulter-Smith's paper that it is a job he and his colleagues, as obstetricians, must do having regard to what they have learned from their psychiatric colleagues. I do not think my friend, Senator Crown, necessarily intended it but it is important to remember that we must respect one another's genuine search.

I have two housekeeping questions that we should ask of all our guests and they are meant in the best spirit. Do our guests mind telling us whether they were consulted in any way by the Department of Health or the HSE post the expert group in the preparation of the heads? I have not had the chance to read the papers in detail but Dr. Coulter-Smith said he was here to give the views of himself and his colleagues in the Rotunda Hospital. Are our other guests here in a purely personal capacity, are they speaking for their colleagues or a majority of their colleagues, or did they consult among colleagues?

My second question concerns Dr. Mahony's point about the X case. She posited the test of the possibility and the challenge is that the Supreme Court in the X case found, without the benefit of a psychiatrist in the High Court, that it was where there was a probability. The difficulty seems to be whether there is any evidence on which psychiatrists could rely that could allow them to say that, as a matter of probability, this will happen. I ask Dr. Coulter-Smith if that lies under his statement about enacting and underpinning the idea that the termination of pregnancy is a solution when there is no evidence to support the intervention. It creates a major ethical dilemma for the profession.

Building on that, the legislation does not just put the obstetrician in the role of carrying out the procedure but of certifier. The obstetrician's certification is necessary along with that of the two psychiatrists. In the same way that under head 2, the doctors are faced with a child of 20 weeks in the womb and every effort will be made to bring two patients out safely and hold off on treatment, as Dr. Mahony and others said. In exercising the certification role, would the witnesses consider asking the psychiatrists whether it is possible to delay the procedure to get the child to the point where it could be delivered not just prematurely but also safely and well?

Chairman:

Tá an t-am caite.

Senator Rónán Mullen:

Is that within the witnesses' capacity under these heads?

Finally, what is the situation in regard to painkilling in these situations under heads 2, 3 and 4 when dealing with later term deliveries?

Senator Aideen Hayden:

Like a number of speakers, I am conscious this Bill is about the preservation of maternal life and we are addressing ourselves to the heads of the Bill. However, Dr. Coulter-Smith's testimony has come up again and again with regard to suicidality. Looking at his written contribution, he says his overriding concern includes self-destruction and termination of pregnancy. He is concerned about the lack of evidence. In spite of Senator Crown's question, I am at a loss as to his answer. If no evidence exists, surely none of his psychiatric colleagues would prescribe a termination of a pregnancy in these circumstances, no more than he would prescribe the termination of a pregnancy on the grounds of heart failure, for the sake of argument. I am at a loss to see how this is relevant.

Dr. Coulter-Smith mentioned that the inclusion of suicidality would lead to an increased demand for termination services. He mentions the difficulty we have with resources in the Irish State but we do not know how many of the 5,000 women who travel abroad do so because they are suffering from mental health issues. Nor do we know whether part of our excellent record in Ireland is due to the fact that women over 45 years of age travel abroad because they believe their lives may be at risk and choose to vote with their feet. We suffer from a lack of evidence. The 5,000 women who travel out of this country may be dismayed to have it suggested that a lack of resources should be a reason they should not have a legitimate answer to their medical and mental problems in this country.

Deputy Billy Timmins:

To clarify, these are the heads of the protection of life during pregnancy Bill, not the protection of maternal life Bill. I have the height of admiration for the medical profession in this country and across the globe. There are many places I would rather be than here but there is a duty upon me, as a legislator, to inform myself. In trying to get that information, if I come across as confrontational with witnesses, it is not the intention. We admire the work they do.

I agree with Dr. Boylan on head 19.

We probably should look again at that issue and the penalty. Notwithstanding that, I hear the term "the chill factor" used continually with regard to the criminal law. Broadly speaking, the concept of the criminal law is to have a chill factor, not a soothing factor. Also, with regard to the issue the witness raised about science and the origin of it, the State gets things wrong. There are many examples in this country of where the State got legislation and policy wrong. The State is not always right, as is evident from the many cases taken against it. In respect of

the X case, the evidence from the psychiatrist was that in the forecasting of suicide there was a false positive in 97% of cases. That is important.

We must take all these factors into consideration when formulating legislation. This is probably the most important legislative measure I have had to vote on in my time in the House and I want to get it right. I compliment the witnesses. I particularly compliment Dr. Coulter-Smith because he has articulated in his document many of the concerns that were expressed to me by ordinary people, medical professionals, gynaecologists and doctors from all corners of the globe. It is really important that the concerns he has articulated are made known. I do not know if a gynaecologist has expressed them in public previously. We have received letters privately and seen letters in the newspapers but they might not have been expressed in a forum such as this. Given what Dr. Coulter-Smith has said regarding head 4, and he has obviously discussed it with his staff, does he anticipate a difficulty in the Rotunda Hospital with head 4 being implemented if the legislation is passed as it is, based on his knowledge of the staff currently serving there?

Deputy Peadar Tóibín:

Everybody here believes that in every case everything must be done to save the life of the mother, regardless of what side of the debate one takes. There are no ifs, buts or doubts about that. Many people are of the view, and they agree with the psychiatric evidence and the advice, that this should be done with a two patients solution, that both patients must be saved in that scenario. I believe the 5,000 women heading to England every year is a double disaster. It is a disaster that those crisis pregnancies occur and it is also a disaster that 5,000 lives are being lost every year. We heard a very moving presentation from Women Hurt yesterday. All of them said that, if necessary, in their situations they would have done everything possible to convince people that they were suicidal in order to procure an abortion. One of the women said that she was coached to say that she was suicidal to procure an abortion. One woman asked me to ask a question here, which is, if that type of abuse were to happen in the future, would the doctors be certain that this Bill would prevent it?

Dr. Peter Boylan:

There is much to cover. Will the legislation force us to do anything against best medical practice? No. With regard to two psychiatrists and one obstetrician having an input into the decision and the patient decides, the patient decides within the law and we also decide within the law. When this legislation is enacted we will all have to work within the law. There is no question about that. There is a huge variety of different experiences. Unquestionably, many women are damaged by termination of pregnancy, and many women are damaged by not having a termination of pregnancy. That is life. Life is messy and we as obstetricians and doctors see all the shades of human experiences. There is a wide spectrum and one cannot just focus on a single particular group.

This Bill is about the protection of life. People have different opinions about the inclusion of foetal abnormality, rape, incest and so forth. However, the terms of this Bill are very straight and we should not get into discussing other issues in this environment. Archbishop Martin's letter referred to the possibility of a baby being left to die or a baby being killed. Those two would be criminal offences. There is no question about that. Everybody must be reassured on that. He raised the question perhaps hoping for clarification of this issue in a public forum. I am very happy to clarify that for the archbishop.

We have dealt with the question of pre-term birth. On the chilling factor and the 14 year jail sentence, I do not have a problem with doctors being held responsible for making illegal decisions regarding termination of pregnancy. That must stay on the Statute Book. No doctor has a problem with that as far as I am aware. I do have a problem with a woman being criminalised if she follows medical advice. I think that is fundamentally wrong and unfair, particularly if she has the constitutional protection of this country if she goes to the UK and has the same procedure. It just does not make sense.

There was a question about the law of unintended consequences and the fear that there would be a very liberal regime of termination of pregnancy as a result of this legislation. The figure of one in 500,000 has been introduced into the debate. That is a woman who commits suicide in the UK, which has a very liberal regime and where there is very easy access to termination of pregnancy, effectively on request. We will never be able to answer the question of how many women would commit suicide in this country if termination of pregnancy was not available because it is available. It is just available in the UK. Therefore, we will never be able to answer that question.

However, it appears that genuine suicide risk in pregnancy is extremely rare. We must trust our professional colleagues in psychiatry who assess this risk on a daily basis. The committee will hear evidence on Monday from experts in psychiatry and I urge the members to listen to the balanced opinions that will be put forward that day, and not to be swayed by ideological opinions. We were asked if we would ask a psychiatrist to delay a termination if the duration of the pregnancy was 20 weeks. We are obliged under this legislation to take due care to do all we can to preserve the life of the baby. It is not a question of a psychiatrist rolling up and saying we should terminate a pregnancy without any discussion between us. We do not act like that. It is not a professional way to behave and we do not behave like that. These will be joint decisions taken in consultation with our psychiatric colleagues, whose opinions we respect and trust.

With regard to the State getting things wrong, I am not sure that is relevant to this. I have made reference to head 19. I do not believe a woman should be criminalised. Yes, everything must be done to save life. That is what this Bill is about; it is about saving lives, which is why it is called the protection of life during pregnancy Bill.

The question has arisen about women being coached to fool experienced professional psychiatrists to believe that they are genuinely suicidal. We have to trust psychiatrists. They are not going to be fooled. They are well able to recognise women who are attempting to pull the wool over their eyes. I do not think there is any question of a psychiatrist in this country being fooled by somebody setting themselves up. Undoubtedly, there will be mischievous people who will try to trick them into the belief that they are suicidal when they are probably not even pregnant in the first place. However, our psychiatrists are a smart bunch of people. They will recognise those women when they walk in and they will be able to deal with it. Do not worry about that.

Dr. Sam Coulter-Smith:

My comments on the first question would echo those of Dr. Boylan. Senator Norris asked about babies being left to die or deliberately killed. There is absolutely no question of that happening in this country. He also asked if termination of pregnancy was the equivalent of the death of a child. It is not, because it depends on the gestation at which it occurs. We dealt

with that earlier. He asked about the different clinical scenarios. Where there is a threat to the life of the mother based on a physical illness, in all likelihood the evidence will be much clearer. Where there is a risk of suicide, the evidence is a little less clear and it makes that situation much more challenging and difficult to deal with. That is where the expertise of our psychiatric colleagues is required. Senator Norris is absolutely correct that whether the intervention occurs because a woman has a physical illness or because she is suicidal, the outcome of that situation will be the same at a particular gestation.

However, I argue that the evidence behind the decision-making is different.

Reference was made to the incidence of suicide in pregnancy. Dr. Boylan has alluded to UK figures. The situation in relation to the UK laws is different. Dr. Boylan has mentioned that where a coroner in Ireland may not record a case of suicide and may record an open verdict, it presents a greater challenge in trying to have an understanding of the actual figures. We can agree, however, that it is extraordinarily rare and unpredictable. Members may ask the psychiatrists when they talk to them next week, but they will tell members it is an unpredictable and rare event.

On the question as to whether I was consulted on the heads of the Bill, the answer is "No". With regard to efforts to achieve maturity, it is enshrined in the Bill that all doctors are duty bound to ensure they make every effort to get the baby to maturity where it will survive, if that is at all possible, and the only reason one would intervene to terminate a pregnancy is if all other avenues have been explored and there is no other option.

With regard to the large number of women who go to the United Kingdom, I agree absolutely that we do not understand the issues they have. I was not suggesting that if termination of pregnancy was required for any of these women, it would not be performed because of a lack of resources, but that if what was described occurred and there were to be a greater demand for the type of service in question in this country, our current resources could deal with it.

On head 4 and intervening in a case of suicidality, no obstetrician would have an issue with intervening and performing a termination of pregnancy if it were to save the life of the mother and if every other avenue had been explored and there were no others.

Dr. Rhona Mahony:

On the question of whether it would alter my practice if we passed the legislation, the answer is “No,” although there are some amendments we have discussed today that need to be taken into consideration. We have had a discussion on the concept of physical illness versus mental illness. One is objective - we have definite signs - and one is very subjective. I am an obstetrician and cannot assess suicidal ideation, but I am very confident that my colleagues who are experts in psychiatry can assess it. They do this very commonly in the course of their practice. As an aside, one very tragic objective outcome of suicidal ideation is death.

On Senator David Norris’s comments, the Bill, of course, is not about physical health but about the risk to life. That needs to be very clear. We are not talking about physical or mental health but about the risk of death from any cause, be it physical or mental. In the majority of cases it will pertain to death from physical causes.

With regard to Archbishop Martin's letter, I really hope that by now it is clear to everyone that we are not in the business of killing babies and there is no question that a baby that is capable of surviving will not be offered every support to optimise its survival. There is no question that a baby born at 28 or 30 weeks gestation would somehow be killed. That is murder, a criminal offence, and out of the question. One must understand that we will do everything and exhaust every single medical avenue open to us to prolong pregnancy such that a baby may achieve viability and to give babies born at early gestations every support to optimise their survival. We do this all the time. It is a very fundamental part of our job.

I have been asked directly to clarify what I am worried about. The 1861 legislation still stands and nobody has yet told me it does not. The Supreme Court judgment is in place, but it has not been legislated for. I presume we are all here because we see a necessity to legislate for the Supreme Court case. We need legal clarity surrounding the termination of pregnancy to save women's lives and the sort of legislation and regulation that will afford us legal protection and flexibility to do our job. It is really important that everyone take on board that the 1861 legislation pertains not only to doctors but also to women. That is very important. The question of women being at risk of penal servitude must be taken on board. Therefore, I welcome this legislation and commend the Government for introducing this long-overdue Bill.

We return time and again to the question of suicide which is extremely rare in pregnancy. I am not a psychiatrist, but I have some expertise in publishing papers and setting up studies. There is no evidence regarding suicide. There is a lot of evidence on mental health and many papers dealing with different aspects, but there is no paper in this country that deals specifically with the outcome of suicidal ideation. Gold standard therapy would involve a randomised controlled trial. That would give us the best evidence. All other evidence is quite flimsy, actually, and one will have different papers stating different things. I do not believe there should be a randomised controlled trial. Are we really going to take women with suicidal ideation and randomise them into two arms, one that is allowed a termination of pregnancy in the belief we are saving their lives and another prevented from terminating their pregnancies in the belief this might result in their dying. That study should never be undertaken. There is no evidence; this is extremely rare and there cannot be compelling evidence when the numbers are very tiny.

With regard to head 19, I agree that we need to be very careful. Women should not be liable for criminal prosecution on the grounds of this, particularly considering that when we may perform a termination of pregnancy, the women concerned would be taking a doctor's advice that they should have a termination of pregnancy to save their lives. There should be no question under any circumstance of a woman being liable legally. That answers that question.

We had a discussion on the circumstances concerning two patients and it was stated 5,000 women travelled to England. That is not the issue; today we are talking about the heads of a Bill that deals with the protection of life during pregnancy.

On the question of suicide, the idea that women will turn up in front of expert psychiatrists and lie in vast numbers and the suggestion our psychiatrists who are extremely well trained and competent have no idea how to assess ideation just have no basis in fact. Furthermore, we need to be very careful. Women with suicidal ideation need to be taken seriously and believed. I would be a very bad doctor if I began every single medical consultation with the presumption that my patient was lying.

We have had a conversation about resources. I would be the first person to say obstetrics and maternity services in this country are dreadfully under-resourced. There is an urgent need to address the resource issues within the maternity sector. The approach we should have is not to fail to legislate in this Bill; the approach should be to address the issue of resources in the maternity sector. I hope the Government will take on board these views and give maternity services the attention they so urgently need and deserve.

Chairman:

I thank our three witnesses, Dr. Mahony, Dr. Coulter-Smith and Dr. Boylan.

Sitting suspended at 5.40 p.m. and resumed at 5.50 p.m.

Obstetric Care Facilities - Smaller Hospitals

Chairman:

We will resume in public session for the fourth and final part of today's discussion and analysis of the heads of the Protection of Life during Pregnancy Bill 2013. I remind Members and witnesses to ensure their mobile telephones are tuned off as they interfere with broadcasting, which is unfair to members of staff. I welcome Dr. Gerard Burke of the Mid-Western Regional Maternity Hospital, Limerick; Dr. Mary McCaffrey of Kerry General Hospital in Tralee; Dr. Máire Milner of Our Lady of Lourdes Hospital, Drogheda; and Dr. John Monaghan of Portiuncula Hospital in Ballinasloe. I thank them for attending these hearings and apologise for the delay in commencing this session. I hope the delay has not discommoded them too much.

Before we commence, witnesses are advised that they are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence in regard to a particular matter and they continue to do so, they are entitled thereafter only to a qualified privilege in respect of their evidence. Witnesses are further directed that only evidence connected with the matters under discussion is to be given. They are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make him or her identifiable.

I call on Dr. Gerard Burke to make his opening statement.

Dr. Gerard Burke:

I thank the Chairman for his invitation to attend this discussion. I welcome the publication of the Protection of Life during Pregnancy Bill 2013 and commend the Government on bringing it forward. I also commend the members of the committee and other Members for the intellectual effort they have put into this debate through the course of the day. It has been a long day, so I will be brief.

On the issue of resources, in the next decade we can expect in the order of 100 maternal deaths in Ireland. It is possible that one, two or three of these potential maternal deaths might be affected by the legislation before us. In terms of the number of possible deaths, therefore, this great intellectual effort will affect a relatively small number of women. It is important that the Oireachtas would at some point address the state of the maternity services. The unit in Limerick which I represent, for example, has the lowest number of obstetricians in the whole of Europe at two per 100,000. This shortage of resources will likely lead to some difficulties in the future.

Turning to the specifics of the heads of the Bill, the first issue that has come up for discussion in my department is the question of what is a real and substantial risk to the life of the woman. I note that this is not defined clearly in the heads and I understand the reasons for that. The issue has been raised in the submission by the Institute of Obstetricians and Gynaecologists, which I support. My personal preference is that there would be an explicit statement setting out that this is a matter which cannot be defined in terms of real numbers or percentages, and that it should really be left to the medical experts to determine. It would be wrong if what is actually a matter for legislators were ultimately to be decided by a court.

We have identified two minor technical issues that should be addressed, the first of which relates to the question of an ectopic pregnancy. It is possible to have an ectopic pregnancy within the womb, in the cervix, in the neck of the womb or in the scar of a previous caesarean section. We are seeing more and more of the latter as the rate of caesareans has risen. One can have a pregnancy that is ectopic but within the womb, and that is an extremely dangerous condition which could fall under this legislation.

The second issue, which was also pointed out by the delegates from the institute, relates to locations. Some 40% of babies in Ireland are born in stand-alone hospitals, namely, the three in Dublin and my own unit in Limerick. Some of the more difficult work we have to do is carried out in the general regional hospital. A caesarean section on a critically ill woman, for instance, would have to be done in a general hospital. That needs to be included in the legislation.

Chairman:

Thank you, Dr. Burke. I now invite Dr. McCaffrey to make a statement.

Dr. Mary McCaffrey:

I thank the Chairman and the committee for the opportunity to contribute to the discussion. Like Dr. Burke, I commend the Government and the legal draftsmen on putting together these legislative proposals under such difficult circumstances. My submission is intended to reflect on how the proposed legislation might impact on the practice of obstetrics in small to medium-sized units, that is, in units with three consultant obstetricians on the staff. There are 12 such units out of the total of 19 in the country, and they deliver approximately one third of all babies. Therefore, they make up a significant number of deliveries. I will not dwell too much on the issue of resources other than to say that, in general, we would tend to be very under-resourced.

There has been a great deal of repetition in the discussion today, so I will address only those heads of the Bill which we consider specific to the practice in our units. I have collaborated

with a number of colleagues in clarifying our position in this regard. In regard to head 2, which deals with the risk to life from physical illness, not being a risk of self-destruction, my understanding is that this relates to cases of severe heart disease, cancer or other major medical illnesses. Under the proposed head, one obstetrician and a doctor from the speciality caring for the significant complex medical condition are required to make a decision regarding ongoing management of the pregnancy. We feel that the bulk of these cases, in general, are likely to be managed in tertiary referral hospitals and are not likely to impact on the smaller maternity units.

The only exception is that in Kerry, Letterkenny and Wexford, which have similar units, during the holiday season the most amazing range of patients about whom one knows nothing arrive as visitors to the area. We are very aware that those women require the backup of intensive care in a general hospital and we endeavour, where possible in our units, to transfer them out safely but we are aware that exceptional circumstances occur and medicine is not always black and white. That needs to be reflected to protect us under the legislation.

Regarding head 3, risk of loss of life from physical illness in an emergency situation, sadly, in the course of our work we deal all the time with patients who have severe impending infection, severe pre-eclampsia or haemorrhage. The legislation now protects us in a way that we were not protected before so we welcome it for those cases. The proposed legislation suggests that one doctor would sign out for making decisions with regard to the care of the patient. It is best practice in most situations that two obstetricians would be involved in such decisions and in general that is what happens. Once again, however, we go back to the fact that in a small maternity unit with only three obstetricians there will always be periods in which only one person is on duty at night and weekends. That person has to be protected and his or her clinical judgment has to be taken on face value. In the January submission I suggested that perhaps where someone felt he or she wanted a second opinion and that was not available in-house, consideration should be given to having a panel of experts in the Dublin maternity hospitals who would be available to people who wanted to collaborate with a colleague.

The wording of head 4, risk of loss of life from self-destruction, should be changed. Suicide is a terrible word but that is what it is. The issue that came up with all the people to whom I spoke is that we do not feel, as obstetricians who are not trained in psychiatry, that we have any role in diagnosis of suicidal intent. We accept and understand that the psychiatrist's input is crucial in this instance. We accept and acknowledge that we can make an input to assist the psychiatrist in managing the pregnancy as it proceeds, if that is what is required, but we do not feel that the current batch of obstetricians is adequately trained to diagnose suicidal intent. We are, however, available to support our psychiatry colleagues in that diagnosis. In all of the conditions involved we realise that there will be situations in which potentially viable foetuses will be born and we must endeavour where at all possible to deliver them in units where they have the appropriate neonatal backup and support for the babies that potentially need neonatal care.

It is also important to point out that not all maternity units and psychiatry units are on the same site. A significant number of hospitals in the country have a maternity unit but no psychiatry unit. If an acutely ill woman is admitted to a psychiatry unit, there will be resource issues in terms of providing a team of psychiatrists to look after her if she is in a maternity unit and *vice versa*. The fact that many psychiatry units are off-site has not been thought about. Equally, many maternity units, as Dr. Burke has pointed out, do not have the backup

of intensive care or general hospital facilities.

My point about head 9 does not appear in my written submission because it was only identified by someone during the course of the day. Under head 9:

> (4) A person who –
>
> > (a) having been directed under subhead (2) to attend before the committee without just cause or excuse disobeys the direction,
> > (b) fails or refuses to send any document or things legally required by the committee under subhead (1) to be sent to it by the person without just cause or excuse,
> > shall be guilty of an offence and shall be liable on summary conviction to a class C fine (not exceeding €2,500).

I assume that nobody will put herself or himself forward to be on a committee unless she or he truly wishes to be there and is a volunteer. Medical and staffing circumstances may overtake committee members in a hospital so that they cannot attend a committee meeting. There was a suggestion that maybe there was a bit of carrot and stick about this provision, with more stick than carrot and that it would be hard to recruit volunteers if they felt they were going to be fined and criminalised. There should maybe be a little reflection on that point.

For a significant number of colleagues with whom I have discussed head 12, conscientious objection, this is a really significant area. There are many obstetricians in the country who have conscientious objections to being involved in providing termination of pregnancy. This must be respected. Under Medical Council guidelines, they are entitled to have conscientious objections. The important point is that the public will know that where the life of the mother is at risk and where medical care is needed appropriately, the care of the mother and her baby will always be paramount for every doctor and that if a doctor has a conscientious objection, he or she will have the facility to provide access to another colleague in a timely manner. That is very important.

Over the past couple of months there has been some suggestion in the media and elsewhere that doctors should have to declare their moral and ethical objections to being involved in termination of pregnancy prior to taking up employment. This has caused fear for a number of colleagues, not those of us currently employed because we have our jobs but people in the future might feel that they would be disadvantaged or discriminated against at interview by an employer who feels that a certain doctor is not going to do terminations but one who will do them is needed on the staff. This has to be taken very seriously because under subsection (3) of head 12, "No institution, organisation or third party shall refuse to provide a lawful termination of pregnancy to a woman on grounds of conscientious objection". If there is a hospital management structure that for whatever reason feels all of its doctors must provide terminations, no doctor should fear that if he or she applies for a job there and has a particular ethical point of view, he or she will be discriminated against in getting a job. That is very important. A few people would like to know who is the "third party" referred to in that subsection because that was not clear to us.

There are some other issues that I feel are worth mentioning that I did not see highlighted in the heads of the Bill but maybe I missed them. One is the issue of resources to allow medical staff to carry out these duties safely under the legislation. I am not here to represent the psychiatry profession but they would say that they struggle under the current resources to

deal with the mental health tribunals and that imposing an added burden on them would be significant. We also have to acknowledge that the majority of obstetricians practising in this country today do not carry out terminations of pregnancy and probably have not done in the past. They will need to have training for that so that they can safely provide care for their patients and do not work outside the scope of their practice. Many people feel that termination of pregnancy is a procedure that is totally and utterly safe but we know from the confidential inquiries in the UK that there can be morbidity and mortality for women after the procedure. Therefore, it is crucial that if we introduce a medical procedure in this country that people are appropriately trained and feel that they can work well within their scope of practice. Another issue that I may have missed arises if the person is under the age of consent. Are there extra legal procedures and requirements that we would need to incorporate into legislation?

Finally, if legislation is enacted there will need to be a period when hospitals and the regulatory bodies can put care plans in place to ensure safe practice so that the legislation is not passed one week and people are expected the following week to provide a level of medical care that has not been communicated to and discussed with those on the ground.

Chairman:

Thank you, Dr. McCaffrey. Our next speaker is Dr. Máire Milner, from Our Lady of Lourdes Hospital. You are very welcome, Dr. Milner.

Dr. Máire Milner:

Thank you very much, Chairman. I will be extremely brief. I welcome the heads of the Protection of Life during Pregnancy Bill as put forward by the Government. It is needed because there are areas of uncertainty that we encounter during our practice. They are not common but neither are they very rare. Our population and our medicine are changing all the time. Women are now falling pregnant at ages and with diseases and on treatments that previously would not have been encountered. This gives rise to logistical challenges and difficulties for us as clinicians.

This can give rise to incidents in which the life of the mother may be threatened. I welcome the bringing of clarity into an area of uncertainty. Dealing with a woman who is critically ill brings its own uncertainties. For us to have a background of uncertainty about our legal position has been very unhelpful and difficult. Accordingly, I welcome this legislation.

With regard to the suicide part of it, this is a more difficult area. Intuitively, while this is a very unlikely scenario, I think we have to recognise that the submission of the Institute of Obstetricians and Gynaecologists pointed out that mental as well as physical illness can have similar indications. I endorse the submission by the Institute of Obstetricians and Gynaecologists and I would be happy to answer any questions the committee may have on that.

Chairman:

I welcome Dr. John Monaghan from Portiuncula Hospital, Ballinasloe, County Galway. I apologise that he was not able to make a submission in January but I welcome him to make an opening statement now.

Dr. John Monaghan:

I appreciate the invitation to speak at this gathering. I previously sent in a submission in early January which dealt with two specific matters which I will deal with today. As I was instructed to deal with the heads of the Bill, I have four points to make this evening. The word I am intending to use is "clarity", which seems to be the word of the evening.

Head 2 refers to risk of loss of life from physical illness. My point on this is personal and relates to cancer. Senator Crown may be one of the most eminent oncologists in the country, maybe in the world. I have a personal point to which he may attend. One of the reasons we are here is the judgment of the European Court of Human Rights in the A, B and C cases. One successful plaintiff, C, was a woman who had been treated for cancer. She was, according to the expert report, "unable to obtain clear advice as to the effect of the pregnancy on her health or the effect of medical treatment on the foetus." If this legislation goes through, as broadly outlined in the heads of the Bill, will a woman such as C be in a better position?

Part of my reason for bringing this up is that the medical risks involved with cancer in pregnancy, which is one of the major threats to a woman's life that may lead to a need for termination, have changed dramatically over the past few years. A Belgian doctor, Dr. Frédéric Amant, has spoken in Ireland several times on these developments and there are several publications in *The Lancet* on the matter from last year, which I attached to my submission. While they may be technical in nature, I added them for two reasons. The first is that they describe the changes in the treatments available and the second is that they deal with the problems of treating cancer in pregnancy. The three that are listed are under-treatment because of fear of treating the baby, late diagnosis and the carrying out of terminations of pregnancy when not required.

My end reason for bringing up this subject is that I suggest to the committee that the legislation should mention somewhere that patients with cancer in pregnancy should be referred to a single cancer treatment centre which has acquired expertise in the management of pregnant patients. One of the articles I attached to my submission dealt with the question of leukaemia or blood and bone marrow cancers. The reason I put it in is that it is an extraordinary complex area. As an average obstetrician and gynaecologist, it is beyond my understanding. My basic idea is that patients who are pregnant and have cancer should have access to a specialist oncology centre with surgery and radiotherapy. There should be one such centre in the country which has expertise to offer this particular group of patients.

My second point refers to head 4, which deals with the risk of loss of life from self-destruction. The other reason we are here today is the Supreme Court case of X, which occurred 22 years ago. As an obstetrician, I do not have any first-hand experience of psychiatry. It reflects an enormous change in obstetric practice that an obstetrician is being asked to intervene in a physically healthy pregnancy. While it appears from the legislation that an obstetrician would be involved in the decision-making, he is referred to otherwise possibly as a technician, suggesting that maybe he should be involved so he does not feel like a technician. However, my gut is extremely unhappy with the idea of a mindless terminator for psychiatric reasons. This decision was made 21 years ago. From the hearings that were held in January, I do not believe any case of suicide associated with refusal of termination has ever surfaced. The evidence from my reading of it seems to be extremely poor. Many of the speakers earlier were happy to take the expert advice of a psychiatrist to act if required. I am

not certain how a psychiatrist can reach a decision on this matter where to date I do not believe any evidence has been produced.

The psychiatric or suicide risk clause has been brought in in other jurisdictions and has been widely - I would say universally - abused. Last year, *The Daily Telegraph* did an exposé of the abuse of psychiatric reasons in the UK, with the use of pre-stamped forms. People went to one doctor to get a form stamped, then to another to get it stamped and then got a termination. I can see no reason, despite the safeguards built into this legislation, that culture could not arise in this country in the future. I am extremely concerned as an obstetrician that I would be drawn into a situation in which a termination of pregnancy will be done for psychiatric reasons without very clear evidence that this is to the patient's benefit. If the baby is going to lose its life in this circumstance, then I would want to be very clear that there is a clinical benefit to the mother. To date, I can see none of that. That is my big issue with the heads of the Bill.

The other matter which I would like to deal with is the question of conscience, which Dr. Mary McCaffrey mentioned as well. I use the term "conscience" rather than "conscientious objection" because the latter implies that this is a problem. Twice in the past few months, as a doctor, I have been told that a doctor should leave his or her conscience outside the room. I would ask the committee to reflect on what it means if a doctor suspends his or her conscience faculties. Conscience is not a religious concept. If one sees somebody beating a child on the street and one continues to do one's shopping, then there is something wrong with one's conscience. It is an obvious thing. For example, if I decided to suspend my conscience with a patient on a waiting list and he offered me €300 to go up the list, then that is a very tempting, painless and invisible transaction which I am sure occurs in the political world. The only thing that will stop a practitioner-----

Deputy Regina Doherty:

That is an objectionable statement.

Chairman:

I ask Dr. Monaghan to withdraw that remark.

Dr. John Monaghan:

I am certainly happy to withdraw it. I was not quite clear what the remark was. I was referring to myself only.

Chairman:

Okay.

Deputy Bernard J. Durkan:

It was a reference to bribery among politicians.

Dr. John Monaghan:

I can assure members that was not my meaning, nor was it intended to be interpreted in that way.

In relation to the conscience matter, conscience has been under attack in the past five years or so in the medical literature. I have attached two articles on conscience to my submission - one hostile to and one supporting conscience. The Bill to be produced should recognise the importance of conscience rather than the importance of conscientious objection, on which I would be happy to answer questions.

In relation to head 19, it appears to be a significant endorsement of the constitutional position of the unborn in this country where it states it shall be an offence for a person to do any act with the intent to destroy unborn human life. I support this. As obstetricians would know, the problem in other jurisdictions is that children, or babies, are directly killed by injection or suction and evacuation of the uterus. I know that previous speakers have referred to this and said they do not see it happening in Ireland. Certainly, surgical termination, as it is called, is more dangerous than medical termination of pregnancy and the Act should specifically prevent doctors from killing a baby, where it is necessary for it to be delivered, directly before it is born, either by surgical means or lethal injection. I ask that this be specifically included in the Bill.

Deputy Caoimhghín Ó Caoláin:

I thank each of the speakers and apologise to Dr. Burke that I was not back in time to hear his oral presentation, but I thank him for his written submission.

I am not directing my questions at anyone in particular, but I am anxious to learn from the witnesses if there are particular differences in their collective experiences because of their largely rural, non-Dublin city locations, as against those of the other witnesses we heard earlier. I refer to some of the questions we asked in relation to the situations that might apply. We presume obstetricians-gynaecologists not being registered on the specialist listing with the Medical Council would be something the witnesses would reflect also because they would have colleagues on the general rather than specialist listing. That is important.

In terms of a smaller number of professional colleagues, does this create particular situations, given the larger body of colleagues those from the major Dublin-based hospitals would have to call on? For instance, I refer to the issue of conscientious objection, to which Dr. Monaghan referred. Are there given situations where the witnesses may not have the complement of necessary professionals to make the evaluations? For instance, in relation to the risk of loss of life from physical illness, we are looking at two medical practitioners - one obstetrician-gynaecologist and other a medical partitioner in a specialist division. Is there sufficient professional cover on each of the hospital sites across the jurisdiction currently designated - the 19 within the proposed legislation - to comfortably ensure there will not be unnecessary delays and that the assessment can be made in a hospital where the woman is presenting and that there will not be a requirement for an examination at two locations on the part of the woman involved? Surely, the professionals would go to her at whatever hospital site she was located.

It was exposed to us when we spoke to the masters of the various Dublin-based maternity sites that they had no intensive care facilities within the three hospital sites. I put up my hand and said I did not realise that. Are there infrastructural difficulties which should be shared

with us and on which we might be able to reflect because I have made the point that the passage of legislation is not only about what it says but also about the capacity to implement and that means resourcing?

I wish to ask about one particular issue which has not presented before, that is, the incidence of ectopic pregnancy. Again, I put up my hand and say I always thought an ectopic pregnancy occurred outside the womb, but it is all about learning, which is why we are here. Are the witnesses making a case to include this in the legislation? Will they elaborate a little on it? Do they accept that we have made no other such exceptions in terms of physical illnesses presenting? Might it not be covered? Would the witnesses' professional assessment be sufficient to determine whether a termination was required in the so-called 7% of cases that present a risk to the life of the mother?

Deputy Billy Kelleher:

We are talking about smaller maternity units, but I presume a lot of the complicated pregnancies would be referred to the larger hospitals. Was there ever a time when a woman had to be referred to England for a termination because the professionals were unsure, because of a lack of clarity in the law, about continuing treatment or intervening to save her life where there was not an immediate substantial risk but a potential risk if she did not receive treatment?

I refer to the broader issue of resources. I know it is not part of the heads of the Bill, but it is critical if we are passing legislation which will immediately, or potentially, overburden maternity services. Dr. Sam Coulter-Smith feels the legislation, as is, could potentially overburden maternity services. Do the witnesses have concerns about this happening in the smaller maternity units throughout the country as a result of the legislation as it is constructed?

Deputy Seamus Healy:

I apologise for the duplication of questions, but in this session we are dealing specifically with how the proposed Bill will affect the smaller and more rural units such as the one in south Tipperary from where I come. I seek clarification on the appropriate locations. I take it from what the witnesses have said the locations need to be broadened because there may not be psychiatric care facilities, for instance, on-site. For example, the unit in Limerick is stand-alone and does not have a coronary care or intensive care unit immediately available. What exactly are the witnesses saying in terms of extending the locations? Are there enough personnel available in the smaller units to actually implement the provisions set out in the Bill? If there are not, what other personnel might be needed? It has been suggested that in most of the units, one is talking about one in three or one person being available every third weekend.

What difficulties are caused by that? The possibility of a local panel, a national panel, or both, has been suggested in relation to that.

I have a related question on how smaller units might be affected by conscientious objection. Could such objections result in personnel not being available in smaller units to undertake the provisions of the Bill?

I would like to revisit a question I asked in the previous session. Do the witnesses feel that the Bill, as currently proposed, gives adequate clarity and protection to medical personnel in their units?

Chairman:

Does Dr. McCaffrey want to start?

Dr. Mary McCaffrey:

I represent the second smallest unit. Clonmel is a little behind us. The questions asked by Deputies Ó Caoláin and Healy about smaller units are quite similar. I think we need to step back and look at the three indications which are outlined under this Bill. When we talk about the risk of loss of life from a physical illness in a medical emergency, we are looking at women who have severe infections, bleeding or severe pre-eclampsia. As I said already, sadly we deal with this every year in all of the small maternity units throughout the country. We deal with it appropriately and in a manner that is clinically appropriate.

Obviously, we all want more resources. In an ideal world, there would be no three-person maternity units in the country. That stance would certainly be taken by many senior obstetricians. We have three-person maternity units at this time. We deliver care to women in emergency situations. We deal with it adequately and appropriately. We link into our sister hospitals. Tralee General Hospital's sister hospital is Cork University Maternity Hospital. Some of our patients from north Kerry go to Mid-Western Regional Maternity Hospital in Limerick. We have access to the expertise from those places.

When a woman who walks in the door needs to be dealt with there and then, we have the resources to deal with her. Ironically, the maternity unit in our hospital has an intensive care neo-natal unit and access to a cardiology service in the town. We regularly do teleconferencing for non-maternity cardiology cases. The cardiology team sends down teams to look after patients who are not pregnant. Our resource is better, in many ways, even though we have a smaller maternity unit.

We were also asked about the risk of loss of life from physical illnesses such as cancer. Severe cardiac disease was the other example that was used. As a general principle, patients in those types of situations tend not to need immediate care within the next hour. We have access to the specialist care units in Dublin, Limerick and Cork. I think most small maternity units have appropriate links and are able to care for their patients. There are multidisciplinary cancer teams. There is an oncology team looking after each unit at this stage.

I am not here to speak for the psychiatrists. The committee will have access to them on Monday. The psychiatrists in my unit appear to think that they would not have the resources to deal with this and that additional resources would be needed. Ironically, it is not an obstetric resource in that situation.

Conscientious objection would never come into play when someone's life is in danger there and then. That has always been our practice at the time the woman is dealt with. Nothing will change in that regard. Obviously, we would expect every doctor to look after an acute medical situation. In a less acute situation, we would expect doctors to meet their requirements under the Medical Council guidelines. If they are not going to look after a

patient, we would expect them to ensure someone else looks after that patient in a timely manner. I would be disappointed to hear there is any unit where a person would suffer due to a conscientious objection of all the staff. I do not think such a unit exists. We will always look after the life of a mother and the life of a baby.

I do not think I have missed anything that was asked about small units. We will keep saying we need more resources. I do not think any woman will suffer in a small maternity unit as a result of a lack of resources if this legislation is enacted.

Dr. John Monaghan:

Deputy Kelleher asked about referring people to England for a termination. I have never referred anybody to England for a termination. I have sometimes referred people there for medical or diagnostic expertise, but I have not done so for a termination. I know that women are referred there for treatment or delivery in cases of congenital malformations, but such cases are not the subject of this legislation.

The Deputy also asked about the overburdening of the maternity services. Our unit at Portiuncula Hospital delivers approximately 2,200 mothers a year. We might encounter one or two cases of serious maternal illness where the pregnancy has to be ended. I think the figure given for the Dublin hospitals was 30 a year. Such cases do not overburden the maternity service. If a patient has a very serious fulminating pre-eclampsia, for example, she might need to be transferred to a tertiary unit in Galway or Dublin. There may be problems with the transfer if there is overcrowding in the tertiary centre. I do not envisage that this legislation will overburden maternity services significantly unless there is an explosion in the number of terminations of pregnancy under psychiatric or self-destruction grounds.

Deputy Healy asked whether psychiatric services are located alongside maternity services. In the rural system, there might be a maternity or general hospital in one town and a psychiatric hospital in another town. In practice, almost all of the rural maternity units are in close proximity to a psychiatric department. I am afraid I did not understand fully the question about the central location of personnel.

The Deputy also asked about conscientious objection. As Dr. McCaffrey said, if one is prepared to allow a mother to die, one is guilty of very serious professional negligence. There has been no maternal death in my hospital, or death of a woman who was transferred out of the hospital, for 29 years. I am sure that is the norm throughout the country. It is not true that the conscientious refusal by obstetricians to offer necessary treatment which might involve termination of pregnancy is leading to maternal deaths. I am sure it has been pointed out already that this country's maternal mortality rate has always been significantly lower than the rate in the UK, regardless of the figures one uses. Similarly, the maternal mortality rate in Northern Ireland, where the UK Abortion Act does not apply, is lower than the rate in the rest of the UK. I do not think conscientious objection could be considered to endanger women's lives in any way. We do not know where conscientious objection would arise in psychiatric cases. I do not know how an obstetrician would deal with an emergency precipitated by suicide. I cannot imagine that scenario.

Dr. Máire Milner:

I want to make a comment about the development of networks around the country. It has been proposed that hospitals would work with a larger centre. In our own instance, the Rotunda Hospital would work with Cavan General Hospital and Our Lady of Lourdes Hospital, Drogheda. In fact, this works very well. Quite a lot of service development is currently ongoing. A huge amount of support and back-up is available from regional centres. This is taking place and being rolled out around the country. This helps greatly as a means of support.

Dr. Gerard Burke:

I shall first mention the psychiatry cases as there is a lot of hysteria about the matter. In my career I have never encountered a patient who was suicidal and was brought to me to discuss a treatment that might include a termination.

Chairman:

I ask the witness to talk into the microphone so that people can hear him.

Dr. Gerard Burke:

This has never happened in my career and I do not expect that it will. The numbers are so small, most of us will never see this in an entire career.

The idea that you would have a patient arriving into your office with two abortion tickets from random psychiatrists is nonsense. That is not the way that medicine works. We would have a working relationship with the psychiatrist. If you did not know the psychiatrist and did not trust them you certainly would not be doing anything near terminating a pregnancy. The institute has made a suggestion in this regard, there would be a second obstetrician involved and I would support that. I can tell you, there are very few of us in the country - 125 consultant obstetricians - and we are not beholden to psychiatrists telling us what to do. We have to do this procedure ourselves so we are going to be absolutely certain that it is thoroughly justified, medically and ethically. That is the way medicine operates.

In regard to Deputy Ó Caoláin's question on whether Limerick is different, Limerick has 5,000 babies and eight obstetricians so it is more like Dublin and Cork. We do not have the problem of small numbers. We have the entire range of sub-specialty facilities available. I would say that when there is any question of a maternal death, the entire resources of the hospitals are wheeled out to deal with that woman. It goes to the top of the priority list, as you can imagine. They are taken extremely seriously. Cardiologists etc. would drop everything to deal with a thing like that.

In regard to resources, we have very few obstetricians. When the country was awash with imported money a few years ago not a red cent was voted to improve the resources by this House. The Deputies were aware of the issues because the numbers were well known but not a red cent was put into maternity services.

With regard to the question of an ectopic pregnancy, this happens in about maybe one in 2,500 cases so we will see a number of cases. In my unit we will see two every year. They are extremely difficult to deal with. They are one of those issues that could come under this legislation. We do not refer people to England for terminations but a lot of our patients, in

difficult circumstances, elect to go to England for a second opinion. Of course, we have a responsibility to make sure, if they are critically ill or unwell, that they do not go to an inappropriate place. They would be pointed in the right direction of where they could get top class care in a university type hospital with a full foetal maternal medicine service. We do not have data on this, in terms of numbers, but certainly it is not extremely rare.

A conscientious objection would not arise in my unit. There are eight of us and I do not think there will be any difficulty about providing opinions and care.

Is there adequate clarity? The one issue that I would bring up is that I think you, the legislators, should determine what is meant by a real and substantial risk to the life of the mother. I think that is your job but because we cannot put numbers on it, because we do not have data, because things change over time, because the timeframe is very unclear, because the dates in the literature are very unclear, and we often only have our expertise, experience and knowledge to work with, I think it would be beholden of the Deputies here to sign that job over to the obstetricians and the other medical experts. I think that should be specific in this piece of legislation. You can trust us in this regard. The people who are in at night and at the weekend dealing with haemorrhages and heads that are impacted, we are not waiting in the long grass to start doing terminations. That is not the way we operate. I think that the Oireachtas can trust the medical profession that it is going to do its absolute best to save every single life. That is what we do, day and night.

Deputy Ciara Conway:

I thank Dr. Burke for his comments and he summed up the debate very well.

I come from Waterford which is a small service - it might dispute that - but I mean in comparison with the ones that we heard about earlier today. I would like to clarify the following matter. If a woman has a pre-existing medical condition is it most likely that she will be referred to Dublin or the specialists? The super specialties cannot be in every hospital. They are in Cork University Hospital or one of the specialist hospitals in Dublin. Is it not good practice for a woman with a cardiac problem, regardless of whether she is pregnant, to be sent to the most senior cardiologist to get whatever specific care necessary? A pregnant woman should also enjoy such specialist care. Is that the current practice in small hospitals? My feeling is that it is but perhaps it is worth saying.

I want Dr. Monaghan to clarify a matter. He said that maternal deaths were higher in the UK and he asserted that this is directly linked to the fact that abortion is available in the UK. Is that what he said? I am not sure about the correlation. If I picked him up wrong, I apologise. However, I would appreciate some clarification on that point.

Senator Jillian van Turnhout:

Deputy Conway has asked my question on specialists.

This morning we heard from the Irish Medical Council and the Institute of Obstetricians and Gynaecologists. The institute, in particular, suggested that heads 2 and 4 should be merged because it does not differentiate in terms of logistical arrangements between physical or mental reasons for considering a termination. They did agree that maybe the number of

specialists involved in the different decisions would vary but that they should not be differentiated within the Bill.

Dr. Monaghan rightly explored with us the complexity of some cases such as oncology and said that each case would be very different. My understanding is, and I was a little concerned with some of the comments made, that psychiatry is a medical specialty and psychiatrists are qualified doctors. However, I know that we will explore the matter more on Monday.

Let us examine the resource issues and availability, especially locally, out-of-hours and during holiday periods. I shall try to put myself in the position of a woman who is in a place that none of us wants to be in, whether it is a physical or mental diagnosis that she has received, what help can she receive from the locality? Will she be referred to Dublin? With regard to the time limits stated in the legislation, are the specialties available in a local area? Will she be referred to a larger unit?

I fully respect conscientious objection and it is important. Do we need to consider, when we are examining geographically appropriate locations, whether we will have an adequate number of professionals employed who have not declared a conscientious objection?

Deputy Regina Doherty:

I had looked forward to hearing the contributions this afternoon because there was some genuine concerns raised with regard to how the process would be carried out differently in some of the smaller hospitals around the country versus some of the larger hospitals in our cities and in Dublin. The delegation addressed the matter but raised more concerns for me after two of the witnesses this afternoon addressed certain things. Dr. McCaffrey spoke about introducing a new medical procedure and by so doing said we would have to ensure that there was specific training provided. Dr. Monaghan talked about the difference between a surgical termination and a medical termination. Now I am confused.

The very clear message we got this afternoon from the three masters of the maternity hospitals who attended earlier was that this is about the protection of life of both the mother and, in all cases except the worst, of the life of the baby. In my head, surgical termination does not come into that equation. In my head, that is not the introduction of a new procedure into Ireland. It is doing something Dr. Monaghan says we are already doing on a weekly and monthly basis and something Dublin hospitals say they already do in terms of medical interventions anyway. Can Dr. Monaghan clarify for me if there is a variance in practice or in the perception of what the uniformity of practice might be, or is it the case that I am picking up what he is saying incorrectly and as something different from the determination of the three masters who spoke this afternoon as to how they see things panning out if the legislation is passed?

Dr. John Monaghan:

On Deputy Conway's question about smaller hospitals and specialists, most hospitals probably have between three and five physicians, that is, medical people, who would generally cover one specialty each. The commonest arrangement might be to have an endocrinologist, a cardiologist, a gastroenterologist and, perhaps, a respiratory physician. Roscommon Hospital, which is near Ballinasloe, has a respiratory physician but there is not one in Portiuncula. There is a cardiologist in Portiuncula Hospital. That would be the

arrangement. In the case of a serious medical problem, such as a woman with a major heart disease, a local assessment would decide the severity. There are many patients with mild cardiac disease being managed in local hospitals, and then the move to transfer them would be made. I do not think there has ever been a problem with referral or obtaining expertise. I referred earlier to the cancer problem, which I thought was different from cardiology. One finds cardiology expertise in Galway and Cork, and specific skills would not be required for the management of pregnant women. If surgery were required, it would not be that much different. I do not know if that is helpful on the specialist question.

I was asked about maternal deaths. There has always been a difference, as is well known, between Ireland and the United Kingdom. The question was whether this was because of abortion. I am not suggesting it is because of abortion, but I suggest that if abortion was a significant factor in the improvement of maternal health, the figures should be better in the United Kingdom than they are in Ireland, especially given that a very large number of terminations are done in UK. I suggest that the results should be better in the UK than they are here if medically mandated abortion improves women's health.

A related issue which I have studied slightly myself is the problem with recruitment into obstetrics and gynaecology in the United Kingdom for the last 35 years. The matter is well written up in the reports of the Royal College of Obstetricians and Gynaecologists. Another study which was published in the *British Journal of Obstetrics and Gynaecology* showed that recruitment into obstetrics and gynaecology was highest in Northern Ireland and lowest in places like Leeds and Oxford. Certainly, Dr. Jim Clinch, who was one of the doctors who was keen to come today but could not, is of the opinion that if an abortion culture becomes widespread, it seriously affects recruitment into obstetrics and gynaecology. That would have been my experience. I worked in the NHS for three and half years in total. Certainly, in my time in the north of England, I used to speak to medical students and ask them if they would consider a career in obstetrics and gynaecology. During the two years I was in the north of England, no student said he or she was interested in a career in obstetrics and gynaecology. When asked the reasons, fear of being sued and a hard-working rota were cited, but the single biggest factor was that students did not like the abortion culture, not for particularly ethical reasons but because it was distasteful to them.

I was asked about psychiatrists as qualified doctors. I cannot second guess psychiatric expertise, but I do not think psychiatric expertise around the country is different to the expertise in the city. Much is made of the availability of perinatal psychiatrists and I am not sure that is as important as has been stated.

Dr. Máire Milner:

Deputy Conway asked about surgical termination as referred to by Dr. Mary McCaffrey. This is very similar to a procedure we employ for miscarriage. Absolutely, there are issues. While I am not sure a consultant would have to retrain, things will depend on the circumstances. This is not in any way going to be a very common scenario and it does not introduce hugely difficult technical or logistical difficulties. Surgical termination is a procedure that is employed every day in some hospitals. It depends. There are now many ways of dealing with miscarriage where the uterus has not started to empty itself. We are talking here about where a woman's life is in danger, which means one is often talking with someone who is very ill. Sepsis, which we have all been hearing about from the case in the media, is often occasioned by the rupture of the membranes and the pregnancy is, therefore, already starting to evacuate

itself. It is similar with severe pre-eclampsia or haemorrhage. Very often, the haemorrhage is coming from the uterus which is emptying itself anyway. I do not think there is a huge concern about technical difficulties. I do not know if I picked up the Deputy's question correctly.

Deputy Ciara Conway:

If I am correct, Dr. Milner is saying that the difference between a surgical and a medical intervention is that a surgical intervention means conducting a D and C whereas a medical intervention means-----

Dr. Máire Milner:

Giving tablets.

Deputy Ciara Conway:

-----delivering the baby and trying to save it.

Dr. Máire Milner:

No. Very often, we use medication in early pregnancy where women have a missed miscarriage. This is an everyday procedure happening several times a day in our maternity hospitals. Very often, when one approaches this medically, one still ends up in theatre as parts of the pregnancy are still left inside. One can use medical or surgical means early in pregnancy. After 12 weeks, it is probably much more likely one will use medical means due to the size of the baby's limbs and the size of the head and so on.

Dr. Mary McCaffrey:

I will deal first with the issue of pre-existing medical conditions. More and more women in the reproductive age group have pre-existing medical conditions who heretofore either may not have been alive or in a position to be pregnant. There are many women who had cardiac surgery as children who will already be under the care of a cardiologist. It is absolutely hard to believe that they would be managed anywhere other than at a tertiary referral unit. For example and as I mentioned in January, the Coombe Women's Hospital has a very specific clinic where it looks after medical problems in pregnancy. They liaise with various specialties. The question the Deputy is asking is whether we refer people on to centres with special expertise. Certainly I do and I am sure most colleagues do. Women are also very well informed now and women who have come from a clinic like that where they have been with a cardiologist since they were two or three years of age will be very well versed in the risks to them in terms of their pregnancy and will already know they need to be under specialist care.

On access to psychiatry at weekends, a woman who is pregnant is no different from any person who walks into an emergency unit at the weekend who is seriously ill, be it with a psychiatric illness or otherwise. Every unit that has a psychiatric service has 24-7 psychiatric care. Whether a person is male or female, pregnant or not, he or she is assessed. The service kicks in immediately as does the liaison team.

I am not sure what the right answer is to whether people should declare conscientious objections in advance. It would be disappointing if people were discriminated against and disadvantaged. The situation will be extremely rare.

With regard to training for new procedures, when I was collaborating around the country this was an issue brought up by a person who felt the institute and the Medical Council should ensure people were versed in the types of procedure and at what gestation one would do a surgical rather than medical procedure. It is really more about guidelines and ensuring everyone is appropriately trained to manage the situation. Managing a miscarriage is slightly different to managing what will be a live child after 12 weeks gestation. It is important to have guidelines that people are aware of. We see people back from the UK with complications from termination. This is in a country where people are trained. In the same hospitals in the UK, some will have operations and some will have medical procedures. It is important to have training, consistency and guidance for clinicians because there will be occasions where doctors will be employed who have never been exposed to these kinds of procedures before.

Dr. Gerard Burke:

With regard to Deputy Conway's comments on Waterford, her clients in Waterford are probably in a better position than many clients in Dublin because the patients in Waterford with cardiac disease will be delivered in a hospital with an intensive care unit and a coronary care unit. I discussed this matter with Professor Fionnuala McAuliffe earlier in the week with regard to a patient I delivered on Wednesday at the regional hospital with cardiac disease. There was no point sending the patient to Holles Street because they would have to bring her to St. Vincent's Hospital. This is a resource issue. This is the Joint Committee on Health and Children and it behoves members to do something about the state of maternity services. It could be solved quite easily and we could build four new maternity hospitals relatively cheaply if we issued a new tranche of the national solidarity bond and called it maternity bonds. It would solve the problem for relatively little investment.

Chairman:

We will tell the Minister for Finance.

Dr. Gerard Burke:

The other issue is a new medical procedure but I do not think it is a new medical procedure. If people feel they were inexperienced, transfer is an option. I agree with the institute that psychiatric illness is an illness, the same as any other, and it is reasonable to merge heads 2 and 4.

Chairman:

We have five committee members left to speak.

Deputy Peter Fitzpatrick:

Deputy Regina Doherty asked a question I was going to ask. Fair play to her. I asked all the questions I had to ask in session 3 but I will repeat one question about which many of my

constituents are concerned. Are the witnesses satisfied the proposed legislation will provide for mandatory care of newly-born children resulting from later stage termination in order to vindicate their equal right to life in the Constitution?

On the list of smaller hospitals, I see Our Lady of Lourdes Hospital in Drogheda, which the people of Louth call a big hospital.

Chairman:

The list refers to other hospitals, not small hospitals.

Deputy Peter Fitzpatrick:

It is doing a fine job.

Deputy Denis Naughten:

I refer to Dr. Gerard Burke's evidence. He flagged an issue flagged in January, which is how to define a real and substantial risk. He referred to it on a number of occasions. Last January, Dr. Rhona Mahony, master of the National Maternity Hospital, raised the specific concern of whether a real and substantial risk is 10%, 50%, 80% or 1%. Interestingly, the evidence of Dr. Gerard Burke contradicts the evidence of Dr. Rhona Mahony earlier. She believes the legislation provides clarity. I do not believe there is but Dr. Gerard Burke could comment on her evidence.

In Dr. Tony Holohan's evidence, he said that there may have been women who had early deliveries due to suicidal ideation. Although two of the witnesses were asked twice, they did not answer that question. I ask the four witnesses whether they have experience of early delivery based on suicidal ideation. Has it happened within their facilities?

We are anxious to have smaller units present to indicate whether there are different implications for smaller units in respect of this legislation. Subhead 1 defines the appropriate location. With regard to Dr. John Monaghan and Portiuncula Hospital, the facility must provide obstetric and mental health services. That is quite close at the moment, with Portiuncula and an acute unit in St. Brigid's Hospital in Ballinasloe. There are two acute psychiatric units in the Roscommon-Galway services, one in Ballinasloe and one in Roscommon. One of these will close in the not-too-distant future. If the one in Ballinasloe closed, would that have implications on the delivery of the service? I ask the speakers from smaller hospitals if they have specific concerns regarding the implementation of the legislation and the definition of appropriate location when they consider the traditional agenda within the HSE to remove the smaller units. A HIQA investigation is ongoing and we do not know what recommendations are going to come of it. Have the witnesses any fear the legislation could be a Trojan horse?

There are normally three consultants in smaller units. Do the witnesses fear that if the three consultants had a conscientious objection to carrying out procedures and one was to retire, there would be an agenda to ensure a new consultant does not have a conscientious objection and would be recruited on that basis?

Are the witnesses satisfied with the neonatal emergency transport service available to them? Will that be adequate in future? Are the witnesses satisfied with the existing level of psychiatric support for pregnant women?

Deputy Mattie McGrath:

I welcome and thank the guests. It is a relaxed session and I find it beneficial. The submission from Dr. Gerard Burke says it is unwise to attempt to produce a prescriptive legislative framework to cover all eventualities. Are clinical guidelines preferable and does legislation run the risk of being overly prescriptive? The witnesses make no reference to head 4 in the submission. Is termination of pregnancy justifiable on the grounds of the mother's threat of suicide? Will many of the witnesses colleagues have concerns about it?

Resources have been mentioned all day. With the conscientious clause and the risk of having to employ dozens more people in the profession, we will not see our children's hospital built until 2050. The date was put back to 2017-----

Chairman:

Deputy Mattie McGrath should stick to the heads of the Bill.

Deputy Mattie McGrath:

I am sticking to the heads of the Bill. I am making a comment outside of the Bill as a member of the committee.

Chairman:

I am being impartial and fair to everyone.

Deputy Mattie McGrath:

The Chairman can be more fair to some than others. I am asking that the Chairman allow me to make a brief comment, within my time, as a member of the committee. Resources are a major issue and have come up all day. Where will we get the resources if and when we pass the legislation?

Senator Jim Walsh:

I compliment the four obstetricians and thank them for their forthrightness. It is refreshing. We have been homing in on suicidality, which is an area of concern for many.

It is quite a subjective area. Could the witnesses comment on the recording of the data, under the heads of the Bill, which only goes to the Minister? We have asked this of other witnesses. It should be done in a manner that is crystal clear, so we know precisely why and in what circumstances it was the only treatment on offer, and this could be reviewed publicly. Will the witnesses give us information in that regard and whether that type of information, with the names retracted, should be available under freedom of information?

Dr. Mary McCaffrey mentioned the conscientious objection issue and, in particular, people opting out. That is a concern if people of a particular disposition exclude themselves from the panels. As we have seen in the media over many months, the medical profession have people on both sides of this argument so the outcomes could be skewed as a consequence. I wish to link that with the comments about the lack of resources which have been made by all the groups appearing before the committee. Resources often lead to shortcuts being taken. Therefore, while it might start in a very thorough fashion, as happened in other jurisdictions, that will change within a short space of time.

Dr. Máire Milner welcomed the Bill and said it gives clarity. Dr. Rhona Mahony also welcomed it for the same reason. However, when Deputy Creed put a question to her about identifying in the Bill where she got that clarity, she was unable to pinpoint the areas. Can Dr. Milner point to the sections in the heads of the Bill which give her the comfort of that clarity?

Chairman:

Thank you, Senator.

Senator Jim Walsh:

still have a minute.

Chairman:

You do not.

Senator Jim Walsh:

Finally, I have a question for Dr. Monaghan and, indeed, all the witnesses. Has there been any case in their experience where they have been so inhibited by current legislation that they were unable to deal with a mother whose life was at serious and substantial risk? Previous speakers were asked that question and only one case was cited, which was the recent case in Galway. I understood the coroner said in that case that, in fact, it was different issues rather than the legislation. Are any of the witnesses familiar with that case to shed more light on it?

Senator John Crown:

I welcome our colleagues. It has been a long, gruelling day. We have a couple more ahead of us and it is great that we have heard such a spectrum of opinions. I must give a slight preamble before the question.

Chairman:

I wish you would not do that.

Senator John Crown:

I must. Sometimes my colleagues here miss one point, which is that in western countries maternal mortality is an extraordinarily rare event. In Ireland in recent decades we have had entire years with no maternal mortality. The occurrence of one maternal mortality is a

disaster. If we have to legislate to prevent one maternal mortality, we should do it. This is not like cancer or heart disease mortality, where there are thousands of deaths per year. This is different and we must treat it differently.

In the previous hearings, I got to the crux of the matter by putting the Dublin folks through a detailed interrogation. We worked out that, although figures are not kept, there are approximately 30 abortions per annum in Ireland within the legal parameters of our Constitution, that is, to preserve the life of the mother. They reckoned there were six to eight in each of the Dublin maternity hospitals and, with a little extrapolation, that is what we reckoned to be the probable total. I have asked some of my colleagues about this and my understanding is that the great majority of these will be for cardiovascular complications, blood pressure emergencies, renal failure emergencies, occasionally haemorrhage and sometimes cancer.

Incidentally, in a long career of practising cancer medicine I have never had to send anybody for an abortion to save their life. It is not typically the way it happens. Many of my patients have made a decision to have an abortion and I have supported them in their decision, but I have never said to them that they need it to save their life.

Of the 30 cases per annum, the great majority will fall into the categories I outlined. My best guess, and I ask my colleagues to comment on this, is that in the majority of those cases it is not a sudden, out-of-the-blue event where a previously normal healthy pregnancy suddenly deteriorates. There is usually a warning - the woman has had pre-eclampsia, which is a blood pressure and kidney problem occurring in pregnancy, or it is discovered that the placenta is dangerously misplaced or that there is cancer-----

Chairman:

Thank you.

Senator John Crown:

One second, Chairman, I have not interrupted anybody today and I have tried to stay within my time, so just hear me out.

My understanding is that in the great majority of cases there will be warning, so the scenario of this type of occurrence occurring in one of the smaller hospitals is very unlikely because the hospitals will generally refer the patients to one of the larger, specialist units at an earlier stage in their pregnancy where they will be cared for by the high risk people. In those rare cases where it will occur in the smaller hospitals, it will be category one or the emergency. It is the one where the patient is either bleeding or dying of blood pressure, the doctor cannot consult, there are no psychiatrists and the patient is not suicidal. The doctor sees a woman whose life will drain from her body in the next few hours if they do not end the pregnancy, something which is very rare. That is my understanding of the only cases the witnesses will see. Is that the case? Should anybody have a right to conscientious objection in that setting? If they do, they should not be in that job.

Chairman:

The final speaker in this section is Senator Aideen Hayden, who is replacing Senator John Gilroy for this session.

Senator Aideen Hayden:

I thank Dr. Burke, Dr. McCaffrey, Dr. Milner and Dr. Monaghan for a really interesting session. As one of the witnesses mentioned, medical treatment is evolving and what we want is robust legislation that allows medics to do their jobs in the future. That is the bottom line. That includes mental health and mental health treatment. I have some specific questions about the heads of the Bill for all of the witnesses.

With regard to head 1, appropriate location, do they have a view on the designated hospitals or do they think that list should be extended to cover all approved hospitals?

At present, the definition of the unborn makes no allowance for where a foetus has no prospect of survival or, indeed, is already dead. Do the witnesses think we should consider changing the definition of "unborn". Dr. Burke has already given his opinion on heads 2 and 4 and their amalgamation. Do the rest of the witnesses have a view, given that the Medical Council and the Institute of Obstetricians and Gynaecologists have indicated that it would be useful to merge them on the basis that they go to the crux of the issue, which is a threat to the health of the mother in pregnancy?

With regard to the requirement in head 4 for two psychiatrists, a view has been expressed that this might be unduly onerous, particularly depending on where one is located in the country. Ironically, it might be more difficult to comply with that requirement in Dublin than it might be in other locations. As Dr. Burke said, one might be less well served in Dublin than one might be in other parts of the country. Is the requirement for two psychiatrists unduly onerous? More importantly, is it unduly restrictive in requiring one of the psychiatrists to come from one of the hospitals that have been nominated for the purposes of carrying out a termination?

As regards the provisions under heads 6, 7 and 8 and the timescales provided, do the witnesses believe those timescales are workable or could they be further reduced?

My final question is about the penalty of 14 years imprisonment provided for under the legislation. Do the witnesses have a view on the severity of that penalty?

Chairman:

Deputy Kelleher indicated he had a question.

Deputy Billy Kelleher:

Have the witnesses ever encountered a case, either through peer discussions or in their own facilities, where they felt they had to refer a woman to England because they were unsure within the current parameters of the law, in order to provide treatment when she returned? In other words, she would not be able to get the treatment until such time as a decision had been made on that. Perhaps they will clarify that.

Dr. John Monaghan:

On the last question, I said "No" earlier.

I am getting a little confused, Chairman, due to the number of questions. The first one I have noted is on the care of newborn children. Was it about the care of newborn children who were born following a termination of pregnancy?

Deputy Peter Fitzpatrick:

Is Dr. Monaghan satisfied that the proposed legislation will provide for mandatory care of newborn children resulting from a later stage induction in order to vindicate their equal right to life under the Constitution?

Dr. John Monaghan:

On that question, one would have to separate the physical illness from the psychiatric component. With physical illness, one may be forced to deliver the baby because one has to do it. Simply, the baby could be born at 20 to 24 weeks; it has to be done. The psychiatric component is unknown. The question has arisen as to whether one could care for the woman until the baby had reached a certain stage of viability. It has been suggested if a child is delivered at 23 or 24 weeks and survives, because of the age at which it is delivered, it is significantly more likely to be handicapped by cerebral palsy or blindness or suffer from another serious life-long disability. I could not say anything more than that on that question.

On the real and substantial risk and the obstetrical element of impending serious maternal illness, an experienced clinician knows a real and substantial risk. Decisions on the medical complications involving cardiology, cancer, etc. are often multidisciplinary and an experienced clinician would know the answer intuitively. The only question to which the answer is unknown is that of suicide. I cannot comment on it.

Deputy Denis Naughten referred to the subhead on obstetric and maternal health and the closure of a psychiatric unit. I would not be able to tell whether the closure of a unit in Roscommon, for example, would affect the unit in Ballinasloe or *vice versa* in terms of the availability of services. There is a centralising tendency within the HSE and, in the past 15 or 20 years, hospitals have gradually been run down. Dundalk, Monaghan and Roscommon are examples. I do not know what the effect from a psychiatric point of view would be. As I said, I am not a psychiatrist. If a problem proves to be an important medical one, the nearer the psychiatric help is to an obstetrical unit, the better. The question on appropriate locations and the removal of smaller units was the same.

Senator John Crown asked about maternal mortality, which he said was exceptionally rare. It is clear that the rate of maternal mortality is rising and has been for approximately the past ten years in the United Kingdom, Denmark, Canada and the United States. There is little evidence that it has risen in Ireland, but I do not think we can tell as yet. There are multiple reasons for the trend. The major one in the United Kingdom has been sepsis, or infection, in addition to increasing maternal age and higher rates of multiple pregnancy. There are many reasons. One component may be training and the care of pregnant women.

On the question about it being sudden or not sudden, it is correct to say many of situations of termination of pregnancy in a rural unit would arise on a Sunday afternoon when somebody arrives in suddenly having seizures, in which case the baby has to be delivered immediately.

Regarding whether one can extrapolate from this to take in the suicide question, I am not going to answer and I am not capable of answering. As I stated, it is a matter of grave concern to me.

Consider the question of having a right to conscience in a smaller department or rural unit. As I said, there is no evidence that conscientious objection has led to any maternal death. Senator Jim Walsh asked about the case in Galway. Certainly, there was no mention of the word “conscience” in the inquest report, which I read.

Deputy Denis Naughten:

Has there been any case of early delivery on the basis of suicidal ideation in Dr. Monaghan's unit?

Dr. John Monaghan:

It was never the case in my experience. I do not know of it ever having been an experience.

Dr. Máire Milner:

Let me take the final point, on suicide. There were several questions on suicidal ideation and the termination of pregnancy at very early, intermediate or late gestations. We were asked directly whether we had had such a case. Psychological and psychiatric problems are very common in obstetrics nowadays as life is tough for a lot of people. We deal all the time with mental health issues. A question was asked about psychiatric support and whether it was adequate. We do not just go to the psychiatrist for psychological or psychiatric support; it is inherent in what midwives and obstetricians do. All members of the team are involved in supporting women.

With regard to delivering in the circumstances in question, it would be common to induce labour a week or two before, or usually within the ambit of, full term. Occasionally, it is slightly earlier on the grounds of mental health. Suicidal ideation is probably more common than we think because most people contemplating suicide do not tell anyone this during pregnancy. As far as we know, however, it is very rare.

Personally, I have had one or two cases in which a woman was in a psychiatric hospital for a condition directly related to the pregnancy. One woman almost died on her first attempt at suicide, but it was never related to the question of terminating pregnancy. It never came up. She absolutely wanted to have her baby; it was the hormonal effect that was in question. The Bill is about the threat to the life of the mother by suicide or physical illness. It would be very rare, but, as with everything, one will see everything in one's practice if one lives long enough.

With regard to the comment made by Senator John Crown on what we are going to see, I do not believe we see anything different in our practices from what is seen in Dublin. We see fewer of the most difficult medical cases. We may not have as many women with congenital heart disease or who are having cancer treatment in pregnancy. We have a lower concentration, but we see the entire gambit. Often, as Dr. Monaghan says, what one must deal with is what turns up on a Sunday afternoon. We are not exactly in a different category; we are dealing with the same spectrum.

I have never referred to the United Kingdom from the point of view of worrying about a woman's medical condition, or in terms of having concerns for her future during the pregnancy. Personally, I have never had to do that, nor has it come into my ambit of practice.

On the question of where I can find clarity in the Bill, I am not a lawyer. I have simply read the heads of the Bill. In several situations in my career I had a worry at the back of my mind about a woman who was very sick with sepsis, in circumstances very similar to those in the Galway case, and I had hoped nature would deal with it. In fact, that is what happened, very happily. Nineteen times out of 20, nature does deal with things, but, unhappily, it does not always do so. For me, my patients and the staff on my team, the Bill gives my practice more clarity. I note this from having talked to my colleagues.

On the conscience clause, I again refer to the comments of all of my colleagues. First and foremost, we save the woman's life. We do not set out to terminate a pregnancy, but one does what has to be done to save the woman's life. There may be time to play with and one's conscience can come into that in some way. It is as likely to be one's skills as one's conscience that will come into play. As Dr. McCaffrey said earlier, if one does not feel one is able to deal with something, if one has time to play with one can refer to another colleague. The woman has a right to life, and that is the primary right. I have dealt with most of the questions.

Dr. Gerard Burke:

My colleagues have dealt with a lot of the issues. I will again refer to the substantial risk and what its size may be. A figure of 10% was mentioned as the smallest one. If, over the next six months, 166 Deputies and 60 Senators were told that 10% of them, or 20 Deputies and Senators, would be dead by the end of that period, nobody would be in this House today. If we reduced the risk to 1%, two Deputies or Senators would be gone. I do not know which two it would be. That is the ridiculousness of trying to put a number and percentage on risk.

We do not know the numbers. When a complex patient comes along one cannot go to the medical literature and figure out the woman's exact percentage risk of dying if she is still pregnant next month or the month after. We simply do not know. The only way to deal with this is to say that the matter is for the opinion of the medical experts. I request that Deputies write that statement into the Bill, namely, that it is a matter for medical experts and the guidelines of committees that will oversee the legislation at hospital level.

In regard to the number of maternal deaths, infection is a particular factor that creeps up on one out of the blue. One does not see it coming. A patient who has ruptured membranes could be very well one day and have very mild signs of infection but could be extremely ill 24 or 48 hours later. My understanding is that there was a significant rise in the number of maternal deaths in Ireland last year. We have a low base, but it is possibly only a statistical chance. We would not be able to say there was a trend unless we had seen the figures for three years or so.

I agree with Senator Walsh that we should have much better data collection nationally on every aspect of medical care, not just this. It should be done so that everybody is clear what the effects of the interventions are; about that there is no doubt.

I answered Deputy Kelleher. I have never referred anybody to England for a termination.

The question of appropriate locations was again raised. There is a strong view from all of us that it should include general hospitals. I also agree that psychiatric illness should be treated in the Bill in the same manner as cardiac or respiratory disease. It is a real illness and carries substantial mortality. It needs a multidisciplinary approach, the same as one would get if one had a heart problem.

Deputy Seamus Healy:

I asked about early deliveries on the basis of suicidal ideation in Limerick.

Dr. Gerard Burke:

Mental illness is commonplace, as are other factors such as drug abuse. If we have a patient who is very difficult to manage due to psychiatric illness or drug addiction, and perhaps has some suicidal ideation, we will try very hard to get her to term - that is, 37 weeks - in order that the baby does not suffer from the effects of immaturity. Some patients develop medical problems which may necessitate early delivery. We would try to care for the patient very carefully until she got to 37 weeks, and thereafter.

Dr. Mary McCaffrey:

The reason things worked best with me going last is that Senator Walsh directed a question to me and I did not get a chance to write it down. Can he repeat it?

Chairman:

I am sure he would. He is not shy about talking.

Senator Jim Walsh:

Dr Burke mentioned that conscientious people can opt out. If they opt out of the panels, given that politicians and medical personnel can be broken down onto one side or the other-----

Dr. Mary McCaffrey:

I have it now.

Senator Jim Walsh:

-----that might skew the outcomes because of the particular opinions of individuals involved. There is also the question of a lack of resources giving rise to a short-circuiting of the system. In other countries, all procedures were fully followed at the start, but within the space of 12 months people were taking shortcuts and notes were being left at reception already signed. A lack of resources generally gives rise to such developments. Do the witnesses know, in regard to the Galway case, whether a lack of resources-----

Chairman:

We are not-----

Senator Jim Walsh:

Dr. Boylan put on the record that in one instance that he knew of-----

Chairman:

Sorry, Senator-----

Senator Jim Walsh:

Or the lack of legislation-----

Chairman:

I ask the Senator to take his seat. He is straining again.

Senator Jim Walsh:

Is that true or untrue?

Chairman:

To be fair, when Dr Boylan made that remark this afternoon I asked him not to reference it.

Dr. Mary McCaffrey:

I thank Senator Walsh. Ironically, I thought about conscientious objection before I came to the committee today, and how the panels would be put together. As I understand it, the personnel who will go onto the panels will be nominated by the various institutes. Obviously, that will be the role of the institute, and it would be nice if there was a balanced approach as to who was on the panels. That would be important.

With regard to the possibility of a baby surviving because he or she was born on the cusp of viability, in the three Dublin maternity hospitals as well as Limerick and Drogheda there are neonatal units on-site. We would be mindful in smaller units that if a woman's pregnancy was going to end in that scenario she would be transferred to a place where full neonatal facilities were available for a baby that could possibly survive outside the womb.

I want to be quite clear about something which has not been said. It is illegal for a doctor in this country to refer anyone to anywhere for termination of pregnancy. It is almost unfair to ask us whether we have referred patients because-----

Senator Jim Walsh:

I did not ask if you referred-----

Dr. Mary McCaffrey:

We have never referred women because it is illegal to do so.

I find it difficult to see how the timeframe could be narrowed any further. A period of seven days is really tight. In an ideal world, one would try to get it as close as possible. A period of five days might be aspirational. There are weekends and panels have to be put together. It would be really difficult.

Merging the heads of the Bill in regard to medicine and psychiatry makes absolute sense.

On Senator Crown's comments, we may be very unlucky in smaller units, but cases always seem to happen on a Sunday afternoon and come out of nowhere.

People do present seriously ill with pre-eclampsia - fulminating pre-eclampsia - out of nowhere. Women do present with sepsis. I know of cases in which people have come in seriously ill. Antenatal care is all about trying to predict in advance the issues that might arise. Looking at the confidential inquiries from the United Kingdom, they are very much into educating primary caregivers to be more mindful of picking up on these issues at an early stage. Unfortunately, however, many of the situations we deal with happen very acutely. I do not believe that in any of those situations any obstetrician would conscientiously or otherwise do anything which would tend not to save that mother's life there and then. We do get people with seizures and bleeding, so that is not an issue. Deputy Denis Naughten asked about the neonatal transfer team. We might talk about that at another time, but it is not appropriate to discuss it under the heads of the Bill.

In regard to the screening of job applicants, interview processes should put the best candidates forward for the job. Providing for rare circumstances is one aspect of the care we provide. What one would want is to have people in these jobs who will ensure the safety and health of the mother. I worked in the United Kingdom for a number of years and one is not allowed at interview to ask questions such as those suggested. I recall only one interview at which I was asked a question like that. I did not get the job and I never knew whether it was because I said I would not do a termination of pregnancy. We would have to be careful of discriminating against people.

With regard to appropriate locations, what is outlined in the heads of the Bill needs to be extended to include general hospitals. Ironically, a woman presenting at Tralee would have access to a wider range of services than in some other places.

Fortunately, I have never seen a patient with suicidal ideation. I have certainly never seen a patient delivered early because of it. In fact, I am not aware of any instance in any unit where I have ever worked.

Chairman:

Thank you, Dr. McCaffrey. That concludes the slot for members' questions. We now move on to questions from non-members, for which half an hour has been allocated. Six non-members have indicated and I ask each of them to be brief to allow time for discussion. I begin by calling on Deputies Bernard Durkan and Billy Timmins and Senator Rónán Mullen, in that order.

Deputy Bernard J. Durkan:

Thank you, Chairman. It is generally accepted that most people in this country, as determined by the referendum in 1983, are pro-life in terms of their support for the equal right to life of mothers and unborn babies. Reference was made on numerous occasions both in January and during the course of today's hearings to the rarity of certain emergency or difficult cases that can arise. In 1992 the Supreme Court made a decision in a rare case as presented to it, as a former judge of that court is on record as having allegedly said. Incidentally, I do not wish to make reference to any case that is currently before the courts or is current in any way.

Chairman:

Does the Deputy have a question on the heads of the Bill?

Deputy Bernard J. Durkan:

I am quick to point out that it is totally inappropriate to have any discussion on that particular subject.

Will the delegates clarify whether it is their view that in the event of a woman presenting with a seriously difficult pregnancy, there is an acceptance, in hospitals throughout the country, that the legislation will provide clarity, that it is necessary and that it will at least facilitate medical staff in giving a universal response to a particular emergency case? In regard to conscientious objection, to what extent is that principle equally distributed between the right to life of the mother and the right to life of the as-yet-unborn baby, bearing in mind that the Supreme Court has made a particular decision in a rare situation?

Reference has been made to the small number of cases that will be covered by this legislation. Senator John Crown observed that it does not really matter how small the number of cases is. In fact, in the event of a small number of cases arising, they may well end up in the Supreme Court, and it will be a matter for that court to adjudicate. If it is generally accepted that the rule of that court is supreme - that it is the law and it must prevail - then the legislation now before the Houses is required because it is in accordance with the court's decision, which is regarded as the supreme decision. Will the delegates comment on that?

Dr. John Monaghan made a reference to surgical means and lethal injection. What is the extent to which lethal injection and surgical means have been recognised as suitable for intervention or termination of a pregnancy in this country? The question was already raised in regard to the gestation period at which one or other can be used. I would like confirmation of that because I am not aware of the situation in this regard.

Will the witnesses indicate whether, in the event that a close relative of anybody in this Chamber were to present in an emergency situation at a maternity hospital, it is recognised that whatever treatment is required for that woman and that baby will be given to them regardless of ethical or conscientious objections?

Deputy Billy Timmins:

There are two lessons we should all take from today's discussion. The first relates to the funding that is needed to upgrade maternal facilities in this State and the second is the need for supports for the thousands of women who have had abortions and are suffering in silence. Those two issues must be addressed.

Earlier today Dr. Peter Boylan mentioned the submission to the committee by the College of Psychiatrists of Ireland. My understanding is that copies of that submission have been given to members. I would appreciate if non-members might also be furnished with a copy before the end of this session.

I thank the witnesses for their contributions this evening. I apologise for missing some of the discussion, but I have their written submissions. Medical and scientific fact is location-neutral and whether the opinion is given from the shadow of the mast at Donnybrook, on the banks of the River Suck or beside the Treaty Stone, I value that opinion in equal measure. I hope the contributions here this evening get the same airing and status as those that were given earlier.

The witnesses might be able to help me with a particular issue in respect of which I am a little confused. Dr. Sam Coulter-Smith, who indicated that he was speaking on his own behalf, expressed grave reservations about head 4. Dr. Peter Boylan and Dr. Rhona Mahony, on the other hand, did not seem to have the same reservations. I understand those two witnesses were also speaking on their own behalf; as I recall, they did not answer the question as to whether they were speaking on behalf of their colleagues. I am trying to ascertain the crossover in terms of whether personal opinion can have an impact on expert opinion, or are they one and the same? One might reasonably assume in the case of medical or scientific information that the facts are there, yet there seems to be such a divergence of views on the implications of head 4. Can the expert view be overshadowed or influenced, subliminally or otherwise, by the personal view?

Senator Rónán Mullen:

I echo what Deputy Billy Timmins said regarding the availability of the submission from the College of Psychiatrists of Ireland.

Chairman:

Copies will be available at 9.10 a.m. on Monday morning in the ante-room. We do not have the facility to have them available tonight.

Senator Rónán Mullen:

Okay, but I understood that the Chairman meant Members of the Oireachtas when he referred to "members" earlier.

Chairman:

I replied to the Senator's question on another matter with reference to Members of the Oireachtas. Unfortunately, the secretariat does not have sufficient staff to make copies available to non-members.

Senator Rónán Mullen:

That is very regrettable.

Deputy Billy Timmins:

If a copy were made available to me I could photocopy it.

Chairman:

Members might take this matter up with the Seanad Committee on Procedure and Privileges.

Senator Rónán Mullen:

If we could get one copy, we could make our own arrangements.

Deputy Billy Timmins:

On a point of order, I could leave to make copies now and bring them back before the end of the session.

Chairman:

They will be available on Monday morning.

Senator Rónán Mullen:

Non-members are being subjected to a regrettable inconvenience in this regard. We are all putting in the full ten hours here.

I thank our expert witnesses, who have been given the difficult shift. How dramatic do they believe the change to obstetric practice in Ireland will be as a result of this legislation, particularly in respect of head 4? Dr. Mary McCaffrey talked about the need for training. She will correct me if I am wrong but I assume she is referring to a need arising out of head 4. I do not imagine that extra training would arise in regard to interventions under heads 2 and 3.

Do the witnesses have concerns regarding - to use the word employed by the Chief Medical Officer this morning - the subjective nature of the psychiatric assessment of suicidality? We heard from the obstetricians in the Dublin hospitals earlier that the figure of one in 500,000 refers to the number of suicides that actually take place in pregnancy. In other words, it is extremely rare.

Dr. Boylan and Dr. Mahony, I think, appear to suggest that this might be connected with the fact that Britain has a liberal regime. The sub-text seemed to be that if abortion were not available more would happen. Do they think that there is a cohort who will access it, if it is legal on this ground, or provided for because it is already constitutionally legal? Do they think that there is any reality in the view that a psychiatrist will be able to say this as a matter of probability and to certify that the person is likely to commit suicide? Does a psychiatrist have any tool, absent of course an underlying mental illness, that enables him or her to say that this is so as a matter of probability? I think the concern that many people have is that psychiatry and mental health have become the means in other jurisdictions in the western world by which the line is fudged between what is medical and what is, for want of a better word, a matter of choice and that medicine has been co-opted and indeed corrupted. Do they have any concerns that this could happen here? The obstetrician does have a certifying role in these cases, not just to carry out the procedure. On what basis will the obstetrician make up his or her mind? Will he or she not simply defer to the two psychiatrists? If that is the case is

it meaningless for the legislation to say that an obstetrician must also be involved at certification stage?

We have talked a great deal about the conscientious objections of those who might not want to carry out or certify terminations. If there is a subjective element to a psychiatric determination in this case do any of the experts believe it might arise that a person who, as a matter of his or her personal philosophy, is pro-choice, might take the precautionary approach when a person presents, given that it would appear that he or she lacks an objective basis on which to certify? Is it possible that a person with that philosophical mind-set might be more likely to certify that the abortion is necessary as a matter of precaution?

Dr. John Monaghan:

My ageing brain is finding it difficult to keep up with the pace of the questions. I will start with Deputy Durkan who asked about the rarity of cases and evidence, referring I think to the X case in the Supreme Court. I was not sure whether the Deputy was referring to other rare cases but his observation on the X case was very interesting. The relationship between the law and the practice of medicine is a very critical interaction in this instance. Next Monday's hearings will be critical for the committee's decision on the question of the psychiatric evidence. My understanding is that if the medical evidence does not support it and we have a legal obligation to the Supreme Court there is a conflict which it is beyond a doctor to recognise. A doctor is ethically obliged to act on evidence. I regret that the expert group did not invite in expert psychiatric evidence because it seems as if this must be done by this committee in a public forum rather than by careful study of the evidence available. It is a very difficult issue and I appreciate the position in which legislators are placed in trying to deal with these two different aspects of the problem, the medical evidence and the Supreme Court decision.

Deputy Durkan also asked about surgical means. I did not check on the lethal injection but I did consult with a colleague yesterday on the question of surgical termination as in suction termination whereby the baby is sucked out and destroyed. This is the sort of technique that has been in use for many years in the UK since abortion was legalised. I asked my colleague whether this is commonly done and she said it is, principally because it is cheaper, even though the medical means are more appropriate. I cannot give any figure for the lethal injection but I know that patients of mine have availed of that and it is not rare but I cannot give any figures on frequency of use.

Deputy Bernard J. Durkan:

At what stage of a pregnancy could it have been done?

Dr. John Monaghan:

The suction termination would be up to between 12 and 14 weeks. The other would be from then on, up to term in some cases.

Senator Jillian van Turnhout:

Is this in the UK?

Dr. John Monaghan:

Yes this is in the UK. I am not talking about Ireland at all. I have no awareness of its ever having been done in Ireland.

Deputy Bernard J. Durkan:

That was my question.

Dr. John Monaghan:

I beg the Deputy’s pardon. I misunderstood the question. We seem to be destined to misunderstand each other.

Chairman:

In fairness to Deputy Durkan, he is easy to understand.

Deputy Bernard J. Durkan:

The other question was about conscientious objection, the equality of the unborn and the mother.

Dr. John Monaghan:

While the State recognises the equality of the mother and the foetus I have never come across, or heard of, a situation in which a doctor would have allowed a mother to die because he or she had a conscientious objection to abortion. That would be an unconscionable action for a doctor. In terms of the management because the child cannot survive without the mother the doctor must act to save the mother's life and in instances the baby loses its life as a consequence.

Deputy Timmins asked about the cross-over between personal and expert opinion. It is very clear from observing people, the Deputy may have observed it in me, that people have particular opinions, however, in the practice of medicine or giving an opinion, whether expert or not, the criterion one uses is whether the person is telling the truth. If somebody is prepared to massage data to suit his or her point of view then we are in a serious ethical situation. An opinion of a personal nature, if it is honest, should be capable of being an expert opinion too, although not all opinions are expert.

Senator Mullen asked about the effect of psychiatric indications on abortion incidence. It is certainly very well known that in the state of California abortion rates expanded dramatically on the basis of suicidal ideation. I cannot give any further answer to that question but the committee has a critical decision to face on the psychiatric evidence that it will hear next week.

Dr. Máire Milner:

Deputy Durkan asked if we are happy that legislation would lead to a universal response in the case of a woman admitted to a facility who is critically ill and whose life is at risk

because of the continuation of her pregnancy. That is the thrust, the hope, the feeling of the institute that represents the body of our opinion, that is, our professional body. It has made a submission endorsing the legislation with some discussion and recommendations. Would it be a universal response? No. We are human beings and the word "universal" is probably misplaced.

Deputy Bernard J. Durkan:

Generally.

Dr. Máire Milner:

Yes. I think so.

Lethal injection is not used to terminate the pregnancy it is used to kill the foetus or kill the baby. To my knowledge it is usually used later in the pregnancy and is given into the heart.

Deputy Bernard J. Durkan:

Is it used in this country?

Dr. Máire Milner:

No.

Deputy Bernard J. Durkan:

Hence it is not relevant.

Dr. Máire Milner:

Correct. Somebody asked about a close relative and whether it is recognised that appropriate treatment would be given regardless of conscientious objections. I cannot speak for every colleague in every situation.

Legislation never guarantees an appropriate response or treatment at all times. That is why I assume the committee is sitting and this is the thrust of the proposed legislation.

Deputy Timmins spoke about personal and expert opinion cross-over. Clearly, there will be causes of cross-over. On suicide, we are talking about women threatening to take their own lives. Yes, it will be difficult to prove or disprove this. Yes, it is subjective and not exclusive to psychiatry but psychiatrists will have more experience in teasing out suicidal ideation than will we.

Doctors, particularly obstetricians and gynaecologists, dealing with pregnant women have significant experience of all of the psychology that goes with being pregnant and the problems and issues that people can have psychologically. Deputy Timmins asked if a psychiatrist would take a precautionary approach. By the time one gets to be a consultant, one is at least 40 years of age with a lot of experience. None of us is infallible but one has to make the best possible judgment. I cannot give an absolute on that. We are human beings but

one makes the best possible judgment in the circumstances. The legislation is looking at two separate psychiatrists and the obstetrician looking after the woman.

Dr. Gerard Burke:

Deputies Durkan's and Timmins's points have been addressed. I am grateful Deputy Timmins intends to upgrade maternal care facilities in the State and will make it his life's work over the next several years in haranguing the Minister on this.

Deputy Billy Timmins:

I might not have much influence after these hearings.

Chairman:

We will make sure the Deputy lives up to his commitment.

Dr. Gerard Burke:

I believe it is feasible to raise the money to do it.

Chairman:

The committee will address the issue of maternity facilities and care in June and July. Deputy Timmins is welcome to come back to the committee on that occasion to make his comments on this issue.

Dr. Gerard Burke:

On the issue of whether we have concerns about the subjective nature of the psychiatric assessment, Senator Mullen knows there is no blood test or X-ray for suicide and it is inherently dependent on an interaction of questions and answers between the psychiatrist and the patient. We do not have any expertise in that.

Chairman:

I am afraid but I must ask Dr. Burke to step back a little from the microphone as there is some interference. The Seanad is not used to people of Dr. Burke's height and stature so the microphone is being obstructed.

Senator John Crown:

On a point of order, what about me?

Chairman:

Gabh mo leithscéal.

Dr. Gerard Burke:

We deal with psychiatrists all the time when discussing medication for patients suffering from depression or more serious illnesses. We have a working relationship with them.

I agree with the institute that the threat of suicide is a very serious matter but it would be a very unusual situation. As I have said before, most of us will never encounter such a request. I agree with the institute that we should have two obstetricians to discuss this matter in detail with a psychiatrist. It is a very big deal and we would give it a great deal of thought.

Dr. Mary McCaffrey:

The proposed legislation does provide clarity for us and it is extremely well-crafted. With regard to the question as to whether someone will get the care they need, the life of the mother is always going to be paramount. Emergencies are always dealt with as such. As Dr. Burke, said earlier, when an emergency presents in any hospital, everyone from anaesthetists, cardiologists and whoever, rolls up their sleeves.

With regard to personal views, my personal practice would be if I ever felt my view was slightly personal and not based on evidence-based practice, one would sit down and discuss it with other colleagues. If necessary, one would ring someone in a specialty or sub-specialty related to the matter. The way medicine is practised these days, people do not tend to practise in isolation but as part of teams. Most hospitals also have governance groups as well.

With regard to Senator Mullen's question on whether this legislation will make a dramatic difference to our practice, I do not believe it will. I believe we will continue to practise obstetrics as we do. I do not believe we will see a dramatic increase in requests for assessments for suicide. I hope not anyway. Senator Mullen needs to ask the psychiatrists about the subjectivity of it but that is the reason there would be more than one psychiatrist on an assessment team. As an obstetrician I do not feel I have enough knowledge of psychiatry to have an input into the diagnosis but to be there to support the team of psychiatry staff in terms of planning where the pregnancy would go from there.

With regard to training, it is not so much training as the need for guidelines. For people who have not been involved in providing termination of pregnancy services - even to decide whether it will be surgical or medical - we will need guidelines. Hopefully, it will be something that will be a very rare event.

Chairman:

I call Deputies Peter Mathews, Arthur Spring, Terence Flanagan and Senator Paul Bradford.

Deputy Peter Mathews:

I thank the four professional consultants for their presentations. I feel I learned much more in this session than in the earlier one on the actual delivery of the safe care for mothers and their babies. I got a much better sense of conversation and real meaning about the whole issue.

We are here to discuss the heads of the Bill. That derives from the difficulty that there is in applying the Constitution's Article of the equivalence of life when it arises in difficult and rather rare circumstances, namely, the threat to the life of a mother. As Dr. John Monaghan pointed out, there was the particular case of the X case on which the Supreme Court made a

majority decision - not a unanimous one - in terms of its understanding based on what had been presented to it which was only a limited picture. The court got a psychologist's report, not one from a psychiatrist or a body of psychiatrists. The court was painted into a corner and had to determine for one case.

We have to be honest about this and decide how we want to express the intention in law as to what is the meaning of the Constitution in its application and what is guided by guidelines from professionals. One point that has come out in this and the last session is that guidelines are delivering excellent care for mother and child. There have been little setbacks here and there which have been accidental and unfortunate, as well as being very tragic for the families involved. For everyone's wife, mother, sister or daughter who is expecting a baby, everything - the whole fire brigade of medicine - will be brought to bear in saving that mother's life. Being honest about it, the expression of the Constitution in its simple English is followed by the fact that the life of the mother is of paramount importance at all times, the profession has a duty of care to that mother at all times and that it will use the best guidelines within its professional specialties at all times to deliver that.

We come back to what even Dr. Boylan spoke about, that is, trust. Dr. Monaghan spoke about that. We have got to trust people. We trusted our mothers not to drop us when they put us in our prams. We trust those around us. Today there has been the hijacking of a few set backs to lead us down various long paths of complication and multi-word argument and discussion and we are getting away from the truth.

Chairman:

Go raibh maith agat. Deputy Mathews is way over time.

Deputy Peter Mathews:

Remember psychiatry was hijacked in Britain, America and France.

Chairman:

We are on the heads of the Bill now.

Deputy Peter Mathews:

France introduced strict legislation in 1975 and today underage girls can go to their GPs and obtain a lawful abortion without the knowledge of their parents. That started from strict legislation.

Deputy Arthur Spring:

The experts, who have provided information throughout the day, have been nothing short of top class. It has been very informative for Members of the Seanad and the Dáil and I think lay people at home, who are watching this, will feel very informed. I acknowledge the fact we are trying to become as educated as possible before we make decisions and I thank the witnesses for their contribution. It is rather unfortunate that the regional areas do not get the same level of attention from the media and maybe from other circles which they warrant. I hope that will be reflected throughout the weekend, if that can be done.

The first observation I have is that the regional hospital could potentially be undermined as a result of the level of ability in the maternity hospitals in Dublin. I think we need to put that to bed. I would like the witnesses to be able to say that in the event of an emergency pregnancy presenting at a regional hospital, the skills and the staff would be adequate and that they could cope with what is under the heads of the Bill.

One of the issues which is pertinent is conscientious objection. One has quite a small psychiatric unit and quite a small maternity unit in a regional hospital. If a psychiatric unit is not adequate to deal with a patient presenting with suicidal ideation, does that mean the patient should be referred to a hospital where there is a substantial psychiatric unit? How would that impact on the ability of that person to be able to obtain the services should she merit a termination due to the fact that suicidal ideation is a reality?

Do the witnesses see the heads of the Bill as appropriate to deal with cases presenting? Can we say this legislation does not provide for a form of liberal termination, or abortion? Can we say it is appropriate to the Supreme Court ruling and that we are living up to what is in the programme for Government?

Deputy Terence Flanagan:

I congratulate the Chairman on chairing today's proceedings efficiently and I welcome the witnesses. Will every effort be made to save the baby's life in every case where a pregnancy is terminated post-viability? In the case of suicide, do the witnesses think there should be a possibility of a review on behalf of the unborn of a decision to certify an abortion under head 4? If, under the provisions of head 4, a termination was to be performed at 23 weeks, would the witnesses refer the case to one of the large Dublin hospital where the baby would have a better chance of survival or do they anticipate or expect that their hospitals would deal with the case? If two consultant psychiatrists agree that a patient is suicidal and that this constitutes a real and substantial risk to her life, which can only be averted by the termination of her pregnancy, could they envisage any situation in which they would disagree with them?

Senator Paul Bradford:

We are now almost 12 hours into today's session and we will have two more sessions next week. We had a number of hearings in January, we have had Dáil and Seanad debates and huge degree of political engagement on this matter. I suppose if anyone was returning to planet Earth from Mars and was given that backdrop, they would think we were talking about a major piece of new legislation or change in the law. However, notwithstanding the debates we have had and the debates to come and a parliamentary process, which certainly in my 20 years plus here, has never been utilised before, we are advised by the Government - the Taoiseach, the Minister for Health and others - that no new law is being put in place, that there will be no change and that this is simply codifying, which the new buzz word. Notwithstanding the hours, weeks and months of debate, this is not about a new law or a change. That is what we are being advised by very senior Government sources. As far as the witnesses are concerned, is this about a change in law and a change in practice? If not, what is it about?

Dr. John Monaghan:

Deputy Mathews drew our attention to something which is extraordinarily important in medicine and in every branch of life and is reported to be disappearing, that is, trust. An English baroness, Onora O'Neill, wrote a book about trust, which has had a huge impact. I have been a member of the Medical Council for the past five years and I bought a copy of it for the members of the council. Many of them found it very useful to reflect on this and a lot it relates to health care. I do not know how to relate it directly to the abortion question but there is certainly evidence from other countries of serious breaches of trust. During the week the trial of an American, Dr. Gosnell, showed there are ferocious breaches of trust and dishonesty associated with what one might call the abortion industry and it would be appalling if that came into this country.

Deputy Spring raised the question of conscientious objection between two psychiatric units - in other words, if a person was suicidal, she would be moved to another psychiatric hospital. Is that correct?

Deputy Arthur Spring:

If there was not adequate provision in a regional hospital, would the person be moved to a larger hospital?

Dr. John Monaghan:

I am sure that would depend on the condition of the patient and so on. As far as I know, there is not a huge amount of transfer between psychiatric units. If one develops a mental illness, one would often stay in the same hospital. I do not think there is sort of specialist centres like there would be for neurosurgery or something like that. I thought the Deputy was referring to the question of conscientious objection in one institution and whether the patient could go to another one, but that was not what he was asking. I would not be able to answer that question. I think it would be best asked of a psychiatrist.

Deputy Arthur Spring:

Dr. Mary McCaffrey referred to Kerry General Hospital.

Dr. John Monaghan:

She might take the question. Deputy Flanagan asked if every effort would be made to look after a child born after a termination. That seems to be the plan, according to what is written. I do not know any doctor who would not make every effort. The question arises, in particular in the psychiatric area, where the patient does not want the child to be born alive. That is why I suggested earlier that it should never be the situation that the child is directly killed in the uterus at any stage of gestation. It would not be unknown for babies to be born supposedly at 17 weeks but to be found to be several weeks further on, particularly in the circumstances of psychiatric illness, uncertain dates and so on. I would strongly advocate that there should be no possibility that a child would be eliminated before it was born. At 23 weeks, certainly if a child was going to be born because of serious maternal illness or because of a foetal reason, it would be transferred to a large Dublin hospital, or to Cork or Galway.

Senator Bradford asked about the suggestion that no change is being made. I think there is a very significant change in the proposed legislation. For the first time, deliberate abortion, as

opposed to forced abortion, will be available in this country. I refer to termination of pregnancy in a formal legal sense, rather than in dealing with medical emergencies. It remains to be seen what effect this will have. I think it is very difficult to predict. As I said before, I am very concerned about the ability to control the psychiatric aspect of it.

Dr. Máire Milner:

Deputy Flanagan asked about the delivery of babies at the margins of viability - 23 weeks - in the Dublin hospitals and the regional neo-natal intensive care units. I draw his attention to the submission made by our professional body - the Institute of Obstetricians and Gynaecologists - which states:

> We highlight the fact that enormous additional challenges to clinical management arise when termination is being considered in gestations approaching foetal viability but still extreme prematurity. In current practice, all efforts are exhausted within medical margins of safety to prolong the pregnancy in the foetal interest.

We are talking about where the mother's life is at risk. This is where the balance has to be achieved. Senator Spring-----

Deputy Arthur Spring:

I am a Deputy for now.

Deputy Bernard J. Durkan:

Very much so.

Dr. Máire Milner:

Excuse me.

Chairman:

Thank you. We will have one speaker, please. Respect the witness, please.

Dr. Máire Milner:

As I have already said this afternoon, I feel the legislation is appropriate to our practice and our patients. I await the contributions to be made by our colleague psychiatrists next week. I do not believe this will lead to liberal abortion. This specifically relates to instances where the life of the mother is at risk. As I have said, our psychiatric colleagues may elucidate the area of suicidal ideation to a better degree.

Senator Bradford asked whether this is a change in law or in practice. Clearly, a change in law is being proposed. Will it lead to a change in our practice? I have spoken already this afternoon about clarity and trying to protect doctors in uncertain situations where there is uncertainty about whether a woman will survive in the rare instance of potentially terminating the pregnancy so that her life may be spared. I was asked whether that will

change my practice. It will afford me a degree of protection and comfort and it will give rise to an improved situation for our patients.

Dr. Gerard Burke:

I would like to respond to what Deputy Mathews said. The majority of obstetricians feel there is a problem about clarity with this. We need clarity about it. In our work, we set out to avoid a termination and to continue with the pregnancy. That is always our aim. A termination of pregnancy is a horrible outcome for all concerned, including the obstetrician. We are trying to make these very difficult decisions and to prolong the pregnancy as far as possible. The actual consultative process with the patient and the other medical doctors who are assisting her will be more open and less difficult - we will be more likely to arrive at the right decisions - if we have clarity and openness about the decision-making process. We feel vulnerable when dealing with marginal cases.

(Interruptions).

Chairman:

Dr. Burke without interruption. Deputy Mathews has spoken already.

Dr. Gerard Burke:

The big issue is how much difference this legislation will make. It will make very little difference - hardly any - to the actual practice of medicine and obstetrics. The number of cases that will fall under this legislation will be tiny. The number of patients in our practice who are at risk of dying is relatively small. The number of those cases that are marginal from a decision-making perspective is really very small. When one starts bringing things like psychiatry into this issue, the number is absolutely minuscule. Most of us will never encounter this situation. I have been a doctor for over 30 years and I have never even heard of a case like this, other than the X case.

I was also asked about deliveries that take place at 23 weeks. The full range of very expensive services is wheeled out to try to save babies that are delivered at 22 weeks. I do not think any babies of that gestational age have survived in Ireland. We would try to save them.

Senator Bradford also asked whether there will be a change in practice. I do not think there will be - nothing significant, certainly.

Dr. Mary McCaffrey:

I apologise to Deputy Spring, who is my local Deputy, if I have totally confused him. I think I have.

Deputy Arthur Spring:

I would like one of the-----

Dr. Mary McCaffrey:

Can I just take the issue-----

Chairman:

We will have no bias or favouritism shown towards Deputy Spring.

Deputy Arthur Spring:

The Chairman will be happy to see the Cork colours.

Dr. Mary McCaffrey:

Can I just clarify what I actually meant? Any person - male or female, pregnant or not - who arrives at an accident and emergency unit in any hospital or at a psychiatric unit tonight or tomorrow night will be dealt with acutely, assessed and admitted. All the services will be rolled out for them. Some psychiatric services in smaller hospitals are concerned that if there is a larger number of review committees and review processes, or if assessments for two psychiatrists have to be done together, that rather than the acute situation might put a strain on the resources of the department in question. As the legislation is enacted and brought into practice, it will be important for the health services to watch what level of resources is needed to allow obstetrics and psychiatry to continue to provide safe practice. My earlier comments did not relate to the safety of the acute situation. They were about the ongoing assessments that might arise. We have all seen how the mental health tribunals are costing a fortune and have taken on a life of their own. That is really what my remarks were about. I apologise if I came at it in a circuitous manner.

Deputy Flanagan raised the issue of viability, which is obviously very important in a smaller unit. We have to acknowledge that the dates of many pregnant patients are actually wrong, despite good ultrasound scanning. If they present very late on in a pregnancy, there is always the possibility that their due date might fall a week or two either way. My personal practice in such situations is to transfer the patients in question to a place where all the neo-natal services are available. I suspect anyone in a smaller unit would do the same. It strikes me now that I did not answer Deputy Naughten's question about neo-natal services and I apologise for that. If the woman is too ill to be transferred, we can deliver the baby locally before getting a neo-natal transfer team to come down, provide the services in the smaller hospital and, if the baby survives, take it to a larger unit. That happens in smaller units on a regular basis.

Senator Bradford asked whether there will be a change in law or in practice. Obviously, if a new law is on the books, then it is a change in law. On the question of whether there will be a change in our practice, my personal feeling is that there will be much more reassurance and clarity in terms of dealing with difficult situations. I know there is great concern about the possibility of opening the floodgates. I think the law is so tight, for example in requiring two psychiatrists and all the support services for the diagnosis, that I do not think the things we do will change hugely. It will provide huge security. It is very hard to be on one's own on a Sunday afternoon in a small hospital, trying to decide whether one will be reported to the Medical Council if one does something and worrying whether there will be gardaí in the hospital the following morning.

There is great security in knowing that I can deliver this seriously ill woman and there is not going to be a witch hunt outside my door the following morning. It is a worry for a lot of people in the current climate with patients.

Deputy Terence Flanagan:

I had four questions. My question on the review clause was not answered and it related to suicide. Does the delegation think that there should be a possibility of having a review, on behalf of the unborn, on a decision to certify an abortion under head 4?

Chairman:

In order to be consistent, I will allow Deputy Mathews to contribute. However, I ask him not to make a speech.

Deputy Peter Mathews:

I know. I want to comment for clarity sake. Dr. Monaghan, I said that the guidelines, to me, from all of the conversations, appear to answer all of the questions of the proposed legislation under the heads. The other lady doctor said-----

Chairman:

Dr. Mary McCaffrey.

Deputy Peter Mathews:

-----that if one goes to an accident and emergency department, one will get whatever it takes, but one will get the same in this too. Dr. Monaghan said that he needs clarity in order to feel safer in the work that he does but he has already said that he feels safe and will do everything that he has to do. That is a contradiction.

Chairman:

That was not a point for clarification. Does the delegation wish to respond to Deputy Flanagan's question?

Deputy Bernard J. Durkan:

Earlier the Chairman indicated that he would allow me a quick intervention.

Chairman:

No. Who wants to answer Deputy Flanagan's question?

Deputy Terence Flanagan:

My question is for everyone.

Dr. John Monaghan:

It has been the situation in the United States where legal representation has been provided for a foetus that is under threat. One of the questions that is also unanswered is what is the role of a father in a situation where termination of pregnancy is to be undertaken.

Chairman:

We will not deal with that now.

Dr. John Monaghan:

I have not thought about the issue myself. It may well be that, in a critical legal battle, I would not see any problem with the child being legally represented since it has a constitutional right in this country.

Dr. Máire Milner:

It may be something that the psychiatrists are interested in and may address next week.

Dr. Mary McCaffrey:

I have never thought about it. I apologise. It would be something new to add on to the legislation that is currently there, so it would be without our remit.

Dr. Gerard Burke:

The foetus is my patient as well. The same with my colleagues, we will do our best for that foetus to see that it gets to viability.

Deputy Terence Flanagan:

Thank you.

Chairman:

Senator Colm Burke absented himself from this session this afternoon and I thank him for doing so. He did not have to do so, but he did it.

We have had over 11 hours of discussion and I propose that we adjourn. Before doing so, I apologise to the ushers, stenographers, sound and secretarial staff for keeping them longer than the prescribed time. We thank them for their patience and work. I formally thank the witnesses, Dr. Gerard Burke, Dr. Mary McCaffrey, Dr. Máire Milner and Dr. John Monaghan for their testimony and presence today.

The joint committee adjourned at 8.34 p.m. until 9.30 a.m. on Monday, 20 May 2013

Heads of Protection of Life during Pregnancy Bill 2013: Public Hearings

Monday, 20 May 2013

The Joint Committee met at 09:30
MEMBERS PRESENT:

Deputy Catherine Byrne,	Sentor Ivana Bacik,*
Deputy Ciara Conway,	Senator Colm Burke,
Deputy Regina Doherty,	Senator John Crown,
Deputy Robert Dowds,	Senator Imelda Henry,
Deputy Peter Fitzpatrick,	Senator Jillian van Turnhout,
Deputy Seamus Healy,	Senator Jim Walsh.*
Deputy Billy Kelleher,	
Deputy Mattie McGrath,	
Deputy Sandra McLellan,	
Deputy Eamonn Maloney,	
Deputy Denis Naughten,	
Deputy Caoimhghín Ó Caoláin,	
Deputy Mary Mitchell O'Connor,	
Deputy Robert Troy,	

* In the absence of Senators John Gilroy and Marc MacSharry, respectively.

In attendance: Deputies James Bannon, Ray Butler, Michael Creed, Clare Daly, Bernard J. Durkan, Terence Flanagan, Dominic Hannigan, Kevin Humphreys, Colm Keaveney, Paul Kehoe, Finian McGrath, Peter Mathews, Olivia Mitchell, Michelle Mulherin, Seán Ó Fearghaíl and Aodhán Ó Ríordáin, and Senators Paul Bradford, Terry Brennan, Aideen Hayden, Fidelma Healy Eames and Rónán Mullen.

DEPUTY JERRY BUTTIMER IN THE CHAIR.

Heads of Protection of Life during Pregnancy Bill 2013: Public Hearings (Resumed)

Psychiatry and Perinatal Psychiatrists

Chairman:

As we have a quorum we will begin in public session. I thank all present for being here bright and early on a Monday morning and I particularly welcome our guests. I remind everybody that mobile phones should be switched off rather than being in silent mode as they interfere with the broadcasting of proceedings, which is unfair to the staff. This is our fifth session in

the series of hearings which the Oireachtas Joint Committee on Health and Children has been asked to conduct in discussing the heads of the protection of life during pregnancy Bill 2013.

I welcome the witnesses to the meeting this morning, as they are here to assist us in analysing the heads of the Bill. I welcome Dr. Anne Jeffers, Dr. Maeve Doyle, Dr. Joanne Fenton, Dr. Anthony McCarthy and Dr. John Sheehan, who will be here shortly. I remind members that we are discussing the heads of the Bill and any comments or questions should be referenced to those heads. To members in particular I say that the language we use should be temperate and moderate, and we should try to avoid being unfair to each other and witnesses. I would appreciate if members could keep that at the back of their minds. I will be very strict with time today, as I reviewed the hearings on Friday. The time allocations will be 70 minutes and 30 minutes and I will end the sessions at the appropriate times. That will mean some members will not be able to make a contribution at certain times, for which I apologise in advance, but we must be fair in the application of time.

Before beginning I remind members and witnesses that witnesses are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to do so, they are entitled thereafter to only qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of the proceedings is to be given and they are asked to respect the parliamentary practice to the effect that where possible they should not criticise nor make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice or ruling of the Chair to the effect that they should not criticise, comment on or make charges against either a person or persons outside the House or an official either by name or in such a way as to make him or her identifiable.

There are 50 minutes for opening statements so I ask Dr. McCarthy to begin.

Dr. Anthony McCarthy:

I am Dr. Anthony McCarthy, president of the College of Psychiatrists of Ireland and a specialist in perinatal psychiatry at the National Maternity Hospital, Holles Street. I am also the psychiatric assessor for the confidential inquiry into maternal deaths in Ireland.

Our written submission has detailed comments on the heads of Bill and we recommend that close attention is paid to these points. Some practical points will need to be addressed and will require some technical amendments to the Bill. This submission was agreed by the council of the college, the sole organisation recognised by the Medical Council of Ireland as being responsible for the life-long training of all psychiatrists in Ireland. This council is the elected decision making body of the college and we know that among our 864 members there will be a wide range of opinions with regard to the sensitive issue of abortion, reflecting the deep divisions in society in general about this issue. Many of these views will be heard today but the submission is the official college position.

This Bill is about saving women's lives. We recognise that the Bill is restricted only to circumstances where the life of the mother is at risk rather than her mental health. We recommend that any woman who has suicidal ideation in pregnancy must be enabled to readily avail of expert psychiatric assessment, and that assessment must be individual, comprehensive, compassionate and not prejudged. Every maternity unit in this country

should have such services, and there is a significant lack in such provision currently, as outlined in our written submission.

As so much will be said and heard today about the risk of suicide in pregnancy, I wish to make some brief overall points as someone who has been working as a specialist perinatal psychiatrist for more than 16 years in a service seeing in excess of 500 women every year. Suicide in pregnancy is real; it is a real risk and it does happen. This is always a tragedy as at least two lives are lost and many others are affected significantly. We must do everything we can to prevent such deaths. Much has been made and will be made about the so-called lack of evidence with regard to abortion and whether it will ever prevent a suicide. I believe there will never be statistical evidence to prove this point one way or other because trying to prove anything statistically for such a rare event is extremely difficult, if not impossible. Only a study involving thousands of women who were expressing suicidal ideation in pregnancy and wanted an abortion, and where half of them had that abortion and the other half did not, for example, if they were prevented from travelling to the UK, could answer this question about statistical evidence. This study will almost certainly never be done, I hope.

As doctors, we must always be aware of research but also be very aware of the limitations of research and of the questions which it cannot answer. In our clinical work, we search always for clinical evidence and not statistical evidence. As doctors, we assess suicidal risk as part of our everyday work and we rely on clinical evidence, our clinical skills and our experience and training in assessing each woman or child individually. There are extra challenges in assessing anyone in emotionally intense situations and where there are potentially serious outcomes, whatever the assessment concludes. Again I stress that we do these sorts of assessments regularly, even if most psychiatrists do not do so in this specific circumstance. Part of suicidal risk assessment always includes assessing the presence or absence of a mental disorder or mental illness and an assessment of the capacity of the individual to make an informed decision. That will be essential here too.

We also always assess for what are called psychosocial stresses, or life stresses. However, some in this debate have tried to present the case that these are somehow mutually exclusive, as if a woman who is at risk of suicide is either mentally ill and hence needs psychiatric treatment or that she just has a psychosocial stress - an unwanted pregnancy - and is then either not really suicidal or her case has nothing to do with psychiatry. Clinical reality and life reality is that frequently there is a complex interaction between major life stresses, mental distress and mental disorder. It is sometimes black and white but most often it is not so. Attempts to present it as such not only does a great disservice to any women who may find themselves in this particular position but also to any person at any time in life who is suffering from major stress, depression or other mental disorder. They too require a comprehensive mental health assessment and treatment, one that does not focus exclusively on the presence or absence of a mental illness but on an holistic assessment and treatment which recognises the individuality of that person.

I will specifically discuss a phrase that is being quoted frequently at the moment that "abortion is never a treatment for suicide". This is true, and abortion is never a treatment for suicide, but neither is counselling, psychotherapy, antidepressants or anything else. There is no treatment for suicide. What society needs to address in general, and what we as psychiatrists have to do specifically, is try to prevent suicide, and this requires looking at the causes of suicide and what can be done to address those causes. The question is not whether abortion treats suicide but is there ever a case where a woman will kill herself because of an

unwanted pregnancy, and if so, what can we do to save her life, and would that ever be a termination of pregnancy? This Bill is about legislating for that very small but real possibility.

There are concerns among many psychiatrists that somehow this legislation will result in them being placed in very difficult clinical circumstances. For some this is because of their religious, philosophical or ethical beliefs, and these must be respected. I welcome that those views will be heard today as well. For others, there is a fear of increased workload for their already overstretched services, and doing this with no extra resources. For others it is a fear of being faced with very difficult clinical issues and dilemmas where, for example, a woman may be genuinely highly distressed, such as after rape, and wants a termination but is assessed as not being actively suicidal because she does not want to die. This woman may just want an end to the pregnancy but she will have to be refused an abortion under this legislation. That will be difficult for her and us as clinicians.

These are real concerns and difficulties but they still must be addressed. They cannot simply be ignored or denied by our profession or by society, and will not be by the college.

Many in the profession see this issue as being predominantly a social and political issue, which psychiatrists are now being asked to solve or arbitrate upon, an issue which society as a whole and the Legislature need to address, and are addressing, which is to be congratulated. As psychiatrists, we want to be there to care for and treat women appropriately, professionally and compassionately and not be placed in a position of social policing. However, again at the end of the day, this is about saving women's lives and we as psychiatrists must be prepared to use our professional skills and expertise to assess and treat pregnant women who have suicidal ideation or intent in pregnancy. If, as a result of this legislation, better psychiatric services are put in place so that expert psychiatric assessments and treatments are provided for all pregnant women in Ireland who wish to avail of such services, women and children's lives will be saved.

Dr. Joanne Fenton:

I am Dr. Joanne Fenton, consultant adult psychiatrist and a specialist perinatal psychiatrist in the Coombe Women and Infants University Hospital. In my role as a perinatal psychiatrist I have treated women attending the Coombe hospital over the past ten years. These women have had a wide variety of problems and difficulties including illnesses ranging from severe and enduring mental illness like schizophrenia to those with less severe illness like anxiety or depression, but which may cause equal levels of distress.

Suicide is a real risk in individuals who have mental illness and has a devastating impact on all those involved with the woman. As psychiatrists, and in particular in my role as a perinatal psychiatrist, we are trained to assess women who express suicidal ideation or intent. It is my role to provide non-judgmental, compassionate care and treatment to these women. The women who present with suicidal intent are in a great deal of distress and it is our aim to treat these women respectfully.

In my years in the Coombe hospital I have seen many women who have had a termination of pregnancy. Each woman has had a different experience and the effect has been different for each. I have never seen a woman where termination of her pregnancy was the treatment for her mental illness nor do I believe that a termination of pregnancy is a treatment for mental

illness. However, that said, I cannot say that there will never be a situation where a woman is in such a state of distress and turmoil that for her, termination of pregnancy is a life-saving option.

The current legislation is very restrictive and many women will continue to travel abroad to seek terminations. There are a number of points which my colleagues and I will address further and are outlined in our written college submission. These include the under-18 age group and those who lack capacity. I believe that two psychiatrists, as outlined in the heads of Bill, should assess a woman who is suicidal and pregnant and be in agreement about their assessments, but should not have to see the patient at the same time. I believe that the obstetrician should assess the woman from an obstetric point of view but not be expected to assess suicidality, which is beyond his or her area of expertise. I believe that the timing between initial referral and assessment and the timing for appeal should be shortened as women in this situation are frequently distressed and a lengthening of time can cause a further deterioration in their mental health.

Many psychiatrists do not wish to partake in the assessments of these women for many reasons and their concerns must be respected. In my role as a perinatal psychiatrist I believe it is my responsibility to continue to assess pregnant women in distress and aim to provide the best and most compassionate care to them.

Dr. Maeve Doyle:

I am Dr. Maeve Doyle, consultant child and adolescent psychiatrist and chair of the child and adolescent faculty of the College of Psychiatrists of Ireland. I welcome the invitation from the Joint Committee on Health and Children to make a submission on specific issues with regard to children, particularly because the X case involved a 14 year old girl, a child, who had been raped and sought a termination because she said that she was suicidal. The written submission, which was sent by the college, includes a number of key and detailed points about the care of children in circumstances where they may be pregnant and request an abortion and how the proposed heads of Bill must be amended to address these. My opening statement summarises some of these key issues.

On the definition of a child, the heads of Bill do not define the word "child". This is very important as in cases involving children there are very specific and complex issues regarding their care which must be addressed. On consent, under the Children Act 2001, and other legislation, a child is someone under the age of 18 years unless married. A person over the age of 16 years can give consent to surgical, medical or dental treatment and it is not necessary to obtain consent from parents and guardians. For psychiatric assessment the law has been interpreted as meaning that until the age of 18, children are still not in a position to legally consent to a psychiatric assessment and, as such, require consent from their guardians. For children in the care of the HSE the issue of consent is even more complex. I make these points to highlight the need for these issues to be considered by those drafting the final Bill.

The issue of confidentiality is also quite complex. Generally, when young people are first seen by a child and adolescent psychiatrist they are informed that what they say will remain confidential unless the information disclosed constitutes a risk to themselves or to others. This may well result in the young people censoring what they say. This is particularly true in the area of sexual activity. The age of consent to sexual intercourse remains at 17 years. In many cases, however, parents of 17 year olds expect to be informed if their 17 year old child

is sexually active, so issues regarding a possible abortion will require expert, experienced and sensitive handling and clarity for the child, family and professionals involved.

While there are no figures available, the occurrence of pregnancy within a population attending a child and adolescent mental health service is rare. For a pregnant young person to attend such a service, the consent must come from her parents. In addition, if the young person is under the age of 17, the professional will have to report to the HSE and the Garda. The likelihood of parents of pregnant girls seeking advice from a child and adolescent psychiatrist as to whether or not to proceed with a termination of pregnancy is, therefore, very low.

What may happen is that in the case of a young girl who is in the care of the HSE, becomes pregnant and indicates a wish to have a termination of pregnancy on grounds of suicidality, the HSE, acting *in loco parentis*, may well seek the advice of a child and adolescent psychiatrist in making that decision. This is probably the main group of pregnant teenage girls for whom the proposed legislation will, in effect, apply.

I hope that the foregoing will draw attention to some of the difficulties which would need to be overcome in any legislation involving young women, children in the eyes of the law, who present with suicidality in the context of pregnancy.

Dr. Anne Jeffers:

I am Dr. Anne Jeffers. I am the director of external affairs and policy at the College of Psychiatrists of Ireland. I am also a general adult psychiatrist. I work with adults between the ages of 18 and 65 and I work in a community based service in east Galway. In an adequately resourced mental health service, general adult psychiatrists work with a multidisciplinary team made up of nurses, social workers, psychologists and occupational therapists. We receive referrals from general practitioners or the emergency departments of general hospitals. I will describe the issues as I see them in this legislation as they are likely to be seen by a general adult psychiatrist.

When a woman finds that she has a crisis pregnancy and feels suicidal, she may follow a number of choices. She may decide to have a termination and may travel outside the State to have that. She may visit her GP who will complete a full assessment, including an assessment of her mental state and the risk of suicide. The GP will offer her counselling and may advise that she seek the advice of a crisis pregnancy counselling service. If he or she has concerns that the woman is at risk of suicide and requires a specialist psychiatric assessment, he or she will refer her to a general adult psychiatrist. The woman may alternatively present directly to an accident and emergency department, especially if she has attempted suicide or has self-harmed. In this case, she will be assessed by a liaison psychiatrist where one exists or be referred to the general adult psychiatrist in the area. Only in Dublin will there be the option of a referral to a perinatal psychiatrist.

A psychiatric assessment involves a private one-to-one consultation where the woman has an opportunity to describe her distress. The psychiatrist identifies the issues contributing to the suicidal risk. These issues include any symptoms of mental illness and the psychosocial stresses affecting the woman. Each woman's presentation and circumstance is unique and the psychiatrist will provide a comprehensive and non-judgmental assessment. A psychiatric assessment is therapeutic in itself where a woman is given an opportunity to discuss her

concerns and stress in a confidential setting and a safe and supportive environment. For many women, the outcome of this assessment will reduce her fears and she may decide to continue with the pregnancy. Where the woman and the assessing psychiatrist and team believe the termination of the pregnancy is the only way to avert self-destruction, a second opinion would be requested. Ideally, a psychiatric social worker or other key team member would also be involved in this assessment and in the provision of ongoing support for the woman. It is important to be aware that not all teams have social workers. It is anticipated that in all except rare cases, the psychiatrist will recommend interventions other than termination of the pregnancy. The legislation is extremely restrictive and it will not apply to the majority of women. In these cases, the psychiatrist will ensure the woman has access to non-directive counselling around the options, and these options include adoption, parenting or information about travelling outside the State for termination.

As psychiatrists, we are used to working within a legal framework in using the Mental Health Acts. We are used to the importance of wording within the law. Head 4 of this legislation clearly states that it would not be an offence to terminate the pregnancy only if the psychiatrists jointly certify in good faith that there is a real and substantial risk of loss of the pregnant woman's life by way of self-destruction and, in their reasonable opinion, that this risk can be averted only by that medical procedure. Reasonable opinion is defined to mean an opinion formed in good faith which has regard to the need to preserve unborn life where practicable. The emphasis is on the risk only being averted by termination and the regard to the need to preserve unborn life. This wording will restrict the use of this legislation to extremely rare cases.

Dr. John Sheehan:

I thank the committee for the opportunity to contribute. I am a perinatal psychiatrist working in the Rotunda Hospital in Dublin. A perinatal psychiatrist is a psychiatrist based in a maternity hospital and he or she treats women in pregnancy or, for example, following delivery. I also work as a liaison psychiatrist in the Mater Hospital, Dublin, which has one of the busiest accident and emergency departments in Ireland. Last year, we had the highest number of treated episodes of attempted suicide in the State, and part of my work is assessing and treating people who present with attempted suicide. I therefore work both in a perinatal setting and in an accident and emergency department setting.

I will confine my comments to the aspect of the Bill that is pertinent to psychiatry, namely head 4, which is concerned with the risk of loss of life from self-destruction. It has major implications for psychiatrists. First, there is a fundamental difference in the management of medical and psychiatric emergencies in obstetrics. In obstetrics, medical emergencies and psychiatric emergencies require different interventions. In a medical emergency, speedy delivery of the baby is required while, in a psychiatric emergency, speedy delivery of the baby is contraindicated. It is exactly the opposite of that required in a medical emergency. In a psychiatric emergency such as when a patent is depressed and has suicidal intent, the patient may have impaired capacity and should be advised not to make irrevocable decisions. The patient probably cannot give informed consent. Those of us who see people with suicidal intent often see people who feel overwhelmed, unsupported and hopeless and who are often desperate and agitated. The person often has what is called cognitive constriction and can see no other option in front of them except ending his or her life. Such a patient needs professional help, not an urgent termination of pregnancy.

Second, psychiatrists are doctors, not judges. If head 4 is enacted, psychiatrists will be asked to determine if there is a real and substantial risk to the life of the mother in order that she may procure a termination of pregnancy. This is a role in which Irish psychiatrists have not been involved to date. Many will not see this as their role as medical practitioners. The role could be construed as making psychiatrists the gatekeepers to abortion. Psychiatric practice relates to assessment and treatment of patients, not assessment and adjudication. Psychiatrists are not judges.

My third point relates to the women who currently travel abroad for terminations. In the submission to the committee earlier this year, the three Irish perinatal psychiatrists - Dr. McCarthy, Dr. Fenton and myself - stated that with more than 40 years of combined clinical experience, we had not seen a single case where termination of pregnancy was the treatment for a mental disorder. If head 4 is enacted, however, it may well change the patient profile currently seen by Irish psychiatrists. It is likely that women will be referred from that population who currently travel for abortion. The extent of mental health problems and suicidal ideation among that population is unknown and, hence, the utilisation of the proposed legislation by that population is unknown.

Fourth, it is impossible for psychiatrists to predict the future. The explanatory notes for head 4 state, "It is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate". The risk of a woman dying by suicide in pregnancy is between one in 250,000 and one in 500,000 live births.

The risk is exceedingly small. In practice, therefore, it would be impossible for any psychiatrist to accurately predict which woman will die by suicide in pregnancy. Being unable to predict who will die by suicide is, therefore, likely to lead to multiple "false positives". Psychiatrists are trained to assess and provide evidence-based treatments not to predict the future.

My final point relates to the potential adverse effects on the woman's mental health due to late abortion. There is no time limit set in the heads. That is, termination could, theoretically, occur up to a very late stage of pregnancy. Late abortion could potentially have a very deleterious effect on the woman's mental health.

Chairman:

I thank Dr. Sheehan. We are now moving into Members' time which is 70 minutes. I remind Members questions are on the heads of the Bill. In the context of the language we use and the way we behave in the Chamber, if we could be tolerant and respectful towards each other it would be appreciated and, perhaps, remarks could be confined to the heads of the Bill.

Deputy Billy Kelleher:

I welcome the witnesses. On head 4, how do the witnesses see the role of the panel in terms of a woman's crisis pregnancy? She may or may not visit her GP or may present at an accident and emergency unit. Her first port of contact, probably, will be through a psychiatrist if she is to go forward for assessment under the panel process. There would be a psychiatrist who would assess the woman in distress. If she felt that the only option available to her was a termination there would be a second assessment by another psychiatrist and an obstetrician. What I am trying to understand is whether the witnesses believe it should be just

an assessment process or an assessment with care? In other words, when a woman presents to a psychiatrist I presume it is not a just a box-ticking exercise. I assume they would look at all avenues to see what supports this particular woman in crisis pregnancy needs, as opposed to just assessment, and moving her on to somewhere else. Many people are very concerned about this particular area. I would like clarity on where the witnesses see a role not necessarily on the adjudication but on the counselling, assistance and support.

There is another area I wish to question. Dr. John Sheehan points out that every year an unknown number of women go abroad in crisis pregnancy for a termination. We do not know the exact number who are in deep crisis mentally and psychologically. He said there could be an increase in the profile of people who will present under this legislation. One could argue it is a good thing that women would now try to seek support, assistance and counselling when in crisis pregnancy as opposed to just making the fateful decision of getting on an aeroplane and going to Britain without any supports or services around them. Perhaps he would elaborate on that particular issue?

The other issue is that if legislation is passed, it will need resourcing, particularly if there is an increase in presentations by women who may be suicidal or with suicidal intent or suicidal ideation. One may argue that is a good thing because they would be making contact with the health services but do we have the resources in terms of psychiatrist assessment, supports and counselling if there is an increase in the number of women seeking assistance or a determination on their mental status?

Deputy Caoimhghín Ó Caoláin:

I join with the Chairman in welcoming each of our guests this morning. I wish to put a question specifically to Dr. McCarthy. In relation to the five obligations of the State as set out in the expert group report two of them are referred to as follows: to establish criteria or procedures in legislation or otherwise for measuring or determining the risk to her life, and the other, to provide precision as to the criteria by which a doctor is to assess that risk. Does Dr. McCarthy believe that the draft legislation before us fulfils both of those two criteria from his professional perspective? For the panel, there is a requirement for three professional opinions, somebody from obstetrics and two psychiatrists. I would like to ask for your individual opinion. We would like to know, whether, in the witnesses' respective opinions, this number is too high? Does the requirement of unanimity of all three medical professionals render it difficult or, perhaps, even unworkable in practice and place an undue burden on the woman? In relation to their respective experiences - and they have indicated they reflect both City of Dublin and outside the City of Dublin experiences - will the issue of conscientious objection have any impact on the numbers available, those in practice associated with the respective 19 indicated-for-approval sites? Many psychiatrists are not actually associated with any of these yet one must be in terms of the way the draft legislation is presented. Do you see difficulties presenting there? In your own opinion, who should lead the process? It is not clear in the legislation whether it should be an obstetrician or two psychiatrists. One would expect it would be one, at least, of the two psychiatrists and that person would be attached to the individual site.

In regard to the appeals process because it is particular to head 4 on suicidality, is the timeframe reasonable and workable? Before the Chair pulls me up, as we have only three minutes to ask questions and elicit as much information as possible, I wish to ask Dr. Maeve Doyle, in her role as child and adolescent psychiatrist, if the Bill deals adequately or at all

with consentive and minor adults or adults without capacity - that may or may not be under her particular expertise but perhaps she would like to offer her opinion. That is very important. She is only one of two voices coming from a child and adolescent view over the course of today's hearings. I would like to know each of your respective opinions.

Deputy Mattie McGrath:

I too welcome our guests and thank them for their attendance. Part one of the test for abortion on suicide grounds, as per the X case, is that as a matter of probability there must be a real threat posed to the life of the mother by way of self-destruction. Can psychiatrists judge, as a matter of probability, whether someone will commit suicide? Can they point to any published research supporting their answer and their views? Would they contend that this part of the X case test is generally unachievable from a psychiatric perspective? The X case judgment stated that abortion could be the only way of treating suicidal ideation. Is there psychiatric evidence for what that judgment presupposed, namely, that abortion can be a form of unnecessary mental health treatment?

In paragraph four of his submission, Dr. John Sheehan said that in a psychiatric emergency, speedy delivery of the baby is contraindicated as it is likely that the patient has an impaired capacity and should be advised not to make irrevocable decisions in such a state. This is particularly relevant in cases where a person may have developed a transient and negative pessimism, hopelessness or despair which, with treatment, is generally resolved, as stated earlier. In light of this, what does he make of the calls to drastically shorten the processes for deciding on whether a termination in such circumstances in permissible and should such processes be strengthened rather than shortened?

Chairman:

I thank the Deputy. Does Dr. McCarthy wish to start? I will take questions in groups of three.

Dr. Anthony McCarthy:

I thank Deputy Kelleher for his questions. He raised the issue of the number of women who may go abroad but who now might come here and maybe that is a good thing. It is quite extraordinary sometimes that those who are most opposed to any legislation here, almost totally disregard the fact that, yes, of the thousands who go abroad, most, no doubt, have no mental illness or anything of the sort.

Unequivocally, within that group there are women who could do with expert psychiatric care that might well reduce their mental health difficulties. These women could be psychotic, have voices in their head telling them to kill the baby. It might be the worst they have ever done. We have seen some women who have suffered after abortions because they regretted them, and maybe if they had had a psychiatric assessment and treatment, those women would not have gone abroad and would have been treated here and they and their children would now be alive today. We completely disregard these women.

On those who are worried about and want to protect the unborn, we are completely ignoring this reality that there are women going abroad now. We want to pretend that they are not our issue, that if they go abroad and have an abortion that is just not our issue, and we only want to address those who are here now and who want to present in this tiny little narrow window.

This is a personal view rather than a professional view. I think it is a sign of our national ability sometimes just to ignore difficult questions and say let them go to England, Northern Ireland, Norway or wherever they go now to have their terminations or, increasingly, let them take their medication that they buy over the Internet and take it in their hotel rooms here or in their homes, and abort their babies here, as women over centuries have done. I have seen women, now in their 80s, who have talked about sticking knitting needles in themselves before abortion was available in England. There is a terrible Irish social history of the treatment of women in pregnancy who are in distress and if some of those women, who now go and maybe will regret it afterwards, could have professional care and support here, no doubt some of those women could well be treated, some of those women could well be helped and some of their children might be alive today, and that would be a very good thing.

With regards to the panels, the workings of the panels will be difficult. They must be organised. The reality is that the first psychiatrist will have to see the woman. If that psychiatrist, after that evaluation, comes to the conclusion that a termination would be important here - this is a very rare group because I re-emphasise, looking at the procedure here of seeing three different people, the vast majority of women will continue to go to England or take their medication or whatever it is as they are not going to come near us - he or she will then ask a second psychiatrist for a second opinion. I note Deputy Ó Caoláin asked the same question - do I think that is reasonable? In the current social situation in which we live in Ireland, but also as it is reasonable clinical practice, in difficult situations like this it is very reasonable to ask for a second opinion, as long as the obstetrician is not also being asked to assess her suicidality way beyond his or her level of competence. Some of the comments from some of the obstetricians on Friday last just showed a complete failure of understanding of mental illness and mental distress and the reality of the sort of women with whom we deal in our clinics. That will have to be dealt with.

We need an increase in resources. Between Dr. Sheehan, Dr. Fenton and myself, if one added all of our sessions together, that is not one consultant post in this country. All of us are part-time. There needs to be a huge increase in resources. That is why I finished my opening statement saying that if the result of this is better resources in hospitals for women, that would be a really good thing.

To address Deputy Ó Caoláin's specific question on precision, some of the questions that Dr. Sheehan raised about psychiatrists not being judges and Deputy Mattie McGrath's question about probability, truthfully, we must make probable decisions every day of the week. When somebody comes in to me - not one psychiatrist the committee will hear today will not be regularly in a situation in an emergency department or in an inpatient psychiatric ward or wherever saying: "On probability, I will let this person go home because my clinical judgment is this person will not kill themselves." I make that decision every day of the week. Equally, there is not one psychiatrist who will talk here today, whether for or against this legislation, who has not written on a Mental Health Act form officially "I am certifying this person into a psychiatric hospital today against their will on the basis of a risk to their life.", because we are making clinical judgments here that there is a suicidal risk. If any psychiatrist standing up here today says we cannot make these predictions, ask that psychiatrist, "Have you ever written on a mental health form saying, "On the balance of probability, this person needs to be admitted into hospital against their will, and sometimes treated against their will, because my view is that they have a significant suicidal risk.". That is what we do in our work all of the time and it will not be any different here.

With regards to the issue of unanimity, it is important the psychiatrists are unanimous. Of course, they can be unanimous. Most likely, our unanimous view will be that a termination here is not likely to help. That is likely to be our view because of the tiny little group we will be seeing to whom it would apply. I have total confidence that in the vast majority of cases psychiatrists will be able to agree, "Probably, No.", because of the restrictiveness of this legislation, but sometimes, "Yes".

We pointed out in our submissions real practical difficulties because of conscientious objectors - I fully support conscientious objectors - about the heads of the Bill as there could be one, for example, Dr. Sheehan, working in the Rotunda on his own. If he does not agree or I do not agree in my hospital, there must be a panel of persons outside and that must be looked at in the heads of the Bill.

On appeals being too long, I am very concerned about the appeals process being so long, particularly because a small number of these women may be very mentally ill. A woman may be very unhappy that we have turned her down, and for two weeks she may have a mental illness untreated. People are worried about what the appeals process will lead to and suggest stretching it out so that no woman will have an abortion who might regret having an abortion. I am worried that if we stretch it out for too long women who need psychiatric treatment will be missed. That is very important. The committee should think of the increased risk because of that. That is the sometimes horrible reality for those of us who have dealt with patients who have gone on to kill themselves.

Dr. Joanne Fenton:

In reference to Deputy Kelleher's questions, with regard to the panel and assessment, the psychiatrist is there to evaluate, to assess and to refer for treatment and it will not be a tick the box exercise. That is our role as doctors - to care for the individual and to make the accurate assessment.

With regard to the women travelling abroad for a termination, we know that there are many who attend. We do not know the specifics of each woman and what her circumstances are, but certainly there would be a number of women who are most vulnerable and have mental health issues. We cannot ignore that group and we need to be able to provide for them here. We need to be able to care for those women.

With regards to resourcing, as has been stated, there are only the three perinatal psychiatrists in Dublin. There are no other perinatal psychiatrists in the rest of the country. Psychiatric care services need to be available for all pregnant women who are attending maternity hospitals. That is essential.

With regards to Deputy Ó Caoláin's questions, I think that there will be an agreement between the psychiatrists and the obstetrician because we are there to care for the individual. We want the best available care for her. It is not about us arguing with each other but providing care for this woman. I am fairly confident that there will be agreement.

With regards to the timeframe, it should be shortened. The longer that we leave a women in distress, the greater her risk of suicide.

On the last question, we are trained as psychiatrists over many years to do risk assessments and to care for and evaluate women. That is what we are trained to do. We cannot predict the future but we are there to give the best available care to these women. That is essential.

Dr. Maeve Doyle:

On Deputy Kelleher's statement that 4,000 women go to the United Kingdom for an abortion, what is quite worrying is that there are no figures at all for children. I am being accused of being a broken record about children, but I will continue to be so.

Senator Jillian van Turnhout:

Keep going.

Dr. Maeve Doyle:

What we are most likely to see is the most vulnerable group presenting again. These are children in the full care of the HSE. They will be subjected to the process here and I do not think it has been thought through adequately.

In terms of resources, obviously child psychiatry is a younger speciality. There are approximately 90 consultants in the country and approximately 70 multidisciplinary teams. There are supposed to be approximately 100 teams. There are five approved centres - that has been referenced in the document - and only 60 beds there. Most of the child psychiatrists are working in the community in catchment area services. Therefore the stipulation in the heads of the Bill that a psychiatrist needs to be attached to an approved centre will not happen and those who are attached to approved centres are not attached to maternity units either. Those are two very practical points that will make this extremely difficult to work on.

The issue of consent, which Deputy Ó Caoláin brought up, will be very difficult for the legislators. If a child is placed in care voluntarily by the parents and is suicidal, pregnant and seeking a solution under this legislation, the HSE and guardians must give consent. What happens if the guardians disagree?

Head 4, subsection 4 states that the woman can always decide whether to proceed with any procedure. That is not elaborated on in the case of a child. How will children presenting with acute psychosis or significant intellectual disability be able to decide whether to proceed? Our interpretation of the Non-Fatal Offences Against the Person Act is that a child may not refuse treatment as she is not viewed as having the capacity to refuse. Therefore, if a panel decides that a child can go ahead, the child may find herself undergoing a procedure that is potentially life-threatening without the capacity to refuse.

There is an appeals process for a woman. It is unclear who can appeal on behalf on a minor. While there is a review procedure, should a panel disagree among themselves on a course of action, there is no equivalent mechanism for disputing guardians. In respect of the unanimity of the panel, if the issue is suicidality, one would expect it would be the psychiatrists' view that would be taken primarily. We would certainly not be able to advise the obstetricians on when it is appropriate for them to carry out their procedures.

Dr. Anne Jeffers:

Deputy Kelleher spoke about the role of the panels. We stated in our submission that we feel nothing in this legislation should subvert the usual pathway to care. We would expect that a woman who finds she has a crisis pregnancy would go to crisis pregnancy counselling services but that we would see anybody who needs input from a specialist psychiatric service. We suggested in our submission that if it is a case in which, perhaps due to conscientious objection, there is no psychiatrist to see the woman, she would be referred to a panel set up by the HSE.

In respect of women who travel, it is very clear, and we have the figures to show, that at least 4,000 Irish women are having abortions in the UK every year. We presume the vast majority of these women are mentally and physically very healthy. They have nothing to do with psychiatry and psychiatrists have nothing to do with them. My concern is for the vulnerable women who may have a crisis and may travel for an abortion and it may not be the right thing for them. We do not have a culture or environment in Ireland in which the woman feels she can discuss that and talk openly about it. The other woman is the one who travels for an abortion and believes that the only alternative to that abortion would be to kill herself. We need to ask what kind of a State we are that we would allow a woman to travel in that state. If this legislation can do something about that, it is to be welcomed.

My colleagues mentioned resources. For community mental health teams and particularly social workers, every community mental health team in the country should have the full multidisciplinary team.

In respect of the requirement for three doctors, we generally feel as psychiatrists that we are the ones with the expertise in managing suicide risk. There has been much talk about predicting suicide risk, but when anybody who is suicidal comes to us, it is our job to assess what is going on for them. What are the factors and what is happening that leads them to believe that killing themselves would be a thing to do? We engage with them - not just the psychiatrist but every member of the team - in finding a way to ensure we can keep that person safe. That is what we do as psychiatrists. We do it every day and we know how to do that well.

In respect of the timeframe, the decision should never be rushed, but a psychiatric assessment does not need to take days. For many of these women we would be talking about two or three hours for the assessment, but one can do a second or third one within a few days, so the important thing is that the woman is not left in distress.

In respect of the degree to which we can predict the risk of suicide, as I have emphasised, what is most important is that anybody who is suicidal feels able to access the service and talk openly about their concerns and fears. I think I have covered most things.

Dr. John Sheehan:

To reply to Deputy Kelleher's point about the extensive mental health problems of women travelling and whether some of those women present for help, it would clearly be a very good thing if that happened. One difficulty we have is that we may have a reasonable idea of the numbers of women who travel for terminations but we have no data on the extent of mental health problems in that group. We have no data on how many of those women are suicidal, so when people make comments about this group, they are entirely speculative because we have no data. Would anything that encourages women who travel for terminations to come for help

be a good thing? Of course it would. One only has to look at people such as Bressie on the television last weekend or Alan Quinlan, the Lions and Ireland rugby player, talking about mental health issues and reducing stigma. Anything we can do to help people come forward and seek appropriate help is clearly a very good thing. If that happened, I would be delighted to see it.

Deputy Ó Caoláin raised the difficult question of the numbers - whether there should be two psychiatrists and an obstetrician, and the number of specialists that is required. The core of this question is whether anybody has the capacity to identify that one woman in 250,000 who will go on to commit suicide. Whether it is one, two or three doctors, the number does not improve one's ability to identify that woman in 250,000 to 500,000 because it is impossible to predict with any accuracy when one is looking at statistics as significant as that. The number issue is a difficult one because one is in an area of trying to predict something that is extremely rare.

It must also be said that when we look at the information from the confidential inquiries and the forensic examination of the case histories of women who died by suicide in pregnancy, we see that the very small number of women who die are women with major mental illness such as schizophrenia or bipolar disorder or with alcohol dependence or serious drug problems. This is the group we are dealing with. When one looks at psychiatric involvement, often the psychiatrist is looking at specific risk factors. As Dr. McCarthy mentioned earlier, when we see people with a mental disorder who are deemed to be an immediate risk to themselves or others, the current psychiatric practice is to detain that person is hospital. That, of course, is completely at variance with what is proposed in the heads because they propose that someone who is deemed to have suicidal intent is able to make a decision about having a termination of pregnancy. It is completely at odds with what one would call standard good practice in psychiatry.

Deputy McGrath's point tied in with the question of probability which I covered. In the case of probability, doctors assess risk all the time; I do it every day at work. We assess risk in order to reduce risk, to care for the person and to intervene - including even in certain situations as I mentioned - detaining the person in hospital. That is different from what we are being asked to do and what psychiatrists are being asked to do in this Bill. It is also complicated by the fact that with regard to evidence-based practice there is no evidence base to show that termination of pregnancy prevents suicide. There is no data available.

The question comes up too about whether to shorten or lengthen the duration of the assessments. I do not think that the time is the central factor of importance. The woman's mental state is the central factor. As I mentioned at the start of my submission, a person may be extremely distressed, agitated, perhaps feeling abandoned and hopeless. We see people almost every week in the emergency department who may have been bullied at work or there is a crisis at work; they have self-harmed and they come to the emergency department. They then say, "I am resigning". We say to them: "Don't make any decision now. Wait." Such people need time out and support. They need to consider carefully all their options and then, with the level of distress reduced, they can decide whether to resign or whatever. There seems to be this notion that because a person is expressing suicidal intent that the response has to be a rapid termination of pregnancy. That flies in the face of what we do at work every day of the week. It is exactly the opposite of what is regarded as good practice.

Senator Jillian van Turnhout:

I thank all the experts for their very compelling contributions. I have specific questions about head 4 of the Bill. I refer to the submission from the College of Psychiatrists of Ireland which proposes that the term "absence of clinical markers" is incorrect. This has already been referred to this morning. They talked about the absence of biological markers but that there are clinical signs and symptoms. Given the debate and the discussion on Friday, it would be useful and informative if the expert witnesses could elaborate on the reason they propose that this would be deleted from the legislation.

Dr. Doyle raised the issue of the definition of "child" in the legislation. I say to Dr. Doyle not to be afraid to be a broken record on this issue. It is startling that "child" is not defined in the legislation. I am very mindful that we are talking about the X case. Dr. McCarthy said in his statement that, "Suicide in Pregnancy is real, a real risk, it does happen". That is a fact which needs to be clearly stated. He referred to the issue of consent, in particular, with regard to children. It is often the case that consent is regarded as one-way, that a person consents to a medical procedure. However, a person can equally refuse to give consent for a procedure. We need to be very mindful of the use of the word, "consent" with regard to the child. I am thinking in particular of children in care. If I am correct in reading between the lines, other children may have choices because their parents may choose to travel with those children but a child in care will not have that choice. What if the parents do not agree to that? What if that child is in care because of parental abuse, yet the parents may interfere in the choice made by their child? This is an extreme situation which may only arise in one case, but that is still a child in the care of the State.

In the view of the experts, should the legislation include a specific provision with regard to children in the care of the State? I am concerned that such a child could be almost smothered in the process by the number of people who may become involved. This would add to the difficulty for a child with suicidal ideation or intent.

Deputy Peter Fitzpatrick:

I welcome the expert witnesses. If a patient is suicidal and suffering from mental illness, will she be legally competent to give permission for an abortion in accordance with head 4 of the Bill? Where a patient is suicidal, would the provision of full-time care, which includes close observation, reduce the risk of self-destruction to a significantly low level? If a patient has stated suicidal intent but is not suffering from mental illness, which criteria will be used by psychiatrists to decide that a real and substantial risk of suicide exists? If a patient is suicidal but not suffering from mental illness, what psychiatric and medical treatment can be provided?

Deputy Denis Naughten:

Following from Deputy Fitzpatrick's last question, what happens in a situation where someone has refused alternative interventions? How would this situation be dealt with by psychiatrists? The College of Psychiatry of Ireland's submission is very clear that suicidal assessment should be left to the psychiatric profession. How does this fit into the system of multi-disciplinary medical teams?

How does it stand with regard to the tests that must be included in the psychiatric assessment regarding the need to preserve the life of the unborn? What are the particular skills of psychiatrists in making that assessment if they are doing so on their own? The witnesses have

stated that obstetricians should not be involved in this part of the decision, yet in the submission it is stated that child psychologists should deal with children but that perinatal psychologists should not necessarily deal with adults. I ask the witnesses to elaborate on that point. There seems to be contradictions in the presentations.

What happens if the risk of suicide is as a result of non-fatal but serious life-limiting foetal abnormalities? I am trying to find out the differentiation between early delivery and induction prior to viability. In the case of a patient with a medical illness, the obstetricians endeavour to continue the pregnancy in so far as it is possible but in some cases where the woman wishes to have a termination - please correct me if I am mistaken - I presume it is important that induction would take place prior to viability. How do doctors deal with such a situation if the woman presents late with a non-fatal serious foetal abnormality which is very close to that 22-week threshold of viability?

Dr. John Sheehan made the point that the procedure in the legislation contradicts good practice in psychiatry. I ask him to elaborate. I ask him to give his views on the fact that with regard to infanticide, women who have recently delivered are treated differently from anyone else in society who may be accused of murder.

Dr. John Sheehan:

I will begin with the first question on the absence of a clinical marker in head 4. There is no specific clinical marker to assess suicidal risk. A risk assessment will include whether a person has a current mental disorder, such as depression or a depressive illness. It will also examine alcohol or drug use and then it will look specifically at a whole range of risk factors. We also take other factors into consideration such as gender because suicide is four times more common in men than in women; the peak in suicide depending on age with a peak in young men and in older people. There is a range of factors to be taken into consideration. However, there is not a scientific formula. There are different scales, for example, the use of what is called a hopelessness scale. These scales are helpful.

However, I think all we could actually say it that these are helpful as opposed to being definitive. Therefore, there is not a definitive clinical marker in that regard.

The second question raises an interesting issue concerning a person who is suicidal and has a mental illness. The bread and butter of psychiatry is seeing people with mental illness or mental disorder who, for example, may be suicidal. Good standard medical practice comes into play there - that is, everything from evidence-based treatment, such as cognitive therapies, day hospital care and admission to hospital. There is a wide range and medication may be used. In those situations, dealing with a person who is suicidal with mental illness, the principles are to target the mental illness and keeping the person safe.

It gets more difficult when a person does not have a mental illness. Anybody who works in an emergency department, particularly in the inner city, regularly sees homeless individuals who essentially want a bed for the night. They will come in and say they are suicidal and I need to be admitted. When one delves down to what is going on, they need a bed for the night and that is what they are looking for. They know that by asking the question in that way, that is how they can access a bed. It becomes much more complex when one is dealing with issues that do not relate to mental illness or mental disorder as such.

The liaison psychiatry faculty, of which I am a member, represents doctors who largely work in emergency departments and see people who have attempted suicide. They would question the validity of an assessment of an individual who does not have a mental illness but who, for example, is requesting or demanding something. It can be quite difficult to be certain and accurate in an assessment when a person does not have a mental illness or mental disorder.

I also wish to allude to some other points. If a psychiatric assessment is done by a psychiatrist or a member of a multi-disciplinary team, in certain services members of the multi-disciplinary team have conducted assessments of people presenting after self harm. Nationally, it tends to be a psychiatric assessment but there are services that have involved people from the multi-disciplinary team concerning people who have done self harm.

We warmly welcome the clinical care pathway programme which is coming down the tracks. It will involve having specialist nurses doing assessments of people post-self harm. We welcome that but it is not a psychiatrist doing the assessment there.

Finally, I will deal with the issue of infanticide, which is extremely rare. Resnick divided infanticide into two types: early and late. Early infanticide was where a mother killed her little baby within 24 hours after delivery. In that situation, the woman was often usually very young, completely unsupported and immature. She felt she had no other option but to do what she did, but certainly did not have a mental illness.

Infanticide that occurs later is related to major psychiatric illness and usually what we call psychosis. This is very rare and clearly very tragic when it happens. That is the issue concerning infanticide.

Dr. Anne Jeffers:

To start with, we would see it as a question on the absence of biological markers, rather than clinical markers. I do not think people will be asking obstetricians to explain how they do their job. It is really difficult for me to distil down the amount of training and expertise I have, the 30 years' experience and working with multi-disciplinary teams, to try to adequately get across the expertise of a psychiatrist in assessing suicide.

I will give an example of somebody who might come to us in this situation, Often, it is a young woman who may herself have had experience of extreme abuse in her childhood, may have been raised in care, may already have had children taken into care, and may be coming to us with the prospect of going through another pregnancy when she fears that the child may be taken into care also. These are women who, because of their circumstances, have not been able to build up the normal social supports that the rest of us rely on to get by. They come to a psychiatrist and a multi-disciplinary team. A social worker will meet with them and a psychologist will be involved. Between us all, we will be offering support to this woman. We are not just talking about a once-off assessment, we are talking about ongoing care and support. The important thing is that we identify where the hopelessness is coming from, identify what the issues are and what we can do about them. That might describe how we, as psychiatrists, assess clinical risk.

I was interested in Senator van Turnhout's statement that we may only be speaking about one case of somebody who is in care or a child in care. A lot of the women we see in these stressful situations would themselves have been in care and often have children in care.

Senator Jillian van Turnhout:

Okay.

Dr. Anne Jeffers:

On the issue of whether somebody who is suicidal can give consent, once again it is about working collaborativley. That is what we do in psychiatry - we work closely with the individual who comes to us with the problem and we ensure that, as regards decisions that are reached, the person is capable of making that decision. It is very clear in the Bill that the person has to, although they have not addressed the issues where the person does not have the capacity. We will certainly be working with the person who has the capacity.

If they do not suffer from a mental illness, this is a difficult area. The whole issue of what we do if somebody comes to us and we think there might be another intervention other than a termination, yet they are very determined that a termination is the only answer. The Mental Health Act would not be applicable in this case. There may be cases but it is hard to describe. I think we would have to try to understand why the person was reluctant to take on any of the treatments we are suggesting. That goes back to their childhood experience and their psychological make-up. There are usually reasons why people cannot avail of treatments that we may be offering. That is what we do in our day-to-day practice, but there may be cases where we have to say to women, "This law doesn't apply to you". They have autonomy and have to make their own decisions. In practice, that is not going to be a decision that is made by one psychiatrist - it is part of the team approach.

The question was raised concerning how one handles a situation where somebody will not accept treatment. The issues of early induction and infanticide were also raised. I will leave these matters to the perinatal psychiatrist.

Dr. Maeve Doyle:

I was very pleased with Senator van Turnhout's contribution. It was heartening to acknowledge that we are here because of the predicament a child found herself in.

I will talk a little bit about child psychiatry. We work in a multi-disciplinary way and child psychiatry was probably invented in a multi-disciplinary way. That is because we consider the children as part of a system with family, school and the wider environment. As child psychiatrists we assess for the presence and absence of psychiatric disorder. We are well used to working with our colleagues and tend to devise protocols where we look at deliberate self harm and suicidal ideation, but we always have access to the psychiatrist to determine whether there is an actual mental illness.

I think Senator van Turnhout's question on whether specific elaborations with regard to children and adolescents may be needed is a good one because the complexities of the situation with regard to consent, refusal, capacity and so on are not very well understood. I will give members a short example with regard to the admission of young people to inpatient units for mental health assessment and treatment. The child's guardians can sign the admission form on behalf of the child, assuming the relevant guardians are happy to so do. In the absence of that consent and if a determination has been made that a child requires admission to an inpatient unit either for assessment or treatment, then recourse is made to the

Mental Health Act 2001. In addition, if a child is in the care of the HSE and admission is sought, the practice, based on legal advice, is that the protection of the Mental Health Act is sought. In cases in which a child is 16 or 17 years old and explicitly states he or she does not wish to be admitted, while his or her guardians are keen that he or she be admitted, it has been deemed prudent to seek the protection of the Mental Health Act in case a situation arises in which the treating team may be obliged to physically administer medication against the will of the young person. The overriding principle in all of this is that the welfare of the child is paramount. However, it is the appropriate adults who determine what is, in fact, in a child's best interest and perhaps something such as a guardian *ad litem* might help in this procedure. I really wish to highlight that it is not that the legislation is unworkable - we will work with it- but we need to flag, in particular for children and adolescents, the additional layers that must be considered.

Dr. Joanne Fenton:

I will address some of the questions from Deputy Fitzpatrick, the first of which pertains to an absence of clinical markers. As Dr. Jeffers mentioned earlier, we are trained to carry out risk assessments and to look after carefully and treat the women. It takes many years to do this but we are very competent in making those assessments. In the case of a woman who presents for an assessment stating she wants to have a termination and who is psychotic, it would be our role to treat that psychosis, rather than making the judgment to have a termination. Consequently, it is within the capacity. In addition, we would make that decision along with the obstetricians. We would make our psychiatric assessment and then would speak with the obstetricians, so we would work as a multidisciplinary team.

Dr. Anthony McCarthy:

I thank members for a number of interesting and thoughtful questions. I will not refer specifically to the child issue because Dr. Maeve Doyle has covered it well and adequately. I note that, again, there are technicalities on which we really must work and while none of them is insuperable, we must work on them. In addition, I will not answer anything further about clinical markers, as that point already has been made.

Yes, suicide is a fact. When people talk about figures, such as one in 500,000 or one in 250,000, it is desperately important to note we actually do not have a clue because these figures are based on the fact that this is a country, the United Kingdom, in which abortion is directly available. I am on that confidential inquiry that considers those maternal deaths to which Dr. John Sheehan has referred but, yes, absolutely, those who commit suicide in the United Kingdom at present nearly always are mentally ill. However, that does not at all account for all the other hundreds of thousands of women who have terminations in England and who may well be mentally distressed and may well have that termination because they are suicidal. Nothing captures that at present and nothing will. Consequently, one must be very cautious about that sort of evidence.

Again, I will not address Deputy Fitzpatrick's questions too much because I believe I covered that issue in my opening statement. I agree that some people have mental illness and it must be treated. In the case of some people, it is mental distress. In the reality of our clinical work, we really are dealing with the complex interaction between stress, distress and mental disorder. If only life were black and white and one could say these ones are mentally ill and should be treated psychiatrically by getting them into hospital and observing them carefully,

whereas these ones are in psychosocial distress and should be dismissed. That is not life and every one of you in this room knows that. It is much more complex than that and our jobs and experience are to weigh up these factors. As for the woman who refuses alternatives, we are not naive. If a woman comes to me, having refused all other alternatives, my question will be "Why?". Why is she sitting in front of me if her only option is a termination of pregnancy? Why has she not gone to England? This will be part of the process as we are not fools and it will be a highly complex discussion. The question will be whether she is trying to test the legislation or is it the case she cannot leave the country for some reason. As for the idea that this would be blocked in some way or that she will present in that way, namely, that she refuses everything else and consequently it is up to me, in itself that is a very complex interaction. We are used to dealing with people who put us under all sorts of stress to make decisions. Dr. John Sheehan made reference to people in the emergency department who threaten to kill themselves unless they are given some methadone because their methadone was stolen in the hostel. We are used to being put under pressure. While that might seem like a job that most of you would not like, I love my work. It is really complex but it also is very human. We are aware of the complexities and interactions and are not naive.

A member, whose name I did not get, asked a very good question about multidisciplinary teams. While we work in multidisciplinary teams, there are times when, as psychiatrists, we are the ones who must make that final decision. We have talked a bit about involuntary detention within hospital and it is the consultant's name that goes on that form. Similarly, for someone who has been previously detained, it is the consultant's name that goes on the discharge from hospital form. If that patient appeals against his or her detention in hospital, I as a consultant must go into that room and defend. It is not my multidisciplinary team, just me. Consequently, as psychiatrists we are used to being the individuals who take these decisions. That is our responsibility and duty and is one for which we all are very well trained.

On the viability issue, I agree there are highly complex issues about viability. I think that really is up to our obstetric colleagues to deal with. There are of course complex, painful issues that sometimes must be dealt with. If a woman is six weeks pregnant, my conversation with her will be very different when compared with that with a woman who is 16 weeks or 26 weeks pregnant. We know that. Why does she wish to get rid of that baby? Does she wish to get rid of the baby or does she wish to kill herself? Moreover, if she wants to get rid of that baby, is it because she cannot bear having that baby inside her? Perhaps she has an eating disorder and already has taken three overdoses in the course of that pregnancy because she cannot deal with that real distress. I am sure it is difficult for all of you to understand but I refer to an anorectic who sees herself as totally fat and the issue actually is that she wants the baby out. This is in contrast to someone else who wants that baby killed because it is her father's child or because she actually is in a relationship with a guy who she should have left years ago. When she got pregnant, in that ridiculous way she would do, she kind of imagined that somehow having a baby with him might make him be nice. However, we know that, actually, men are more likely to have affairs during their partner's pregnancy and certainly levels of domestic violence increase during pregnancy. We men do not come out well out of all this. This is a woman who already has been kicked three times in the stomach in pregnancy and who knows now that if she is pregnant, her issue is that if she has this baby, she will never get away from him, because he will be the father of the child and she will be obliged to stay in this country because he will have rights. Consequently, she has a choice, namely, does she kill herself or does she get rid of that baby or perhaps both, but if she has that baby she is stuck. If this conversation takes place at 16 weeks or 22 weeks, yes, we

would try to help as much as we can. However, if anyone can say there never will be a woman in this circumstance, he or she really does not understand the messy, horrible nature of life sometimes. I refer to the real mess, the bloody issues that go on. That is the reality which we must deal with and assess, not as cold pre-judgmental black-and-white people but as real professionals who understand mental illness, mental disorder and capacity, but who also understand that, sometimes, it is not black and white and is not easy.

Finally, while talking about bloody issues, let me get back to infanticide, to which I referred the last day I was here. I got a lovely letter from a priest afterwards thanking me for raising this horrible part of Irish history, namely, the history of hundreds of women who committed infanticide every single year in this country during the 19th century and the first 50 years of the 20th century. Wonderful studies have been done on this issue and these were real. The study to which Dr. John Sheehan referred is about infanticide now and not about infanticide then. Infanticide then was not all about mental illness or anything like that. It was about women who found themselves in extremely difficult situations. The treatment of unmarried women, women with unwanted pregnancies in this country is not great, is it? I refer to the Magdalen laundries, industrial schools and psychiatric hospitals. We as a profession played our part in having women in hospitals for many years. For what reason? We colluded with unwanted pregnancies.

The reason I stand here, not just as a perinatal psychiatrist but as a human being and as president of the college is to say that should stop. We must do anything that will protect women in these circumstances. The women will be treated with dignity and respect. If at all possible, the life of their unborn child will also be preserved. That is not only my responsibility under the Constitution and the law but also as a human being and as a father. If a woman goes on to kill herself, her child or children die as well. Such situations happen. They are real and it is our job to prevent that.

Chairman:

We have 23 minutes remaining in the session. I apologise to members, as not everyone will get to contribute in this session. Six members have indicated to speak. The next three to speak will be Senators Ivana Bacik and Colm Burke and Deputy Mary Mitchell O’Connor.

Senator Ivana Bacik:

I thank the witnesses for their compelling evidence and for clarifying a number of important points for us. First, that psychiatrists have the experience and expertise to assess suicide risk, that it is something they all do routinely and that in particular they are used to operating within the statutory framework of the Mental Health Act and of adjudicating on detaining people against their will on the basis of their clinical assessment. That is very helpful to us in the context of some of the comments we heard on Friday. It is also helpful to hear from them that abortion is not a treatment for mental illness but rather it may in rare cases be required in order to avert the risk of suicide. That is the language of the Supreme Court and of the heads of the Bill. That is helpful as that is what we need to work within.

Psychiatrists have also pointed out the highly restrictive nature of the legislation, and as a result the reality that for the majority of women who travel – the 4,000 women - every year for abortion will continue to do so and will not avail of the highly restrictive procedures in this country. Dr. Doyle put it extremely clearly that the majority of the very small number of

women or girls who will avail of the measure will be those in the care of the HSE who are unable to travel otherwise. The comments on the amendments on children are very important.

I wish to ask a couple of specific questions on other points about amendments. In head 4 there are currently two specific restrictions on psychiatrists requiring that both of the psychiatrists will be employed at a centre registered by the Mental Health Commission and that one would be attached to an institution where a procedure is carried out, in other words, a maternity unit. Concern was expressed on Friday that this was too restrictive, as there would be too small a pool of psychiatrists from which to choose. Could the witnesses comment on the point and whether we should broaden the definition?

As a criminal lawyer I am extremely concerned about the definition of the criminal offence involved in a head that has not yet been referred to today, head 19, in particular the criminalisation of women. Some of the witnesses have pointed out the reality that many young women in particular are availing of abortion pills over the Internet resulting in self-induced abortion in this jurisdiction. Under the current wording they would be subject to criminalisation and a 14-year penalty. As psychiatrists, do the witnesses believe that would have a chilling effect on women seeking help in after care?

My final question is for Dr. Sheehan. I apologise if I misunderstood him, but is he suggesting that a girl like X who is suicidal because of her pregnancy and has been denied an abortion would never commit suicide? How would one care for a young woman or girl in that situation who wants to kill herself because she is denied abortion. She is very clear about that. Does he suggest she would be detained involuntarily for the duration of her pregnancy? That is a serious suggestion. I apologise in advance if I misunderstood his meaning.

Senator Colm Burke:

I thank all of the contributors this morning. The submission on the role of psychiatrists in making the decision is in line with the Medical Council's proposed amendment under head 4, which was presented to us on Friday, namely, that the psychiatrists would sign off on the psychiatric issue and then there would be consultation with the obstetricians. Do psychiatrists feel that GPs should have a more involved role in the decision-making process or are they happy with the Medical Council's proposal to deal with the issue?

The second issue relates to pregnant adults under psychiatric care at present. How is the issue of consent currently dealt with if, for argument's sake a decision is taken that a person needs a caesarean section? Does current legislation allow medical practitioners to take a decision without referral to a judicial process?

The third issue is one about which I have serious concern. It relates to expectant mothers aged under 18 or under 16. What clarification needs to be provided in the heads of the Bill to deal with the issue? What protection must be provided for the expectant mother, the parents and the doctors dealing with such cases? What clarification would the witnesses suggest is required under the section?

Deputy Mary Mitchell O'Connor:

I thank Dr. Maeve Doyle very much for raising serious issues around the legislation. We must examine specifically what she has raised today. I thank those witnesses who mentioned compassion. As a woman and a mother I really appreciate that.

Dr. McCarthy stated that all assessments must be individual, comprehensive, compassionate and not prejudged. He stated that he is the president of the College of Psychiatrists of Ireland and a specialist in perinatal psychiatry. Does he foresee that some women will be prejudged by his profession if the Bill goes ahead?

It has been stated that there are 864 members in the College of Psychiatrists of Ireland. A recent survey was completed by approximately 130 members. I wonder why the other approximately 600 psychiatrists did not answer the survey. Was the survey widespread? In my ignorance I thought there were only approximately 130 psychiatrists in total.

Chairman:

Could Deputy Mitchell O'Connor please address the Bill?

Deputy Mary Mitchell O'Connor:

This is relevant because we received information on the survey by e-mail.

Dr. McCarthy asked a question which I would like to echo on whether psychiatrists have ever signed a form for involuntary detention of a patient due to the risk of them being a danger to themselves? Could they ever foresee that they might have to do that for a pregnant woman? I will leave it at that. Perhaps the Chairman will allow me to speak again if necessary.

Chairman:

We will not have time but if I can I will. Three other members have indicated and I will take them now if that is okay. I accept it is difficult on the witnesses but I wish to be fair to members who have been present all morning. I call Senator John Crown, Deputy Catherine Byrne and Senator Jim Walsh.

Senator John Crown:

In formulating the decision as to whether suicidality will be in the Bill, the five witnesses have the same rights as any five citizens of our country in a popular referendum. The decision has been made by the Supreme Court, which according to Article 34.4.6° of the Constitution states that the decision of the Supreme Court shall in all cases be final and definitive. That can be challenged by the people in popular referendum. That has happened twice. On the first occasion when it was asked clearly and unambiguously it was defeated by a margin of 2:1. There really is no constitutional mechanism for us in this Chamber to decide that we are not going to include suicidality or that we are going to specifically exclude suicidality from a Bill which allows abortion to save the life of the mother.

What we need the witnesses to do, which they are doing very well, is to inform us about some of the relevant practical issues. The reality is psychiatrists do not change the Constitution but they determine psychiatric practice and the psychiatric evidence base. Therefore, when constitutionally mandated psychiatrists at some hypothetical – I believe it may never happen

– occasion in the future are confronted with a pregnant woman who is suicidal and are asked to make an adjudication within the rules of the law which we will be asked to pass sometime during 2013, it is their job to formulate the evidence base which best informs the psychiatrists who will be in that position. In truth, what they have told us today is very useful.

I have a few specific questions to ask. One is to my very old and dear friend and colleague, John Sheehan. If we believe that there will be a net transfer of women who are now going to the UK for abortions to this country - in the event that this new regime occurs - we have to ask why. It will happen for one of two reasons. The first reason is that they are legitimately going to the UK because they are suicidal to seek a legal abortion which they believe might not be freely and legally available in this country. The other alternative is that they are not going to the UK because they are suicidal but will try to game our system. To game our system they will need to do it with the free, voluntary, informed collusion of two psychiatrists.

There is no other way round this and some of our witnesses in January were tying themselves in knots about this, saying floodgates will open but women will not lie. They never explained what the mechanism would be. We will have informed psychiatrists who have the evidence, which tells them a woman is or is not suicidal.

I am a little confused by one thing. In the course of my job I must frequently take histories from people who are very distressed. Sometimes they say they often think of ending it. That is a red flag to me and I must refer them to a psychiatrist who is more skilled than I am in assessing the likelihood that suicide will nor will not occur. I am hearing this morning that psychiatrists cannot do that and I am troubled by that. I feel very vulnerable when I do not send someone to a psychiatrist in case some tragedy happens. As an oncologist who has had a patient commit suicide, I need to know we have the back-up of psychiatrists on this.

Deputy Catherine Byrne:

This morning I looked at the logo for the College of Psychiatrists of Ireland - wisdom, learning and compassion - and those are what this Bill is about. We must have the wisdom to make the right decisions, the learning skills to listen to witnesses and above all, we must all have compassion. Unfortunately this is not about the lovely, beautiful 4,000 women who go to England every year. It is not about them. I agree about the length of time for the appeals.

Have any of the witnesses in their profession, because of the increase of illegal drug taking by young women, particularly in Dublin, any evidence that more young women who are pregnant with mental illness are contacting their practices? Is that leading to people wanting to end their pregnancies?

Senator Jim Walsh:

Capacity to consent is an issue. Could we get some idea if what this entails? My understanding is that where a major decision is being made by someone who has a mental illness, not to talk about being suicidal, it does not stand up in law and he or she would be discouraged from doing it. Abortion is an irrevocable decision which would be recommended.

On a point made about the X case, would the witnesses comment on the progress in psychiatric medical evidence in the last 21 years since the X case? We know the Supreme Court and the High Court got no psychiatric evidence at that stage.

When the obstetricians were in on Friday, they were very strong on doctors being ethically obliged to act on medical evidence. The institute chairman emphasised this in his report to us. Above all, they maintain "do no harm" and the two patient model was something they espoused. The witnesses today all agree abortion is absolutely not a treatment for suicide and I am glad that has been reinforced on the record. That would present a moral dilemma for them in that they will be asked after the decision is made by psychiatrists that someone is suicidal. How accurate is that prediction likely to be? We heard evidence on the last occasion that a British study showed there were 97% false positives.

A woman might present who is 26 weeks into the gestation period and who says she will commit suicide. She may well feel she is going to commit suicide because she wants an abortion, she does not want to have this baby. She is not happy with an early inducement, which does not satisfy her suicidality, she wants an abortion. What would the witnesses do? What would they certify with regard to abortion or inducement?

Chairman:

We have nine minutes left in this session. I will be fair to everyone.

Dr. Anthony McCarthy:

Absolutely, 14 years seems extraordinary, as we know so many women are already doing it here. That is the truth of the matter.

In reply to Senator Colm Burke, we agree with the Medical Council and recognise the role of the GP and the importance of consulting with the GP where possible. Consent for caesarian sections is an obstetric issue and as a psychiatrist, I have no comment to make about consenting to caesarian sections.

Specifically to answer the question about the survey of 113 psychiatrists, I am sure every one of the 864 members of the college got the survey, I certainly got it. When I saw myself misquoted or selectively quoted in it, and a comment that all psychiatrists who attended the last time all agreed, and the complete ignoring of comments that Professor Veronica O'Keane made, I thought it was survey not even worth answering because it just was not a survey that anyone could stand over scientifically.

Senator Crown asked a specific question about capacity. It is a complex issue and we could talk about it for hours. That is why the Legislature has been resting for a very long time trying to get capacity legislation. Capacity is not a simple concept. Someone can be mentally ill and still have capacity. Someone might not be mentally ill but not have capacity. A person could have capacity for some decision making but not others. It could be due to mental disability or brain injury. It is a complex issue but we certainly must think about it when making any of these decisions.

Have I ever certified someone? I have certified a woman into hospital who wanted to kill her baby. She had a delusional voice in her head telling her to do that. Clearly abortion would not

have been the treatment of choice. She was very distressed at the time but very relieved afterwards. Equally, I have seen people who have stabbed themselves in the stomach and who have taken multiple overdoses in pregnancy who were not mentally ill, they were profoundly distressed and at serious risk to their own life and the life of the baby. We must dismiss the notion that somehow we can neatly discriminate between mental illness and distress because they interact.

I answered the question on the issue of the 26 weeks and suicidality the last time. I would say to Senator Crown that if there are psychiatrists who will not assess his patients, I will be delighted to see them if necessary and will happily stand over my views.

Dr. Joanne Fenton:

With regard to head 4, the number of psychiatrists being attached to the maternity hospital, it is restrictive and must be re-examined. There are only three of us attached to maternity hospitals.

The role of the GP is key. The GP will often know the patient best and be able to do initial non-directive counselling and refer on as needed. There was a question if women will be prejudged. Our role as psychiatrists is not to prejudge individuals presenting for assessments, our role is to act as treating psychiatrists and give care and compassion and not prejudge any woman. I do not think that is going to happen.

Have pregnant women been signed into hospitals for suicidal ideation? Absolutely. There are people who are psychotic and who need treatment for their mental illness. If they are treated for their mental illness, that will avoid the question of termination or the need they felt at the time.

I have seen people with an increase in substance use and suicidal ideation. Substance abuse is all around, particularly in the inner city, and in the suburbs. We must treat the individual on her substance abuse and suicidal ideation.

Dr. Maeve Doyle:

On the role of the GP, some parents will take a child who is pregnant to their GP and some will not, and will take other decisions. It is important to note in some of the recent reports on children in care, only a third of the children in the care of the HSE had a GP. That is being looked at now.

There would have to be some easing out for child psychiatrists in the number of doctors on the panel given there are only six child psychiatrists working in approved centres, none of whom are attached to obstetric units. All the remaining child psychiatrists are in catchment area communities.

I do not know who asked the specific question about how one would sort out the various consent issues that arise in respect of those aged under 16 years and 18 years. The Law Reform Commission produced an excellent document on this matter, the recommendations of which have not been enacted. Clearly, the matter needs to be addressed.

Dr. Anne Jeffers:

On the issue of all doctors being linked to approved centres, our submission states that this issue needs to be examined. Not every maternity hospital has a psychiatrist working in the unit and this issue needs to be addressed.

The general practitioner is of great importance. As general adult psychiatrists, we work very closely with GPs and we believe it would be sufficient where it states that one of the psychiatrists would contact and discuss with the general practitioner. We will discuss with the GP in these cases at any rate.

On the issue of prejudgment, as we stated, at an individual level we do not judge before we have listened to and heard the individual's story and account of his or her difficulties.

On the survey, I was sent a copy of the survey and, likewise, my concern was the way in which the questions were posed. It was difficult to answer in a reliable way. As psychiatrists, we are trained to evaluate evidence and the literature and we drum it into our trainees that we have to be very aware of bias. We must look at who are the authors of the study and what their thinking may have been. We also have to be aware that when we are reading the literature we put our own biases on what we read and we often remember and zone in on something that already supports what we believe.

On the practical issues, all psychiatrists would be very competent at assessing suicide.

On the capacity to consent, I emphasise that, other than in cases of psychosis which has been referred to, most people with mental illnesses have capacity and are able to make informed decisions.

On the accurate of our decisions, in psychiatry our predictions are often more accurate than in other areas of medicine. Our work is about understanding where the individual is coming from. That is what improves the accuracy in assessing suicidal risk.

Dr. John Sheehan:

I will reply to some of the questions that have not been covered so far. Senator Bacik asked if I could state that X would never commit suicide. I do not believe any psychiatrist or doctor can ever make a statement that a certain person will never commit suicide. It is equally true, however, that it is also impossible for a doctor to state that somebody will commit suicide. The position in which psychiatrists are potentially placed by the legislation is to state that there is a real and substantial risk that the person will complete suicide. Even studies that looked at very high risk populations, which do not include the population we are discussing, show that in such very high risk populations an expert will be wrong in 97 cases out of 100. Prediction is, therefore, very difficult; in fact, the word I would use is "impossible".

To tie this in with the issue raised by Senator Crown, psychiatrists are experts in assessment and treatment. However, this brings us back to the same area, namely, one of prediction, which is something psychiatrists cannot do. While we are extremely good at dealing with and managing risk, in other words, reducing risk, prediction of the future is something completely different.

On the issues of assessing people in a compassionate manner and prejudgment, I return to the point that the group we are talking about are individuals who are extremely distressed and

may be utterly hopeless and see no way forward except ending their life. That is the reason I stated that the management of a psychiatric emergency in that type of situation is totally at odds with the management of an obstetric emergency.

Chairman:

At this juncture, I formally welcome to the Chamber the former Democratic Senator from Arizona, Dennis DeConcini, his wife, Patty, and Mr. and Mrs. Jim Kelly from Washington.

We will now have 30 minutes for non-members. Seven speakers have indicated and I call Deputy Terence Flanagan, Senator Rónán Mullen and Senator Fidelma Healy Eames.

Deputy Terence Flanagan:

I have questions for the experts on three areas under head 4. Has the Irish College of Psychiatrists given significant consideration to the way in which the health grounds for abortion in other jurisdictions have been abused, particularly by pro-choice physicians, to permit abortion on wider grounds? In the United Kingdom, for instance, some medical practitioners have flouted the law by pre-signing abortion consent forms. Should the proposed law be more cognisant of the real possibility that abortion safeguards will be flouted, especially by those who consider that such safeguards limit the expression of abortion rights?

If the experts formed the opinion that a patient who was 20 weeks pregnant was suicidal and this constituted a real and substantial risk to her life which could only be averted by the termination of her pregnancy, would they feel obliged, under the proposed legislation, to try to delay the termination for a number of weeks until the baby was viable or should the law in this case explicitly provide for such an obligation? Are the experts familiar with what occurred in the State of California before the United States Supreme Court decided in Roe *v*. Wade that abortions could be performed for a variety of reasons, including to preserve the mental health of a pregnant woman, and only if a hospital committee consisting of two or, in some cases, three physicians unanimously agreed that the pregnant woman was suffering from a mental illness to such an extent that she was dangerous to herself or to the person or property of others or was in need of supervision or restraint? The standard was essentially the same standard as that used for civil commitment. It is highly relevant, despite this highly restrictive exception made in 1970, that more than 65,000 abortions were approved by hospital committees and almost 63,000 abortions were performed. Clearly, physicians who believed in the right to abortion manipulated the inherent subjectivity of the mental health ground for abortion to make abortion more accessible. On what possible basis can we be assured that, over time, this psychiatric exception in head 4 will not be similarly abused? Should the safeguards in the draft Bill not be strengthened to counter against such abuse?

Senator Rónán Mullen:

I thank all the experts. I will first pose a housekeeping question which I have put to previous expert groups and will also ask subsequent expert groups. Will the witnesses indicate whether they have been consulted or contacted by the Department, Health Service Executive, Ministers or officials on the heads of the Bill since the expert group report was published? Were they consulted on the paper presented by the College of Psychiatrists?

Dr. Sheehan makes an interesting point that psychiatrists, as medical practitioners, do not view this as an appropriate function. Does he mean that this is not so much a matter of conscientious objection but one that is not considered to be good medicine by many psychiatrists?

He also states that speedy delivery is contraindicated. Is he saying that we are proposing to legislate for something a psychiatrist cannot know and should not do?

On the question of capacity, can it be said, definitively, that a person who is suicidal has capacity for making irrevocable decisions? Is it possible that suicidal thoughts always affect consent at some level? What are the witnesses' views on that issue?

Are the witnesses concerned that what is being proposed here, following on from Deputy Flanagan's questions, could be the means of bringing about a greater demand for abortion for what might be termed social reasons, however tragic and difficult the human circumstances may be?

I wish to ask the psychiatrists generally whether there is any other case where psychiatrists certify for something, when a person presents with suicidal ideation, that is to the detriment of somebody else's rights? Is there a precedent for that? We hear of court cases where people ask, for example, not to be deported and mention that they are suicidal and we sympathise very deeply with such situations. Have psychiatrists ever certified for something that would be to the detriment of the rights of a constitutionally-protected actor, in this case the unborn, or indeed, somebody else? Have they ever certified against somebody else's best interests?

In the view of the psychiatrists, where abortion is certified, is there any way of knowing that this will not turn out to be adverse to a woman's mental health? We are conscious of the non-existence of any evidence based on the cohort of people who present as suicidal, but there does appear to be evidence, albeit contested, that there is a low to moderate increase in mental health risk to women associated with abortion. Could that include the cohort of women who are suicidal? Could a psychiatrist be concerned that, in certifying for an abortion under this legislation, he or she might be exposing a person to such risk or indeed, have no way of knowing that he or she is not?

Senator Fidelma Healy Eames:

I thank the panel for sharing their professional expertise with us and applaud their stamina. My first question is directed to Dr. Maeve Doyle, who is sharing her experience of the very complex area of child and adolescent mental health. Under this proposed law, could Dr. Doyle grant a 14 year old pregnant girl with suicidal intent an abortion without her parents consent? Where are the parents in this situation? What about the situation where one parent agrees but the other does not, in the case of separation, for example? I am conscious that this is a very complex area. A young person in care may already have suffered abuse, abandonment and so forth, but are we not in danger of loading another injury on her with abortion, knowing that there is evidence that post-abortion, girls and women do experience suicidal thoughts?

My next question is directed to Dr. John Sheehan and concerns head 4. In the last few months we learned about a brave young man, Donal Walsh, now sadly passed on, who asked young people to turn away from suicide. With this Bill, are we in danger of normalising suicide,

suicidal threats, suicidal ideas and so forth in society, by providing for a law that is a gateway to obtaining something else? Is this not a potentially dangerous practice, akin to a positive reinforcement? Suicide is being used to get an outcome, in this case, an abortion. Might I say, it need not be just an abortion. If the Government passed a law tomorrow morning providing a mechanism whereby a person could get a 50% reduction in his or her mortgage once there was a stated, certified risk that he or she was suicidal, a lot of people would surely avail of that. We are talking about changing behavioural norms here. We have seen this happen in other jurisdictions which has led to the opening of the floodgates. Why, therefore, should we have head 4 if there is even a possibility of its abuse, when balanced against two rights, namely, the right to evidence-based treatment for the pregnant woman and the right to life for the unborn child?

Deputy Brian Walsh:

I thank the witnesses for their very helpful, valuable and insightful contributions to the proceedings this morning. Dr. Anthony McCarthy's contributions in January were equally insightful. To what extent does he believe that his contributions were taken on board in the drafting of the heads of the Bill that have been presented? He expressed very serious concerns on the national airwaves about the prospect of vulnerable pregnant women having to present in front of a panel of psychiatrists and obstetricians. He went on to say, subsequent to the interview he gave to "Morning Ireland", that he felt that many of his peers from the College of Psychiatrists would be very reluctant to engage in that process. Is there a fear that the void that creates - if it does create a void - could be filled by more liberal-thinking psychiatrists? Have the heads of the Bill, as presented, allayed any of the concerns of Dr. McCarthy?

My second question is more general. Can a trend be identified in research over the past ten or 15 years relating to abortion and women's mental health? I note that the Royal College of Psychiatrists in the UK issued a report in 2008 which very much departed from its earlier position on this issue. The college warned of the risk of mental health breakdown in women who underwent an abortion. Does the panel consider that such a change in position reflects in any way a trend in the findings of research over the last ten or 15 years?

Dr. Anthony McCarthy:

The first Deputy who spoke referred to manipulation. He raised the prospect of doctors manipulating stuff, abusing their responsibilities, flouting the law and so forth. I cannot promise him that no doctor in the country will do that, in the same way that I cannot promise it for any politician, obstetrician or, indeed, anyone else in this country. I can certainly say that the standard in psychiatry, in general, is such that I would hope, at all times, practitioners would not do that. Anybody who does that is breaking the law. There is a constitutional obligation to protect the life of the unborn, where that is practicable and I would hope that every psychiatrist in the country would practice that. I agree that society in general should be alert to the possibility that individuals may flout the law and it is the responsibility of the State to make sure that does not happen.

In response to Senator Mullen's question about Department of Health contact, as far as I am aware, as a college, we were not contacted in any way. As individuals, I cannot speak for Dr. Sheehan but I know that my other colleagues were not contacted. I had one telephone call from the Department, which fed into the radio interview referred to. I was asked to check if it

was true that there were really only three perinatal psychiatrists in the country. In the body politic, the question had arisen of having three or even six people to assess women and having another six to assess on appeal. That would mean that 12 people would be involved and I was asked if it was true that there were only three perinatal psychiatrists here. I was also asked for some of the details of attachment. I was consulted about that specific question but not about anything else.

I was asked if I believed my contribution was taken on board. I would point out first that it was not my contribution but a joint statement to the Oireachtas agreed by myself, Dr. Fenton, Dr. Sheehan and Dr. Doyle. We agreed it together and it was not a formal position of the college. It was a contribution from three of us as perinatal psychiatrists and Dr. Doyle as a child psychiatrist, who we wanted to be there. No questions were directed to her on that day but I am pleased that she is here today and questions have been directed to her. As to whether that contribution was taken on board, I would hope so. We met here in January to inform and are here today again to inform. We are not here to tell the Legislature what to do. We are here to inform Deputies and Senators about the reality of clinical practice and the realities of the situations we have to face. I really do hope that our contributions are taken on board and I think some of the heads of the Bill do reflect some learning that is going on for the legislature and the Department.

Regarding the particular issue I spoke about in the aforementioned radio interview, I had heard that there was a possibility of many psychiatrists being involved. Then *The Sunday Times* published an article suggesting that up to 12 doctors might be involved in assessments. Frankly, I thought it was my responsibility, as somebody who deals with difficult women, to speak up. Who came up with the conception that a woman who might be suicidally depressed in pregnancy would see 12 people. What was he or she thinking? Was the thinking based on the idea of some young girl who got drunk one night and had casual sex, who did not take the pill and got pregnant, and who would come along and fool us and, therefore, we must have 12 people to hear her? Did he or she ever think that this woman may have been sexually abused or raped, that the baby might be her father's or that she might have already tried to remove that baby by stabbing herself in the stomach? How could such a woman be expected to talk to 12 people?

That is why I came out so animatedly that morning on "Morning Ireland". If that has had an effect, I am very glad it has had an effect.

Dr. Joanne Fenton:

The proposed legislation is very restrictive and with regard to my role as a perinatal psychiatrist, I would not be intending to abuse it. I think Dr. McCarthy has discussed that further. With regard to a lady 20 weeks pregnant who is suicidal, that consultation would be done with the individual and again with the obstetricians. I would discuss it clearly in depth with them.

With regard to having been contacted by the Department of Health, I have not been contacted by them. I was consulted with regard to our written submission today. Our role - certainly my role as a perinatal psychiatrist - in looking after pregnant women who present with mental health issues is not just to look after the woman. I am looking after the woman and the life of the unborn child. That is my role and that is certainly not ignored by my colleagues and me.

Dr. Maeve Doyle:

I think I will just confine myself to the specific questions. I am sorry I do not know the Senator's name.

Chairman:

Senator Healy Eames.

Dr. Maeve Doyle:

I believe she referred to the scenario of a 14-year old with suicidal intent. I was not clear whether that person was living in an intact family, but I think she meant she was. In this case, I understand the parents would have gone to the GP with the child.

Senator Fidelma Healy Eames:

I am actually not saying that. I am asking-----

Dr. Maeve Doyle:

The Senator had two scenarios, sorry.

Senator Fidelma Healy Eames:

I am asking whether Dr. Doyle could certify an abortion or a termination for a 14-year-old girl, living in the family home but without the consent or knowledge of her parents.

Dr. Maeve Doyle:

The answer to that is "No". We cannot carry out a psychiatric assessment without the parent's consent under the age of 17. Is that okay?

The second scenario, I think, was a young person in care. The Senator did not specify the age, but-----

Senator Fidelma Healy Eames:

Similar.

Dr. Maeve Doyle:

-----I think she was talking about the fact that the person had probably experienced a lot of abuse in life and family disruption. I suppose my view would be that we as society had failed that young person and indeed her parents. The question would be whether that child was in voluntary care - that is placed there with the agreement of the parents. If that was the case they would be guardians, likely, or may have applied for guardianship if separated and they would have to be consulted. If on the other hand it was involuntary care, then the HSE is in loco parentis. My understanding is that the HSE would apply for that from the panel and whatever decision the panel made would carry on. Is that okay?

Senator Fidelma Healy Eames:

Could I-----

Chairman:

No.

Senator Fidelma Healy Eames:

Just to get the second part of that question.

Chairman:

No, sorry. The Senator has been in twice already, sorry.

Senator Fidelma Healy Eames:

It was not answered. To be fair it was not answered. I thank the Chairman again.

My question was as follows. By certifying an abortion for that young person, are we in danger of loading another injury on her, given the real evidence - post abortion - of suicidal intent and feelings?

Dr. Maeve Doyle:

I suppose my view would be that would be expertly assessed by the two psychiatrists and whatever other relevant people from the HSE.

Dr. Anne Jeffers:

On the question as to how we stop psychiatrists breaking the law, as psychiatrists, we do not want to get involved in anything that is not our job. As psychiatrists, we see ourselves as dealing with people who are vulnerable. Similarly to the obstetricians, we believe that the people, to whom this law will apply, will be coming to us anyway. I do not think a situation will arise where there will be opportunities for that.

On the next point on being contacted by the Department, I have not had any contact. On the fact that it is not appropriate for a psychiatrist to be involved in this process, as I said earlier, if we look at the numbers of Irish women who are having abortions in the UK, the vast majority of those women are mentally and physically healthy, and that has nothing to do with psychiatrists or psychiatry. Our concern and my concern would be for vulnerable women - the women who are making decisions to have an abortion and it may be the wrong decision for them, or the women who are travelling for abortions who are quite convinced that the only alternative to an abortion is to kill themselves. I fell we have a responsibility both as a State and as psychiatrists to see those vulnerable women.

On capacity and consent even though somebody is suicidal we see that all the time. People can have the legal capacity to make decisions even though they are very distressed.

I was asked whether there is any other situation where a psychiatrist would certify against someone else's best interest. We would emphasise - the law is very clear on this - that we are there in the best interest of the mother and the unborn. We are only talking about situations where if the mother dies the unborn also dies.

Is there any evidence to support that the psychiatrist has no way of knowing whether the abortion would, in fact, worsen her mental health? Certainly a vulnerable woman who has a termination in a country where she can receive care and support is surely in a much better position than a woman who feels she has to leave the State to have that termination.

On the issue about normalising suicide, we are very aware that we have a very serious problem with suicide. Reference was made to seeking a mortgage reduction. Tragically many people have completed suicide because of financial difficulties. In recent years, as general adult psychiatrists, we would have seen many people who on the face of it may have looked as if it was financial difficulties but in fact people, who have survived serious suicide attempts and have had an opportunity for expert and specialist care, have been able to work with us in resolving the difficulties and issues they have. It gets back to the point that for anybody who is suicidal the important thing is having the opportunity to talk about it to have that non-judgmental compassionate hearing where we can sit down with them and try to work out what the problems are and that there is always another option other than killing themselves.

On the college of psychiatry and the quotation of the report, once again I must warn - we have heard it from the beginning - about any evidence. This is a group that is extremely difficult to have any evidence on and we have to be very aware of the tendency towards bias.

Dr. John Sheehan:

I will try to deal with a number of the questions. The first was whether the abortion safeguards could be flouted. At face value, the heads appear to be restrictive. Yet the international experience is that what initially appeared to be very restrictive, in practice has turned out to be not restrictive. At face value one could say the heads appear restrictive, but how it might work in practice is a different question. Again it ties into the point I made earlier on the application of the law to women who travel. We do not know the extent of mental health problems in that group or the extent of suicidal ideation. Therefore we cannot say with any accuracy how this will work in practice. On face value it looks restrictive, but the practice is another question.

Senator Mullen asked about contacts with the HSE, the Department or a Minister. I have had no contact from any such people. He also mentioned the college position. I was not party to the college statement, which was devised by the council of college. It has been made available from this morning to college members.

The Senator made a point about good medicine. I have not looked at the issue of conscientious objection - I have been focusing on head 4, which deals with a woman who has suicidal intent and whose life can only be saved by a termination of pregnancy.

As stated, Dr. McCarthy, Dr. Fenton and I, with more than 40 years combined experience, have not seen one case in our work as perinatal psychiatrists. The question about what the Bill, if enacted, might do to the position of psychiatrists was raised. That was one of the

points I tried to address earlier. I believe it will cast psychiatrists into a role they have not been in to date. That is a change in role for psychiatrists. It is quite different to, for example, the working of the Mental Health Act, under which there is the option of detention of a person with increasing suicidal risk. This Bill as drafted deals with the woman with increasing suicidal intent whose life can only be saved by a termination of pregnancy, which is an entirely different situation.

On the question of precedent and whether any of us would have to certify an individual, which certification would depend on the rights of another individual, I am not aware of that. Again, as mentioned earlier we would detain a person in his or her own interest, which would not impinge on other rights. On the evidence of termination of pregnancy increasing the risk of mental health problems, there is evidence to show that termination of pregnancy can increase the risk of mental health problems. We see many women who suffer post-natal depression following normal delivery. The answer to whether termination of pregnancy could increase the risk of mental health problems, is "Yes, it could". There are many things that would do that.

The point made by Senator Healy Eames is interesting. It ties into the nature of our society. In my personal opinion, one of the reasons for the dramatic increase in suicide, particularly among young men, is because it is now an option. In other words, it has become "an option". There are a lot of very complex social factors as to why this is so. When one looks at the legislation and the message it sends out, that is a most interesting viewpoint in terms of whether this is potentially normalising suicidal threats. That is a serious aspect of this that probably has not yet been discussed or fleshed out here today. It is a relevant point.

Chairman:

There are eight minutes remaining in this slot and seven speakers wishing to contribute. I will allow questions from Deputies Billy Timmins and Michelle Mulherin and apologise to those who did not get in.

Deputy Billy Timmins:

I have two brief questions. With regard to the expert group, I heard Dr. McCarthy say on radio that the College of Psychiatrists in Ireland nominee was not accepted by the Minister.

Chairman:

I ask the Deputy to speak to the heads of the Bill.

Deputy Billy Timmins:

The heads of the Bill are founded on the expert group. As such, this is an important issue.

Chairman:

With respect, we are dealing now with the heads of the Bill.

Deputy Billy Timmins:

I may be wrong but as I understand it there are only three perinatal psychiatrists in this country. I would be surprised if one of those people was not a member of the expert group. Perhaps Dr. McCarthy will confirm if that is the case.

With regard to the survey referred to by Deputy Mitchell O'Connor, as politicians we accept the bona fides of everybody's evidence. Where a conflict of information or view arises, we try to drill down and find the basis for that conflict. It is clear to me based on what I heard in January and today and from various submissions I have received, that there is clear division within the profession of psychiatrists. Unfortunately, it is that profession with whom the buck will ultimately stop. I do not envy them their position. Dr. McCarthy stated that many in the profession predominantly believe that this is a social and political issue. Unfortunately, it has landed at the door of professional psychiatrists.

Dr. Boylan mentioned on Friday that the College of Psychiatrists of Ireland, which is an elected decision-making body representing more than 864 members, made a single submission on behalf of all members. I note Dr. Boylan is not a psychiatrist and may not even be a member of that body. If I understood Dr. Sheehan correctly that survey was made available to members this morning. Were all 864 members surveyed and what, if any, was the response? I note some of the witnesses were agitated about only 113 people having been surveyed, which issue I will take up with the drafters of the survey, some of whom may be here this afternoon. It is a serious issue if people are misrepresented in that survey.

Deputy Michelle Mulherin:

I thank the psychiatrists who have presented to us. I have two questions for them. First, it was stated almost universally by the witnesses that none of them has experienced the type of case for which we are seeking to provide. Therefore, when we try to dig down we are at a bit of a loss, at least from our perspective. However, we have the experience of the X case. Do the witnesses believe the evidence presented in the X case would have been sufficient to justify a termination under this draft Bill? It is a case in point that is not mentioned.

Dr. Fenton stated in her address that she has not encountered any woman who required a termination of pregnancy as part of her mental illness treatment. However, she did not rule out there ever being such a case. I presume that best practice is in general based on clinical research. At what point would Dr. Fenton believe that would be a safe decision to make? Would it be at the point when there is clinical research to support such a decision or when suddenly a need arises? I do not mean to be over-simplistic. While the witnesses are the experts we are also looking to other jurisdictions. We are told there may be a limit or certain perspective on the evidence available here because we currently we do not have an abortion regime, except in respect of the X case, which is more vague. Could fears be allayed by the insertion, as is the case with the Medical Council guidelines, into the Bill that due regard be given to clinical research in the area of psychiatry? I find it difficult to understand how, never having encountered such a case, psychiatrists could suddenly find themselves able to deal with such a situation. I respect that it may happen but when it does would there not be a requirement to look to best practice, including in other jurisdictions if not available here, or would they wait until there is clinical research to show such a step would be required?

Dr. Anthony McCarthy:

I am not sure if I should respond to Deputy Timmins's question about the expert group.

Chairman:

It is not relevant to the heads of the Bill. Dr. McCarthy is not compelled to respond to it but may do so if he wishes.

Dr. Anthony McCarthy:

I am happy to do so. Obviously, when any group is being established, nominations are sought from various bodies. I have been previously asked to nominate persons to other committees. As regards whether I have a problem with the nomination of a particular child psychiatrist to the expert group, the answer is "Absolutely not". I was asked the specific question of whether the college was consulted to which I responded that it had been and nominated Dr. Fenton and myself. The Minister selected the child psychiatrist, which is perfectly okay. I have no problem whatsoever with that and do not believe anybody in the college would have a problem with it either.

Of the 864 members of the College of Psychiatrists in Ireland, 113 responded to the survey in a particular way. It is a pretty small group of people. I am surprised it was not larger, reflecting the division in society in general and the uncertainty in political parties, among families and so on. We understand that there are people who disagree. We accept that.

Senator Fidelma Healy Eames:

On a point of order, only 302 psychiatrists were surveyed.

Chairman:

The Senator has contributed four times already and may not do so again.

Dr. Anthony McCarthy:

With regard to the council of the college, to be a member of the council one must be elected. Every member of the council is elected.

(Interruptions).

Chairman:

I ask for respect for the witnesses, please.

Dr. Anthony McCarthy:

Each member is an elected member of council. The council made the decision. Like everybody else, we were given a brief time to consult our members. We quickly emailed every member of the college seeking their views on the heads of this Bill. Those who have made the most noise and expressed dissatisfaction with the college, claiming it is not representative, individually sent a written submission to the council. All were considered at council.

Equally, we held a meeting, which included Dr. Sheehan, to discuss overall issues in advance of discussing them at council. As the elected decision making body of the college, council is the sole approved body recognised by the Medical Council. We made that decision unanimously and all of us on council would stand over it.

Clinical research would be impossible on the specific issue before us because abortion is available in England. I described in my opening statement - I do not know whether the Deputy was here - what such a study would have to do in order to prove this. In regard to whether there is a clinical study on suicidal assessment in general, absolutely there is. In respect of our guidelines and studies on assessing the risk of suicide, we can never predict a suicide with certainty. We are not actuaries but we are experts at assessing risk and, where we can, treating the causes of that risk and managing and helping the individual concerned. A significant body of research has been produced over many years on that specific issue. On the issue of abortions there never will be such a body of research and if we are waiting for that obviously there will be no legislation.

Dr. Joanne Fenton:

I will answer the question on my written submission and the research to which Dr. McCarthy referred. It would be impossible for us to carry out a study of women who were suicidal and obtained abortions and those who did not. When a woman presents to me with suicidal ideation, I assess her and provide the best possible care and evaluation. I am not waiting for the paper to come up. I will assess the lady to the best of my ability and, in consultation with another psychiatrist and obstetrician, make a decision in the interest of the health of the woman and the unborn child.

Dr. Maeve Doyle:

My comments will be brief. On the question of whether legislation on the X case, with the evidence as presented now, would meet the requirements, it is impossible to know if I am not one of the two psychiatrists or the obstetrician making the decision. I am sure - or hope - they would know.

Dr. Anne Jeffers:

I agree with the comments on the role of council as the governing body. As a college, we agreed to comment on the heads of the Bill in terms of how they relate to psychiatry and its practice but decided we would not comment on abortion. Many of those who expressed concerns about the college council feel that we should not be involved in this legislation at all. On the issue of whether we would suddenly be put in a situation in which we are not sure what to do, in practice a clinical decision would be made. It is tempting to speak about resources while we are here but many of the women concerned have difficulties in supporting their children and may have inadequate social worker care and other supports. Many of the women with whom we deal have had children who were taken into care. They often say to me that if they had more support they would have been able to look after their children.

Dr. John Sheehan:

I will focus on the question of research because, as Dr. McCarthy pointed out, it would be almost impossible to conduct the sort of trials we are speaking about. However, it is true to

say there is no evidence base to indicate that abortion prevents suicide. Much of what we speak about is in the abstract. We speak about suicidal ideation, intent or plans but when one tries to quantify the extent of the problem, one examines the number of women dying by suicide in pregnancy. That goes back to the confidential inquiries in the UK, which offer the only reliable data at present. Out of more than 2.5 million deliveries over a three year period, there were four deaths in pregnancy by suicide. Each of these deaths was likely related to serious mental illness. Although we do not have the research base to back it up, and we cannot say there is research evidence, we can quantify the numbers involved. That is the extent of the numbers.

Chairman:

I thank our guests for voluntarily giving of their time to assist us. I also thank them for making their submissions. I apologise to members who did not have an opportunity to contribute but we have agreed our rules.

Sitting suspended at 12.05 p.m. and resumed at 12.20 p.m.

Psychiatry

Chairman:

I again thank everyone for being here. This is our sixth session in a series of hearings that the joint committee has been asked to conduct to discuss the heads of the protection of life during pregnancy Bill 2013. I ask all members to be brief in their contributions. If people do not interject more than once, it will be fair to everyone. In the last session some members could not get in because certain things happened. If people could keep their comments brief, it will allow for greater participation by members.

I welcome to this session Dr. Yolande Ferguson, Dr. Peadar O'Grady, Professor Veronica O'Keane and Dr. Eamonn Moloney. Like all of our expert witnesses, they are here to assist and give of their time voluntarily. I thank them most sincerely for being here and assisting us. Before we commence, I remind them of the position on privilege. Witnesses are protected by absolute privilege in respect of the evidence they are to give to the committee. However, if they are directed by it to cease giving evidence on a particular matter and continue to do so, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against a person or persons or an entity by name or in such a way as to make him or her or it identifiable. Members are reminded of the long-standing parliamentary practice or ruling of the Chair that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make him or her identifiable. With that, I call on Dr. O'Grady to make his opening remarks.

Dr. Peadar O'Grady:

I am very grateful to be able to make an opening statement to the committee. I am giving a statement on behalf of Doctors for Choice Ireland. I have had experience as a consultant child psychiatrist for the past 20 years but also some specific experience of certifying children and

young adults under the terms of the Supreme Court judgment in terms of their eligibility to access an abortion, not something of which there is much experience. I understand Dr. Maeve Doyle referred to this earlier in terms of the types of women or children who might end up being dealt with under the legislation, as proposed.

According to the World Health Organization's 2012 document, Safe abortion, "In nearly all developed countries, safe abortions are legally available upon request or under broad social and economic grounds, and services are generally easily accessible and available". This largely applies to the services Irish women avail of in the United Kingdom every year. In Ireland the proposed legislation to deal with access to abortion services arose from the Supreme Court's judgment in 1992 that a 14 year old child had a constitutional right to have an abortion in Ireland because of the risk of suicide. Doctors for Choice Ireland welcomes any improvement in the care of women and children who choose to have an abortion. However, we believe reassurance is needed that the Bill will in practice provide for an effective and accessible procedure in a situation similar to that of the 14 year old child in the X case. The risk of suicide in the X case arose in a situation where a pregnant child had become suicidal when she was unable to travel, having decided to have an abortion while pregnant as the result of rape by an adult neighbour.

The opinion of many psychiatrists and other doctors internationally is that the risk of suicide is increased by having access to abortion restricted. While I am not going to go into the detail of how that came about, the internationally renowned psychiatrist Professor Robert Kendell summed this up well in 1991 in his review in the *British Medical Journal*. The title of the paper is, "Suicide in pregnancy ... much rarer now: thanks to contraception, legal abortion and less punitive attitudes", reminding us of the issue of stigma involved in suicide in pregnancy.

In Ireland restricted access to abortion services is most likely to arise as a result of an inability to travel, a point made well this morning by Dr. Anthony McCarthy, president of the College of Psychiatrists of Ireland. This means that women who are too sick, young, poor or disabled to travel are at particularly high risk. Women who are migrants or whose pregnancy involves a fatal foetal abnormality or which arose as a result of rape or child sexual abuse also experience difficulty in accessing abortions through impairment of their ability to travel. Children are not specifically mentioned in the legislation, even though they are more likely to experience difficulties in their ability to travel for an abortion and to be at increased risk of suicide as a result. The costs of travel for an abortion are higher for children as they usually require a parent or guardian to travel with them because of their greater requirement for practical and emotional support.

Our concerns about the legislation come under three headings: delays in accessing abortion which might occur, the exclusion of certain categories from access to abortion and criminalisation of women and health workers who take part in abortions which do not meet the guidelines laid down.

As for delays, Doctors for Choice Ireland is particularly concerned that the Bill contains elements that will cause unnecessary delay in accessing abortion services, causing an unnecessary prolonging of an emergency level of risk and requiring more complicated procedures because of that delay, for example, surgical instead of medical abortions. In Britain most abortions are medical abortions. They do not involve a surgical procedure and do not, in fact, involve an obstetrician, which is a notable point.

In the case of eligibility for abortion on the basis of a risk of suicide, imposing a requirement for three doctors will cause unnecessary delay and, including the general practitioner, we may be talking about four doctors. There is no medical basis for differentiating between a medical emergency and a psychiatric emergency, as the Bill does, a point alluded to by Professor Murphy of the Medical Council on Friday. All psychiatric emergencies are medical emergencies. Only one psychiatrist or GP is required to certify eligibility for an abortion. It is clearly the view of Doctors for Choice Ireland that one does not need any doctor to certify eligibility for an abortion as a necessity, but, if one wants to, only one is required. Obstetricians should not certify eligibility in cases of suicide risk.

This should be done either by a GP or a psychiatrist, and by that I specifically mean giving advice about eligibility on the basis of suicide risk, not his or her potential involvement in an abortion procedure, a point of practice in which the psychiatrist is not usually involved. If this legislation is enacted, it is likely that women and children will already have had non-directive counselling and will have given informed consent before seeking an opinion on eligibility of the grounds of a risk of suicide.

The Bill requires the psychiatrist certifying eligibility to be employed in an institution registered with the Mental Health Commission, which is another point regarding a delay. Most consultant child psychiatrists are not employed in this way. This is an unnecessary requirement. Specialists are required to be registered with the Medical Council and this should be the only stipulation. Specialists should not be required to be attached to any specific institution. Most abortions in developed health services are medical abortions and do not need any hospital facilities necessarily. The term "reasonable opinion" should be replaced by the term "opinion" and the term "unborn" should be replaced by medical term "foetus".

Regarding exclusions, women and children in situations of rape, child sexual abuse and fatal foetal anomalies will, unfortunately, have to wait for further legislation to allow for the option of abortion in those cases, as this Bill does not provide for this, and this is a serious limitation of it.

I take on board the advice of the Chairman, Deputy Buttimer, about keeping our language temperate and moderate but Doctors for Choice are at pains to point out that a 14-year criminal sentence is not a moderate or temperate element of the legislation. With regard to that, the inclusion of a criminal sanction of up to 14 years against women or doctors will hamper good practice and increase the risk of suicide in vulnerable patients through stigma and its emotional consequences - fear and distress. Fear of prosecution, a noted chilling factor, can only cause further delays in access. The notion that women who are forced to travel for an abortion in a situation of fatal foetal anomaly, for example, are carrying out the equivalent of a gravely serious crime worthy of 14 years in prison is particularly offensive. The prospect of prosecuting children and or their parents or those carrying out a home abortion with medication bought on the Internet is also very concerning. The overwhelming support in 1992 for the constitutional right to travel for an abortion confirmed that Irish people do not consider abortion a grave crime, as did the lack of any prosecutions before then for abortions procured abroad. To our knowledge criminal sanction has not been seriously advocated by any party to the debate thus far on access to abortion services. As criminal sanction is thus dangerous, offensive and manifestly absurd, it should be removed from the Bill.

As there is a gross lack of expertise in Ireland, which I think the medical profession in Ireland is well ready to admit - we do not have abortion services located in Ireland, although we have abortion services for Irish women but they just happen to be located largely in Britain but also, in so far as we know, the Netherlands and perhaps Spain; we are not so sure where people access them because we do not count that, research it or follow it up - we humbly submit that the Oireachtas Joint Committee on Health and Children should take advice from a relevant health care agency that has experience in providing an abortion service. The British Pregnancy Advisory Service, for example, provides the majority of abortions availed of by women from Ireland every year and that service has already offered its assistance to the committee.

Chairman:

I thank Dr. O'Grady. I call Dr. Yolande Ferguson and welcome her here.

Dr. Yolande Ferguson:

I thank the Chairman. I am a consultant general adult and community psychiatrist based in the Dublin south central psychiatric service and also in Tallaght Hospital. I am a member of the faculty of the adult executive of the Irish College of Psychiatry and a member of the Joint Forum on Mental Health between the Irish College of Psychiatrists and the Irish College of General Practitioners.

I thank the committee for this opportunity and I welcome this legislation. Psychiatrists are unique among medical practitioners in that we deal with legislation as part of our everyday routine clinical practice in the form of the Mental Health Act 2001. We have extensive experience in performing assessments to ascertain whether our patients meet the legal criteria set down in that Act. We also routinely defend those decisions in mental health tribunals. We bring that expertise and experience to the enactment of this legislation.

I will restrict my statement to heads 4, 6 and 8. I believe the constitution of the assessment group in heads 4 and 8 requires revision. These heads address an infrequent circumstance. For the most part, this represents a woman or child in the early stages of pregnancy who is distressed because she is pregnant and generally does not have a mental illness. They are most likely to present to their general practitioner in the first instance. If the doctor dealing with them is sufficiently concerned, he or she will then make a referral to the appropriate local psychiatric service. Psychiatric services in Ireland, like most other countries, are arranged on a geographical basis with community mental health teams addressing the needs of the local community. There are also specialist teams who provide for the needs of children, as Dr. Peadar O'Grady mentioned, and for those with intellectual disability. The psychiatrists who are the clinical leads for these teams are expert in assessing suicidal risk, whatever the circumstance. The general practitioner has been assigned a peripheral role in this legislation, a consultative one. They should have a central role, followed by an assessment by one psychiatrist, in line with the procedures under the Mental Health Act. This means that two doctors would be involved in the assessment process, which would thus not differentiate psychiatry from other medical specialties in this legislation.

The assessment group in both heads is made up of an obstetrician and two psychiatrists. First, as was mentioned by Dr. Peadar O'Grady, there is a requirement that both psychiatrists are attached to an institution registered with the Mental Health Commission. This does not reflect

psychiatric practice. Child and adolescent psychiatrists are rarely attached to such an institution. Some general adult psychiatrists who provide community-based care are also not attached to an institution because their services divide the inpatient and the outpatient roles. I suggest that this be replaced by a psychiatrist who is entered on the specialist register with the Medical Council. The head also states that one psychiatrist must be attached to an obstetric unit, and again this was raised as an issue this morning. The head and the explanatory note contradict one another in that the head states attached to "an appropriate place" and the explanatory note states attached to "the appropriate place". While clarification is required as to whether the head specifically demands that the psychiatrist must be attached to the unit in which the procedure would take place, I recommend that this requirement be removed. These are women and children who cannot contemplate reaching the point of the booking appointment for an obstetric unit that is the usual entry to perinatal psychiatry. This requirement imposes an unnecessary restriction. Their needs can be accurately assessed by an appropriate specialist, such as a general adult or child and adolescent psychiatrist.

I propose that a panel be established by the Executive, much as the Mental Health Commission form a panel for the workings of the Mental Health Act. Ideally, the psychiatrist who is involved in their care would be on the panel to provide the psychiatric opinion. I should add that an obstetrician should not be expected to perform assessments out of their area of expertise. It is also proposed that a consensus must be reached between all three doctors. Could we envisage where an obstetrician is placed in a position where they veto the assessment of two psychiatrists on the assessment of the risk of suicide? As the head is currently written, the woman or child could have seen up to four doctors, including her general practitioner, at the end of the assessment process. If the case proceeds to an appeal, she will have been seen by a total of seven doctors. The time period for the appeal process set out in heads 6 and 8 should be shortened to a maximum of 72 hours for each stage of the appeal.

This legislation must serve to alleviate rather than add to the distress of the women and children for whose needs it seeks to address.

Chairman:

I thank Dr. Ferguson. The next speaker is Dr. Eamonn Moloney.

Dr. Eamonn Moloney:

I thank the Chairman and the committee for this opportunity to speak them today. I am not a member of any particular interest group in this area. I speak to them as a practising consultant psychiatrist and as a clinical director of one of the largest catchment areas of mental health services in the country. The inpatient base is at Cork University Hospital, CUH, where the approved centre is based, and on the site of that hospital is one of largest maternity hospitals in the country, Cork University Maternity Hospital. That hospital has more than 9,000 deliveries per annum. In CUH, more than 600 people are seen for assessment following suicidal behaviour on an annual basis, and many more present with suicidal ideation.

As clinical director I have overseen the implementation of new legislation in the form of the Mental Health Act 2001 within the service over the past six years, and as clinical director I have an ongoing responsibility to ensure that the appropriate legislative procedures are followed. My comments on the heads of the Bill are from that perspective and primarily

relate to the practical application of this proposed legislation. I was also a member of the Mental Health Commission for five years up to April of last year and so I have a particular interest and expertise in this area.

The current operation of the Mental Health Act 2001 leads me to believe that this legislation could be practically implemented but I will suggest some areas where I believe amendments would ensure that a suicidal woman with a crisis pregnancy is managed in the most appropriate, humane and timely manner. I will also describe the relevant proposed care pathway that I believe is the best way this legislation could be implemented.

I will comment on head 2, particularly in relation to the need for the number of medical opinions required, and talk about a proposed pathway. In my opinion the requirement for two psychiatrists and an obstetrician to certify that a woman is eligible for a termination of pregnancy is excessive. Two medical opinions should suffice. One of these opinions in my view should be a general practitioner and the other a consultant psychiatrist.

Although the heads of the Bill state that a general practitioner, GP, should be consulted where practicable, I believe the importance of the general practitioner needs to be recognised in their everyday care of patients. In terms of health strategy in Ireland, the importance of primary care physicians in primary care centres - primary care teams - is acknowledged. GPs have a wide range of experience of dealing with people presenting to them with emotional and psychological difficulties. The importance of the GP is recognised in the explanatory notes by virtue of his or her long-term and in-depth knowledge of the woman as referred to in head 4(2)(a)(1). The GP clearly has a unique perspective on the woman's particular circumstances in relation to, for example, her social supports, relationships, previous pregnancies, any history of sexual assault or abuse, and general family background.

It is likely in any event that the woman will consult her general practitioner in the first instance for confirmation of pregnancy and discussion of the options for what may be a crisis pregnancy. The woman's general practitioner would have experience in carrying out assessment of the woman's mental state, or perhaps more than one assessment, over a period of a few days. He or she may then certify that the patient is acutely suicidal, that there is a real and substantial risk to her life, and that this risk can only be averted by a termination of pregnancy.

A general practitioner is likely to have considerable experience of assessing suicide risk and of making a medical recommendation for detention of persons under the Mental Health Act. This has been referred to previously. Both GPs and consultant psychiatrists are used to dealing with these situations. The GP is well-placed to carry out a similar type of certification process under this proposed legislation. If the GP is satisfied that the appropriate criteria under the Act are met, he or she will inform the executive which will then either confirm an appointment with a psychiatrist that has already been made by the GP or arrange for an assessment by a relevant consultant psychiatrist. That is the first medical opinion.

The second medical opinion should be done by a consultant psychiatrist. This doctor should be drawn from a panel of consultant psychiatrists who are agreeable to operate the enacted legislation. This process is similar to the pathway for hospital admission under the Mental Health Act where a consultant psychiatrist must assess a person brought to an approved centre following appropriate application and medical recommendation. A consultant

psychiatrist has a particular expertise in assessing suicide risk so it is appropriate for them to carry out this assessment.

This process of consultation with a GP and referral to a consultant psychiatrist for further assessment reflects the usual and ideal care pathway for all suicidal patients. It is likely to be the least distressing process for the pregnant woman, the most appropriate way of accessing the assessment and care that the woman needs and is a process that is practical, as evidenced by the current operation of the Mental Health Act.

A further medical opinion is not necessary in my view and the explanatory notes for head 2(3) refer to the Mental Health Act 2001 to support the need for only two medical opinions where there is a risk of loss of life from physical illness. The assessment of suicidal intent is one of the core skills of consultant psychiatrists who are carrying out such assessments on a daily basis.

We have heard that there is no data to confirm the accuracy of psychiatrists in predicting suicide but the relative rarity of completed suicide and the inability to determine the number of people saved from death by suicide following appropriate suicide assessment and intervention means that this exact calculation is not possible because the studies cannot be done. They would be unethical and would involve not treating some people who were suicidal, treating another group and then comparing the outcomes or else denying one group of suicidal pregnant women access to an abortion, not denying the other and seeing what happens. These are impractical and unethical studies which will never be done. We have very clear data on self-harm in this country and it is clear that women in this age group are at high risk of self-harm, and self-harm is a single best predictor of subsequent suicide, with one in 100 people, following an episode of self-harm, dying by suicide in the following year.

The fact that we cannot accurately assess this does not mean that suicide risk assessment carried out by a woman's general practitioner and a consultant psychiatrist are inaccurate. In mental health services throughout the world, it is ultimately the consultant psychiatrist who makes the decision about suicide risk. Mental health legislation throughout the world, as in this country, dictates that the consultant psychiatrist decides on whether criteria are met for admission of an individual under the Mental Health Act, and one of those criteria is risk of suicide.

In my view the involvement of an obstetrician in the assessment of risk of death by suicide is not appropriate as it is outside their area of expertise, as others have pointed out.

I do not believe it should be necessary for the consultant psychiatrist to be attached to an institution where such a procedure is carried out as this would unnecessarily restrict access to appropriate and timely assessment, which could be done by a consultant psychiatrist not necessarily attached to that hospital.

Moving on to head 4 - formal medical review procedures, I believe the timescale proposed of up to seven days to convene a committee and up to a further seven days to form an opinion could lead to a potential delay of two weeks following a woman's appeal to a decision being made. This is likely to cause considerable distress, which could be alleviated by shorter timeframes of 72 hours to the convening and 72 hours to a decision being made.

In relation to head 8 - the review in a case of loss of life through self-destruction, again, the requirement that the consultant psychiatrist shall be employed at the appropriate location is in my view unnecessary. Most women at risk of suicide in the early stages of pregnancy would be most likely to be seen by a general adult community psychiatrist or a liaison psychiatrist following self-harm rather than a perinatal psychiatrist employed at an appropriate location. It has already been pointed out that there are very few perinatal psychiatrists. Despite the fact that Cork University Maternity Hospital is one of the largest maternity hospitals, it does not have a perinatal psychiatrist, although emergency care is provided by the liaison psychiatry team based at the hospital. Again, the proposed timeframe is too long and a delay of up to seven days should be shortened to 72 hours.

The decision of the review committee should be by majority decision. This is the case for decisions made by the Mental Health Review Tribunal under the Mental Health Act where three persons on the tribunal decide on whether to revoke or affirm the detention of the person under the act. A simple majority should be sufficient, and that should also apply under this legislation.

In summary, the certification procedure proposed here ensures that the most appropriate and relevant medical opinions are obtained and that the usual care pathway and referral processes for suicidal women are followed to minimise any unnecessary additional distress to the pregnant woman. This process is similar to the current procedures under the Mental Health Act 2001 and so the practical application of the legislation can be assured.

Professor Veronica O'Keane:

My name is Professor Veronica O'Keane and I am a professor of psychiatry in Trinity College Dublin, a consultant psychiatrist for the HSE at the hospital in Tallaght and I run a research programme in perinatal depression. I led a national perinatal psychiatry service in London for five years in the Maudsley Hospital serving all of the UK. I was concurrently head of perinatal psychiatry in King's College Medical School, from where I led a research programme in perinatal depression. I have published extensively in the scientific literature and I have written a book on perinatal psychiatric disorders during pregnancy. I have co-authored the standard clinical assessment tool for perinatal psychiatric disorder and I was an expert for the National Institute for Clinical Excellence, NICE, UK guidelines for the management of perinatal depression in the UK. I have set up two general hospital psychiatric services, with one in Beaumont Hospital and another at Addenbrooke's Hospital in Cambridge. I have researched and published on the topic of suicide assessment.

I am delighted to be here today and to have the privilege of advising our legislators on the heads of the protection of life during pregnancy Bill. The sole purpose of this legislation is to provide law as established in the Supreme Court ruling in the X case; namely, to provide a service for women who, unless they have an abortion, are in danger of dying. A woman's right to this service has been established in Ireland in our law and Constitution. There has been vigorous campaigning against the right for women to have their lives protected during pregnancy established in primary legislation.

Our role, as psychiatrists, is to facilitate the provision of this proposed service for women who express suicidal intent and request an abortion in this context. Women who are suicidal because of an unintended or unwanted pregnancy - I will refer to this as a crisis pregnancy - will be the main users of this service, given the extreme rarity of requests for abortion in

women who are mentally ill during pregnancy. Primary care, adult and child psychiatrists, rather than specialist services, should and will be the main service providers. We have been told by the European Court of Human Rights that the service should be "accessible and efficient". To this end, a national panel of those prepared to lawfully engage with this process should be established and an efficient executive should be put in place to efficiently administer requests for termination of pregnancy by Irish citizens. The GP should make the recommendation for an abortion and one psychiatrist should assess the suicidal risk. Details of the practical implementation of these recommendations are contained in my Oireachtas submission. My colleagues have given recommendations, all of which I agree with.

Some legislators may continue to hold and express views about the "suicide" clause. A consistent argument is that "allowing" the suicide clause will remove the only effective barrier to "abortion on demand" and will provide a mechanism for women who want an abortion to get one, even if they are not genuinely suicidal. The argument goes that some psychiatrists will be complicit in this process or may not have the requisite professional skills to be able to predict suicide. Another argument is that abortion is not good for mental health and is not a treatment for suicidal intent.

Underlying all these arguments are deeply problematic assumptions about the credibility of women, the reliability of psychiatry as a medical discipline, the meaning and management of expressed suicidal intent and the concept that doctors or legislators have the power to control women's reproductive autonomy. The proponents of these arguments have caused some confusion, and the arguments require clarification so that head 4 can be implemented and run without unnecessary obstructions.

First, with regard to credibility of women, we do not practise psychiatry by disbelieving patients. A key ethical principle underlying all medical care is the relationship of trust that is taken to exist between a doctor and the patient. We regard all patients who we see, in the first instance, as being truthful and credible. Second, with regard to the scientific evidence that suicidal ideation is difficult to assess, it has previously been said by people in the Irish College of Psychiatrists that we measure suicidal intent using clinically established markers. A crisis pregnancy is an emotionally traumatic experience which is potentially life-changing, and a woman who expresses sudden-onset suicidal intent is at a high risk of killing herself.

We do not require scientific evidence to understand the self-evident truth that young women in crisis kill themselves. Some 20% of deaths among young Irish women are by suicide or self-destruction, that is, in the same age range when women are most likely also to have an abortion. In other words, suicide is a common cause of death and is a recognised public health problem that is part of a national clinical programme in this country. The message that suicidal intent is difficult to assess and manage is untrue and the national office for suicide prevention is holding workshops for caregivers to help ordinary and non-professional individuals identify suicide risk, helping to increase the safety of individuals experiencing suicidal ideation and get further help. The message we want to get to people is that we can efficiently and safely manage suicidal ideation.

The phrase "abortion is not a treatment for suicide" has been iterated and reiterated, as has the contention that there was unanimous agreement among psychiatrists at the Oireachtas hearings in January that this was the case. This is not true. I gave evidence at the Oireachtas hearings in January and I did not give any evidence to support or reject the idea that abortion is a treatment for suicide. This is recorded as a matter of fact and was witnessed by this

committee. The reason I would never say this is because a treatment implies that a doctor prescribes or at the very least recommends an intervention. A treatment involves a doctor in a process of active advice, and in the case of abortion, the woman rather than the doctor is requesting the procedure. The psychiatrist would only determine eligibility. Therefore, neither the woman's GP, the assessing psychiatrist nor the obstetrician carrying out the procedure would be advising a patient that she ought to have an abortion. Abortion is not a treatment as the doctor is not involved in giving advice.

There are no treatments for suicide and we manage underlying risks and issues that the individual presents us with. There is no evidence that any treatment prevents suicide. As outlined by Dr. Moloney and Dr. McCarthy earlier, such studies would unethical. There is scientific evidence from epidemiological studies that certain interventions reduce the suicide rate, for example, such interventions would include treating depression or removing access to lethal methods, such as charcoal in eastern countries and domestic gas in the western world. Reducing access to such means of lethality reduced suicide rates. The same is true for abortion. Abortion legislation was introduced in the UK because unsafe and illegal abortion was the leading cause of maternal death in the 12 years prior to the introduction of the 1967 Act. In 1950s Ireland, 10% of Irish women who killed themselves were pregnant.

Studies about whether abortion is bad or not for a woman's mental health have been taken out of context. The studies subject to public debate have all taken place in countries where abortion services are available, and in those cases we are considering women with a choice of continuing with the pregnancy or having an abortion. In scenarios where abortion services are not available, unwanted pregnancy is a leading cause of death, which we know from geographical and historical studies.

As I said previously, this is why we have abortion legislation.

My last point is that Irish women have an abortion service. It does need to be acknowledged that women in Ireland have abortion rights that they exercise as cognisant citizens through their right to travel. This very limited legislation that we are discussing is just a small concession to this reality in that it provides for the right to an abortion within our own health services when a woman is too sick or distressed to travel abroad. The constituency which is opposed to this legislation has spoken about suicide and abortion in abstract, moral terms. This is very regrettable. Irish women have often been portrayed as unreliable, sometimes manipulative and nearly always as passive. We need to acknowledge that it is the law that women who are in such dread about a pregnancy that they want to kill themselves and their foetus have a right to have an abortion in this country. As the Taoiseach said, this legislation is not conferring any new rights for women. This is an established right.

Chairman:

Thank you. I acknowledge in the Visitors Gallery Mr. Paul Linton from Chicago. He is here assisting the Family & Life movement. I also welcome Mr. Patrick Carr who is in the Visitors Gallery and who has been here since Friday. We now have 70 minutes for members of the committee. I ask members to be conscious of time and to confine their remarks to the heads of the Bill.

Deputy Billy Kelleher:

I welcome the witnesses and their contributions. We are trying to confine ourselves to the legislation before us in terms of the heads and what we will have to adjudicate on later. Dr. O'Grady said abortion should not be confined to the locations prescribed in the legislation and should be available elsewhere too. I want to get some clarity on that. While we are talking about the legislation, we are also obliged to act within Article 40.3.3° of the Constitution which states that there is an obligation to vindicate the life of the child. I presume one would need to carry out these procedures in a place where, if there is a viable foetus, that life would be saved, where possible and practicable. I presume that is only in a number of hospitals that would have all the neonatal services and facilities available, and all that flows from that. I would like some clarity on that.

Some women are suicidal in pregnancy and some are suicidal because they are pregnant. Is there a differentiation in how people would assess that? Many women in crisis pregnancy travel abroad to have an abortion and that happens day in day out in this State. There is no point in our denying this. Regarding the proposed panel system of two psychiatrists and an obstetrician, how would the witnesses see a woman presenting herself? Would they see it in terms of assessing her suicidality or assessing it and treating it and looking at options as opposed to ticking the box and referring her on to somewhere else? Would they see it as a doctor-patient relationship whereby they would assess, provide therapy and treatments if that was more suitable than a termination as requested by the woman, but which may not be suitable in terms of the treatment of her underlying condition?

In the context of the broader issue regarding obstetricians not being involved in the panel system, clearly an obstetrician would be the person who would have to carry out the procedure late in pregnancy at the very least. I assume there would have to be some discussion on how that multidisciplinary approach would work.

Deputy Caoimhghín Ó Caoláin:

I join in the welcome to each of the panellists this morning. There is a number of shared common points in each of the presentations but I have picked on one to tease out - because that is our job, to get a clearer understanding - and that is the role of the general practitioner. It is very unusual and interesting that across the four psychiatrists before us this morning they have each, both orally and in their written submissions, placed great emphasis on the importance of an enhanced role for the GP. I hope they forgive me for focusing on that.

Dr. Ferguson, in her presentation, says the GP should have a central role and takes the view that only one psychiatrist is required, ensuring that there would not be a differentiation between psychiatry and the other medical specialties. On Friday we teased this out with others from across the field of obstetrics. A view was expressed there that two of the heads could be amalgamated so there would be no difference between the medical and the psychiatric approach. Would that be a shared view? Could each witness indicate that please?

Professor O'Keane makes the point that the GP should make the recommendation for an abortion and one psychiatrist assess the suicide rick. Is that the order in which it might happen? Could she elaborate on that so that I could have a better understanding of it? She also speaks about "no specific referral pathway reflected in the legislation". It has not been set down. She also makes the point that attendance at the applicant's primary care practice should be included in the legislation as the first point of contact on that pathway. Could she elaborate a little on that?

Dr. O'Grady also speaks of this area but says obstetricians should not certify eligibility in cases of suicide risk. It would be accepted even by obstetricians that two psychiatrists are crucial. I do not think any of the obstetricians would have argued that they would have primacy in that respect. However she then says this should be done either by a GP or a psychiatrist. I ask her to elaborate on that.

In conclusion and before the Chairman closes me off, I must ask Dr. O'Grady a question because the footnote on the first page of his presentation states that he has experience in certifying eligibility for an abortion. He is the first to say that before the committee either on Friday or today and I am sure he is not unique in that respect of those who will appear before us. It is a very important, relevant point. We are told this presents in only the most rare of cases. The perinatal psychiatrists this morning reconfirmed that over their combined 40 years' experience none of them has ever taken such a decision. Could Dr. O'Grady please expand on that to give us some sense of understanding of it? Would any of his colleagues like to share whether that has also been their experience?

Deputy Seamus Healy:

I welcome our guests and thank them for their presentations. Dr. Moloney made a very important statement when he said it is his belief that this legislation could be practically implemented. I took it from some of his contribution that he was effectively speaking about the mirror imaging of the legislation here reflecting the procedure of panels under the Mental Treatment Act. Am I correct in that? If so, could he clarify that and expand on it slightly for us? I have a brief question for Professor O'Keane. Accessibility was a serious consideration regarding the European case. Would she be happy that this legislation provides an accessible pathway?

Professor Veronica O’Keane:

The first question Deputy Kelleher asked was the difference between being suicidal in pregnancy and being suicidal because of being pregnant and that is a very important distinction because if somebody is suicidal when they are pregnant it does not mean they are suicidal because of the pregnancy. When somebody is suicidal we would have a very open view about what is causing it.

The individual may be depressed or there may be circumstances other than pregnancy. She may have been suicidal prior to the pregnancy and the pregnancy may be an additional stressor. There are all sorts of reasons somebody may be suicidal and we are looking specifically for somebody who is suicidal because of the crisis pregnancy. It is entirely credible that somebody would be suicidal because of a crisis pregnancy. A person might also have a series of stressors and series of difficult life circumstances and adding an unintended pregnancy to that could precipitate suicidal ideation but may not be the cause.

Our intervention is always aimed at what an individual presents us with and, in assessing an individual, we look at their vulnerabilities. Some people have a vulnerability towards motherhood and that might be a long-term psychotherapeutic issue. We look at their life circumstances. If it has been caused by a rape, that is a complicated issue. We, therefore, look at all the reasons somebody might be suicidal. This legislation is directing us towards evaluating suicidal ideation in the context of just having an unwanted pregnancy and if there are other issues - which relates to what Deputy Ó Caoláin said - when the assessment takes

place, it will not be a unidimensional assessment just looking at whether this woman is suicidal because of a crisis pregnancy. A psychiatric evaluation is a complex, multi-layered assessment. We look at historical events, a person's biography, current mental state, social circumstances and personality characteristics. We would assess all those and intervene at whatever level is appropriate. That could be on several levels. The complexity of the case and the care pathway will depend on what we assess as the problem and on the patient's needs. If, for example, somebody was in a crisis and that was the straw that broke the camel's back, we would try to dismantle all the other causes and deal with them separately and singly. That is the way we approach problems. We try to break them down and deal with them individually.

However, there will be cases and that is what the legislation is about. We are not minimising the complexity of individuals' psychological make up, their biographies or their lives. We are saying we will deal with all that but there will still be rare cases where a woman will be suicidal because of an unwanted pregnancy and they are the cases the legislation is intended to address. In the case of the other ladies who present, they will get treatment as usual.

The second question related to the pathways to care, which I have probably answered and the final question related to accessibility. It is important that we make sure that the service is accessible. That is why we are pushing the role of the GP here because everybody should be registered with general practice. The role of general practice will become more important in the health care provided to citizens through primary care. The primacy of primary care in an individual's health is one of the major thrusts of health policy currently. The way to make this most accessible to women is to say, "Go to your general practitioners. They know you." They will be able to evaluate whether this is a real crisis requiring an abortion or something that requires counselling to help a woman come to terms with something. The role of the GP cannot be underestimated. It is also emphasised in the legislation but I would like this to be brought into the regulations and the way the legislation is implemented in the same way it is in the Mental Health Acts. If somebody is unwell, he or she must go to a GP who then has to recommend that he or she be assessed by a psychiatrist. That answers the question about recommendation. The recommendation is if the GP thinks the woman is suicidal, she should be referred to the specialist panel for assessment of suicidality.

Dr. Peadar O'Grady:

Just before answering the questions, I would like to point out that Doctors for Choice made a detailed head by head submission and members can read that at their leisure.

Deputy Kelleher raised the issue of a link between viability and location. There is quite a misunderstanding among many people in terms of where viability fits in with abortion. Many, including myself, argue that 100% of abortions should be completed long before viability becomes an issue. The situations in which abortion is an issue in terms of a viable foetus are extremely rare. It is not like the US has the most developed service one can get and, even there, one third of counties have no access to abortion facilities. We are not the only region that has difficulties with access. One in 1,000 abortions involves an issue of viability and therefore, is a small number, 99.99% of abortions happen without viability being an option.

The issue of whether an obstetrician is required is a clinical decision and in our presentation we are trying to distinguish clearly between doctors assisting legislators in certifying, something Doctors for Choice argue clearly is not required medically. If legislators required that from the point of view of assisting legislation and they are looking for certification as all

of the witnesses today have said, this is something we can do. We should do it to assist things to move forward. Must we do it? Not in the scheme of things. In a proper system, we would not need to do it. In general, psychiatrists are not involved in the provision of abortion care. In terms of viability, there is no need to attach to an institution. Where care in a hospital is required, that should be an option recommended by the physician. It does not need to be legislated for. It is already good practice. We know how to distinguish between intervention and certification. The role of GPs is very much that they are the first responders. It does not always happen but we recommend it. They are the people who will start the process of advising a woman or a child about her state of health, including whether she is not pregnant. It is important in dealing with crisis pregnancies well before the issue of viability occurs. The leading reason for delay in abortions in terms of late term is the delay in the diagnosis of pregnancy or of a fatal foetal abnormality and the commencement of non-directive counselling could well be done in general practice as well as the acquisition of informed consent whereby having chosen an option, women in an unwanted pregnancy can choose to go ahead or choose to terminate early with the morning after pill or later through medical abortion, which can take place in a general practice setting. It does not require an obstetric facility to write a prescription and to advise a patient on how to manage medication and engage with follow up care.

With regard to Deputy Ó Caoláin's questions, GP consultation should be optional. It is good that the GP should be consulted even if he or she is not involved in certification. That should not be done without the patient's consent. Heads 2 and 4 should be amalgamated and this was strongly recommended by the Medical Council last Friday. I refer to the order in which it happens. From the point of view of certification, the major restriction we have all pointed out that the major reason for raising the risk of suicide is a restriction on travel. Soon after the Savita Halappanavar case, several women described on radio getting on a plane while actively miscarrying because there was no other option for them. That is the physical case of having to go to Britain while not fit to travel. This came up earlier and we hope such women will not be forced on to a plane while too sick to travel. There may well be cases where women are too distressed to travel and may need to be facilitated to have an abortion in Ireland.

In those cases, non-directive counselling will have happened and informed consent will have happened before the psychiatrist is asked to give their view as to whether eligibility for access to an abortion is met in this case from a mental health point of view. The other case that everybody has mentioned, which is much rarer, is where in the situation of pregnancy a mental health condition arises and the question of whether or not an abortion as an option would be best for the patient. Looking for a mental health input is a much more clinical situation we deal with, and one where Dr. McCarthy said he would be delighted to be asked for his help.

Deputy Caoimhghín Ó Caoláin asked about the GP and the psychiatrist. GPs certify many things such as absence from work. In terms of assessing people for mental health conditions, including suicidality, GPs are the first to respond and psychiatrists are generally quite happy to accept their first-off certification in many instances, and when they need our help they contact us. In regard to certification, I will take more specific questions about my experience. Mainly it had to do with the restriction on travel of children who were in State care where, because of the difference in their parenting arrangements, the decision about travelling with the child to access an abortion in the UK was more uncertain for the carers in those situations than for a parent to make, for example, in the X case. The decision for them was easier or less

complex. They were clearly the parents and they took the decision with their child. It is worth mentioning in that case that the child did not become suicidal until after abortion was restricted, not before. I can answer more specific questions about that. Those were difficult. I think they reflected a genuine concern about the capacity to consent by the carers, but also a concern about the risk of suicide in vulnerable young children. If we have a margin of error in that regard - I think we should do - suicidality in children is a very serious concern and a very serious public health concern in Ireland and not one that any of us in any way take lightly.

In regard to accessibility, the key concern is delay regarding the number of doctors requiring unnecessary institutional restrictions, the dangers of conscientious obstruction and, finally, not ensuring a quick enough appeal time. All of these things can lead to delay and, as we are aware from other countries, are often focused on as ways of denying accessibility, which I think would be in breach of the spirit, at least, of the European Court's recommendations.

Dr. Eamonn Moloney:

In relation to suicide in pregnancy and a person who is suicidal because she is pregnant, obviously the importance of the purpose of a consultant psychiatrist carrying out an assessment in this situation is in establishing whether there is a mental illness. If someone is suicidal in the context of a severe depressive illness, then the priority is to treat the severe depressive illness and, in those circumstances, one would not suggest that because the woman was suicidal she should have a termination. The priority there is to treat the mental illness but there are other cases where there may be no mental illness. Those situations are rare but they will occur and have occurred where a pregnant woman in a crisis pregnancy is suicidal and a termination is the only way of reducing and eliminating that suicidality.

In terms of a panel of psychiatrists, ideally the care pathway should be the GP doing the initial assessment and the certification and referring to a local psychiatrist who could do both, so to speak - see the individual, carry out an assessment, begin therapy if it is needed, or recommend whatever therapeutic intervention might be needed, but they could also certify. This will not always be the case but that would be the preference. I reiterate my belief that the role of the GP is very important and is central to this. I see them as being one of the medical opinions. I would see that one could amalgamate heads 2 and 4 so that two medical opinions are necessary and in terms of the panels and this process, and the care pathway mirroring the Mental Health Act, I would say that the executive of the panel would be formed of eligible consultant psychiatrists and, as far as possible, that those assessments would be done by the woman's local psychiatrist so that there would be that continuity of care.

Dr. Yolande Ferguson:

A number of issues have been addressed by my colleagues already so I will not repeat them. A couple of specific issues arise. Deputy Kelleher asked about the obstetrician role and to clarify that - the Medical Council highlighted this on Friday and to highlight it again - under the heads as currently written, the obstetrician would have an equal right to assess suicide risk as the two psychiatrists. Obstetricians are clearly not trained to assess suicide risk. Like all doctors, they can make a stab at it, so to speak, but they are not expert. That is what we are; as psychiatrists, we are expert. Obviously, it is important that they have a role, and our role would be to consult with them. We do this all the time for many different things. If I have a patient with a cardiac issue, I consult with a cardiologist in the same way as, on this topic,

one would consult with the obstetrician, and obviously the obstetrician has an enhanced role if they are the person proceeding with the procedure.

Deputy Ó Caoláin asked me about the role of the general practitioner. All of us have highlighted that because it works very well with the Mental Health Act. The general practitioner is the person who knows the patient, often very well. They are the people who know the family circumstances. They know the social circumstances. They have a real sense of who the person is. As Professor O'Keane said, under the Mental Health Act the GP is the person who does the recommendation and then the psychiatrist does the certification. That works very well and it could be replicated here.

In regard to amalgamating heads, I do not think psychiatry should be differentiated. There is a long and sad history of psychiatry being seen as somehow outside medicine. Sometimes I hear people who are confused as to whether we are psychologists or psychiatrists. There is some confusion out there about what we do. We are all medically trained doctors. We have specialised in this area. We are as able to make decisions as anybody else. We have the same evidence to back up our practice. In my opinion, the heads should be amalgamated.

Deputy Seamus Healy asked about the Mental Health Act panels and whether if I could see a mirroring. It works very well. The Mental Health Commission advertises and interviews for the mental health panels so there is a good screening process to ensure quality and I think that would work well.

Chairman:

As ten Members have indicated, I would appreciate if they would be concise.

Deputy Ciara Conway:

I thank all the doctors who have given evidence here this morning. My first question is a practical one, looking at that whole issue of pathways. We are very lucky to have four consultant psychiatrists in front of us today. If I was in crisis pregnancy, how long would it take me to see them? That is a real fundamental issue for women and it goes to the core of the issue about pathways. We had five consultants in here this morning. That is nine consultant psychiatrists in the Chamber this morning. If I was in a crisis pregnancy now and was suicidal, how long would it take me to see them? Unless we address that issue, I do not think the legislation can ever become a reality for women who are in distress and who are in crisis.

The second issue, which was touched on earlier, is the criminalisation of women who may have got medication over the Internet for abortion for 14 years. There is another Act and a precedence with which the witnesses may be more familiar than me - that is, the Suicide Act, whereby the person who died by suicide was decriminalised but those who aided or abetted that person faced criminal sanctions. Is that something we should be seeking in this legislation - that we do not criminalise women who seek this life-saving abortion? Of course, we want a deterrent for people who would practise outside of medical guidelines and good medical practice. I would welcome the views of the witness on that issue.

Going back to the issue of pathways, what we need to look at are things that do work in this country. The cervical cancer screening programme is a vital healthcare programme for women in this country that works so efficiently and so effectively and is rolled out by GPs all

over the country, giving women an element of choice. Those are the kind of things that we need to look at if we are to make this legislation a practical, efficient and effective reality for women.

Chairman:

I call Senator van Turnhout.

Senator Jillian van Turnhout:

My question has been asked.

Deputy Peter Fitzpatrick:

First, I want to express my gratitude to those present for attending the hearings this morning. I have just a few questions.

If a patient has stated that she is suicidal but is not suffering from mental illness, what other course is available to a doctor under head 4 other than to grant permission for an abortion?

What criteria will be used to make an objective judgment in the case of a patient who is suicidal but not suffering from mental illness? As psychiatrists, are they aware of any other life-changing decisions that a psychiatrist would recommend as treatment where a person is suicidal?

As psychiatrists, do they consider themselves competent in a expert sense to judge the risk of self-destruction of a patient who has stated that she is suicidal but is not suffering from any other mental illness?

Where a termination is being considered under head 4 near to the point of viability of the unborn child, what steps should be taken to deny a termination so as to improve the chances of survival for the unborn child?

Senator Colm Burke:

I thank the psychiatrists for their contributions.

I want to raise the issue of their submission about the GP and the psychiatrist taking the decision on the psychiatric issue. The heads of the Bill refer to a joint decision between two psychiatrists and an obstetrician. The medical council talks about the two psychiatrists taking the decision and then the consultation with the obstetrician. Do the psychiatrists present have a problem with that proposal? If the decision was the medical council proposal would be taken on board, would the psychiatrists have concerns about that?

The second issue relates to the timescale. The psychiatrists stated that it should be amended to 72 hours. I refer to the smaller units and wonder whether 72 hours is adequate. If one takes as example someone who appears on a Friday evening of a bank holiday weekend, is there an availability of persons to take a decision in 72 hours? In dealing with that, I am merely thinking of such a scenario.

The third issue relates to the expectant mother under 18. What is the psychiatrists' proposal for putting a structure in place to deal with that adequately, both medically and legally; have they any views on how that should be dealt with?

Chairman:

Does Dr. Ferguson wish to start? There are five other speakers.

Dr. Yolande Ferguson:

I will keep it brief.

Chairman:

I thank Dr. Ferguson.

Dr. Yolande Ferguson:

First, Deputy Conway, referring to pathways, asked how long would it take to see me. Obviously, one would not have seen me this morning, but I have left two colleagues who were available for any emergency work. I work for a service that is highly responsive. I see persons where, "As soon as you can get here", is often the response. At weekends and out of hours, we have an on-call service.

I think that is the value of having the psychiatrist who is responsible for the patient's care being the person who does the certification. It allows that normalisation of the process. It is naturalistic. It is not her seeing some random psychiatrist whom she has never seen before and will never see again.

The criminalisation is a concern. The reality is there are many young women in Ireland who are buying their medication over the Internet and taking it at home, or whose parents are buying it and giving it to their children. It is rather distressing to think that these young women could be criminalised.

I suppose we, as professionals, have some anxiety about that aspect of the Bill. The chilling effect has not gone away and one worries that there could be potentially a case taken against one.

Deputy Fitzpatrick's issues generally tended to revolve around women and children who were suicidal but had no mental illness, and I think these are probably many of the women and children who will be addressed by this legislation. Assessment of suicide risk is complex. We approach a woman, not only as a person presenting who is (a) pregnant and (b) suicidal, but in a holistic manner. One looks at what are her circumstances, what is going on for her and what are her options. One explores all of that. One takes that time. We are part of teams and, often, the other team members become involved. At that point, if the only option that she can see is that if she does not have this she will die from suicide, then that is the answer to that question but one arrives at that after much discussion and consideration.

I apologise for not getting the name of the final questioner as I was too busy writing notes.

Chairman:

It was Senator Colm Burke.

Dr. Yolande Ferguson:

He asked if I would have any difficult with the medical council recommendation of two psychiatrists. I would not particularly. The way the Mental Health Act operates is elegant, with the GP followed by the psychiatrist. I suppose I would not have any particular concerns about two psychiatrists but I think the other is better. I do have a concern that an obstetrician would be asked to make an assessment though.

Dr. Eamonn Moloney:

In response to Deputy Ciara Conway, certainly, services are used to dealing with emergencies and someone in a crisis pregnancy who was suicidal would be an emergency and would be seen directly and straight away. Certainly, in the service that we run but, I would have thought, in any service throughout the country, there would be access. Whether that would be a home crisis treatment in some areas, the emergency department or attending the local unit, there would be some response. I can assure the Deputy of that.

I share her concerns about criminalisation of women. The word "compassion" was mentioned on several occasions this morning. That is the way we should look at this rather than looking at criminalising young women who are clearly in very distressing situations.

Psychiatrists and those who work in community mental health teams have an expertise in assessing suicide risk. They have an expertise in distinguishing the presence or absence of mental illness and they have an expertise in helping persons in emotionally distressing situations and crises. They can have a role in helping persons in the crisis situation to resolve that crisis and maybe helping to move her on to other services that may be able to provide more ongoing care and support.

The issue of foetal viability is a hugely complex issue that would involve much consultation with obstetricians and it is not an area to which I, as a psychiatrist, can give an answer. I think repeated reassurances have been given by obstetric colleagues that this will not lead to terminations in later stages of pregnancy or anything like that, and there should be no suggestion that this sort of legislation would lead to anything like that.

We were asked if there is a problem with the presence of two psychiatrists, and the answer is "No". I feel quite strongly that a GP should be involved. Certainly, it would lessen the burden on the individual woman. It is acknowledged that the GP has an important role to play in the heads of the Bill where it states they should be consulted where practicable. I would probably go further than that, but it is certainly workable with two psychiatrists. It just means it is an extra person to see. I suppose the two medical opinions I would see - a GP and a psychiatrist - are sufficient, but two psychiatrists would not make it unworkable in any way.

On timescale, I would hope that panels could be available. I agree with Senator Colm Burke in terms of practicality in those emergency situations which are rare. One is talking about a review panel.

On the issue of consent and capacity in under 18, I would defer to my child and adolescent psychiatry colleague, Dr. O'Grady.

Dr. Peadar O'Grady:

In terms of Deputy Ciara Conway's question about pathways and the delay in referral, it is delay, delay, delay. The concern that we would have is that elements of the legislation are either designed to delay, which we hope would not be true, but also could be used to delay processes and procedures. How long to see one consultant? How long to see two? How long to see three doctors? Is this medically necessary?

I think we are being very clear today that it is not. Outside the legislation, it is not necessary to see any psychiatrist at all unless consulted for a medical reason by a colleague. We are only addressing today the reasons why a psychiatrist might be consulted on the legislative side in certifying for eligibility, which all of us have said we will try to integrate into good medical practice. I am trying to clarify that there are differences here. All of these delays around three consultants are to do with eligibility under the law. They do not have strong connection with good medical practice. As Deputy Conway has pointed out, one, two and three doctors is a matter of delay. There is no medical issue there.

On the question of criminality, as I pointed out earlier, it is dangerous to have criminality hanging over women who may then feel restricted from sharing their medical details openly and on which we rely constantly - even more so in psychiatry. We would not distinguish ourselves from our colleagues but much of what we do is putting someone at their ease so that they can tell us where they are at and guarantee them some degree of confidentiality so that they feel free to do so. It could happen, for example, that 14 years would be hang over someone who, for example, has taken medication ordered over the Internet and would not then say that they had taken it because they feel that it is a criminal act to have done so. They might at some later stage need undergo an anaesthetic. I would never want my anaesthetist not to know what drugs were in my body. That will put people at risk.

The second thing it does is add to stigma. There is much work being done by support and mental health agencies to reduce stigma and to say that travelling as one can, lawfully, to Great Britain and having an abortion in the case of fatal foetal anomaly or for any other reason. To say this is equivalent to a grave crime is stigmatising women unnecessarily. It makes absolutely no difference and seems only designed to stigmatise and delay and for that reason, is dangerous.

There is no need for specific laws to criminalise bad practice. If it requires a registered medical practitioner to carry out an abortion, which it does, anybody who is not so registered should be sanctioned. I do not have an opinion on that sanction but it is up to legislators if the sanction is a criminal one. If a registered medical practitioner engages in poor practice, there is already a process of sanction for poor practice. Most of what we are talking about is not seen as good or bad practice anywhere in Europe. It is not literally a medical issue.

In respect of interventions other than suicide, I see many of my colleagues go to extraordinary lengths. Very often I look at what a colleague, be they a social worker, psychologist, nurse or doctor, is doing and think that they are going above and beyond the call of duty to intervene to support a young person. Given the infrastructure of education, child protection and health with which we are trying to deal, sometimes extraordinary and

heroic acts are carried out on a daily basis by the ordinary mental health workers around the country and they deserve much credit for that.

People have drawn attention to this notion of women hurt by abortion that needs to be addressed and I will take this moment to do so. Women are hurt by abortion. The WHO estimated that 40,000 women died in 2012 from unsafe abortions. The figure changes a lot because it is hard to count them. They were women hurt by abortions. A total of 5 million women were disabled by unsafe abortions. In countries where abortion services are well developed, we still have the concern about coercion. When we argue for choice, we mean choice in either direction. One should not experience coercion but we know that often people do, from relationships and economic stress. We should do everything in our power to make that decision as free from coercion as is humanly possible.

To return to the issue of criminalisation, we should also make it free of stigma. Before the decision is made, every support to make that decision with informed consent should be given. After the decision is made and an abortion or a birth is chosen, we should give absolute support to that person and not stigmatise them. As someone said, there is no right response to pregnancy or abortion. We support people no matter which decision they take, which is already the *status quo*. I do not think there are many left who are trying to demonise women going to Great Britain every year for an abortion. Unfortunately, this legislation does.

The key issues were raised this morning. These will likely centre on children in care with a concern about travel and the ability to help a young person make a decision. These raise issues of consent and the capacity legislation. I am not advising on legislation today and do not pretend to have any expertise in what sort of legislation will address this. The point we would bring up relates to children in care and the capacity of children to make decisions. The greater clarity is brought to that the easier it will be to deal with children under this legislation. I am not convinced there is anything specific required for under 18's in this legislation. There will be concerns about applying it. The question of what appears in this legislation is a matter for the legislators.

Professor Veronica O'Keane:

I will not repeat what my colleagues have said. I do not disagree with any of it. I would like to make two further points. In respect of the two psychiatrists, I believe it should be one psychiatrist because the initial point of contact will be the general practitioner. The general practitioner is in a very good position to look at a woman they know, hopefully, quite well over a long period of time and to say whether they think this woman is suicidal or not. It is not one opinion about suicidality. It is two opinions about it, one which belongs to the general practitioner and the other which belongs to the psychiatrist and, as Dr. Ferguson said, preferentially the local psychiatrist.

In response to Deputy Conway, time is of the essence. We work within structures that allow us to deal with emergencies so there is a certain amount of flexibility, obviously, within a normal medical timetable allowing for emergencies. We respond within hours. GPs and accident and emergency officers telephone us directly and we deal with them immediately. Another problem I have with two psychiatrists is that it potentially slows down the process and also causes unnecessary emotional distress because the woman must repeat her story twice. It is very difficult for people in distress to open themselves up twice. The process of opening up is quite painful and it is a very difficult for a person to tell somebody one is so

vulnerable that one is suicidal and looking for their help. To have to do that twice is putting too great an emotional burden on women.

There is also a practical consequence. If it slows down the process and it could mean the difference between a woman being able to have a medical or a surgical abortion. About 50% of abortions in the UK are medical abortions. This involves taking a tablet and another tablet 12 hours later. This must be supervised medically but it can be done at a general practice level. In the future, more and more early abortions will be medical abortions and will not be complicated procedures. The best strategy in medicine is one that is least interventionist so we want to treat women as early as we can.

I know we are pressed for time but I have an important point to make regarding head 6, subhead (2). This relates to timeliness as well. I wanted to draw the committee's attention to the fact that the last sentence in subhead (2) implies that the medical practitioner in the initial certification procedure need not give an opinion. It is quite dangerous for us to allow the first group of medical practitioners who review a woman not to give an opinion. They should either give an opinion or not give one. If we allow people to not give an opinion, the review panel may also be in a position of not having to give an opinion so the woman could be going from one situation of not having been given an opinion to another.

In my view it is absolutely fair that a group of medical practitioners may say they do not think this woman fulfils the eligibility criteria for an abortion. That is okay. The woman then says, "I want to appeal this decision", and she goes to an appeal panel. However, if a woman is left in a position where a group of experts say they are unable to make up their minds and they do not have an opinion, it is a very difficult situation for that woman. I ask the committee that it should consider that there should be an onus on the group of practitioners who see the woman initially to come to an opinion, even if that opinion is in the negative.

Senator Ivana Bacik:

I thank the witnesses very much for their very helpful points and comments and for reminding us that the legislation is very restrictive but that its purpose is to provide for an accessible and effective procedure whereby women may vindicate their constitutional right to life. It is particularly helpful to hear from Dr. O'Grady who had the direct experience of having certified eligibility under the X case criteria. That is very useful because there was some suggestion in earlier sessions that these cases never arise. I ask Dr. O'Grady to confirm for the committee that in fact they do, albeit in extremely rare cases.

I wish to raise a couple of specific points, first, in respect of the women who are affected. We are reminded that the majority of the 4,000 women who travel will not be affected by this legislation. The reality is it will affect young girls mostly in care or in emergency situations where women are restricted in travelling. The question was raised about specific reference to children. In the earlier session, Dr. Doyle suggested that "child" be defined in the legislation, given the slight anomaly between the legal age of consent to medical treatment and the Non-Fatal Offences Against the Person Act which is 16 years and then 18 years for psychiatric intervention. I ask if the experts have any comment on this anomaly.

I ask for clarification on some technical points. I take the point that all the experts are in agreement that the Mental Health Act gives us a very clear procedure involving one GP and one psychiatrist. The expert witnesses suggest that this arrangement be replicated, not that

there be one GP plus two psychiatrists. I ask for clarification on that point because what is being suggested could potentially put another doctor into the certification process. Dr. Doyle referred to a very practical issue that one third of girls in Clare do not have a GP and asked what is to be done in those instances. The time limits under head 6 were pointed out and this is very important. I take Dr. O'Keane's point about head 6(2), which I think contradicts the language of head 6(1), which does not envisage that there would be no opinion. It envisages an opinion against certifying for eligibility.

On the final point about the issue of suicide under head 19, as Deputy Conway said, the person who commits suicide - indeed, anyone who attempts suicide - is not criminalised under the 1993 Act. Similarly, if we are using that model, I wish to confirm that the woman or girl who attempts suicide in Ireland should not be criminalised.

Deputy Denis Naughten:

I have three brief questions. I ask for clarification from Dr. O'Grady about his earlier evidence. My understanding is that suicidal ideation in pregnancy peaks in or around the end of the first trimester. If that is the case, would a delay in a decision not lead to a greater number of medical terminations rather than surgical terminations, as stated in the evidence given to the committee on Friday by the obstetricians?

The case has been well made this afternoon about psychiatrists and GPs making the decision but that the obstetrician would not be involved. Under head 4 the definition of reasonable opinion specifically states that consideration must be given to the need to preserve the life of the unborn where practicable. I ask Dr. O'Grady to clarify how this can be done if an obstetrician is not involved.

What happens in the case of a woman who does not have a mental illness whose suicidality is based on the fact that she is pregnant with a baby with a very serious foetal abnormality? The decision, naturally enough at that stage, would be quite close to the threshold of viability. What happens in that case? Would it not be the case that there is a far greater frequency than one in a thousand in that cohort? How do we deal with the practical aspects of such a case? Sadly, this legislation means that such genuine cases will come before each of the doctors in the not too distant future.

Deputy Regina Doherty:

I thank all four witnesses. My questions are for Dr. O'Grady and Dr. O'Keane. Dr. O'Keane spoke about the sudden onset of suicidal intent in a pregnant woman. Dr. O'Grady is in agreement with Dr. O'Keane that psychiatrists do not treat suicidal intent; rather, they manage the issues underlying the risk and they deal with those issues. This is where my concern arises. She stated further that she understands the purpose of this legislation is for psychiatrists to assess the eligibility or otherwise of a woman seeking this procedure. She stated that in her view the process is too long, with too many medical people involved, and that the rush to appeal within seven days may mean the difference between a medical and a surgical abortion. While all this might be true, there is no treatment in the middle of all that process. I ask Dr. O'Keane to explain when, in the case of a woman who may present to a GP with genuine suicidal intent because of her pregnancy, does the treatment kick in? Do we immediately go through a process of assessing her eligibility or a certification for a medical treatment?

I am genuinely at a loss. In my head the reason I could satisfy my support of this legislation was that it was not a treatment for suicide but rather an option where all other options had failed. In that context I was happy to accept it . However, I fear from what Dr. O'Keane has described this morning that there is no treatment. A woman will go to the GP and say she is suicidal and requires an abortion and the process will immediately kick in whereby she will be certified as either eligible or not eligible. I am concerned that there will not be any medical care. I am probably mistaken in my interpretation but I ask the doctors to clarify the situation for me.

Senator Jim Walsh:

I will preface my first question by saying that a reply to a freedom of information request from the UK Ministry for health recently identified that between 1992 and 2010, no Irish women availed of an abortion under that section which deals with saving the life of the mother. That abortion is not a treatment for suicide is the clear, unambiguous evidence we have been given at these hearings. Dr. O'Keane conceded this point. To be fair to her, she said that it was for an unwanted pregnancy rather than a treatment for suicide. Abortion can be a contributory factor in suicidal ideation in women who have had an abortion. Many women have committed suicide in these circumstances. What assurances can the doctors give that this can be avoided if they certify a termination? I refer, in other words, to the law of unintended consequences.

We heard evidence with regard to the assessment of patients that psychiatrists, by the nature of the profession, will err on the side of caution when assessing patients. Dr. O'Keane stated that she would believe a woman if she told her she was suicidal. On the other hand, we have heard from women hurt by abortion. Four or five women attended the committee last Thursday who had had abortions in Britain. Two of them said they were advised to seek an abortion on the grounds of being suicidal, even though they were not suicidal. They were subsequently certified by people in Britain in the same profession as the doctors present.

In the United States, there has been considerable liberalisation of abortion with regard to mental health and suicidality. I refer to Dr. Bernard Nathanson's book *Aborting America*. He states that the attack had to be made in the weakest area, the psychiatric indication, which was inexact and immeasurable, yet sufficiently threatening. He said that once a breach had been made in that area, once a few precedent-setting cases had been raised, they could then be poured through in unlimited number. He stated that the proposed threat of suicide was the

Given that that is the experience elsewhere, what engages us is how can we avoid that or how can we get any assurance that a similar thing will not happen here to corrupt the profession in this regard?

The late Dr. Anthony Clare, who was pro-choice but became pro-life in the 2002 referendum, clearly stated that that was his experience in other jurisdictions as well - that the situation of mental health and suicidality were areas that led to liberal abortion regimes in those countries.

Professor Veronica O'Keane:

I will start with the last question from Senator Walsh. I thank him for clarifying that I did say abortion may be a treatment for an unwanted pregnancy and not for suicidality. That may be, indeed, what I did say. I have certainly never said the other.

As regards women being advised to seek an abortion, I can assure the committee that it would be against the spirit of this legislation and would be outside what would be ethically accepted medically for us to do that. Speaking for myself, I am absolutely not going to advise any woman who comes to see me whether or not she should have an abortion. That is entirely her decision; she is making the application to have the abortion. I am not making the application and I am not prescribing the treatment. She is making the application. I am employed by the State to determine, in my professional opinion, whether or not that lady is eligible for an abortion, according to the law. I will not act outside the law but I will enact the law once it is passed, which other psychiatrists may choose not to do.

As regards the question about treatment, everybody who comes to us will be treated. Every single individual who comes into the psychiatric services will be treated with psychotherapy and perhaps daily or twice-daily visits from home treatment nurses. We have access to immediate psychology for them if it is so required. We can talk to their families and can intervene with family therapy. We can bring together teams of professional carers and can assemble them rapidly in response to emergencies like this.

The reason we want to have rapid access is simply to reduce the amount of distress in so far as we can. We will obviously provide a full range of psychiatric treatments and care for every single woman who presents to us, regardless of what we do within the limits of this legislation, which I think is just saying that somebody is or is not eligible. As Dr. Ferguson has clearly pointed out, there is a whole range of interventions and people are treated holistically. They are treated in response to the individual needs and vulnerabilities that they present to us with.

The point I am making is simply that we are not prescribing the abortion. We are not saying to the woman "We think you should have this treatment". The woman is coming to us as an autonomous citizen, asking for an abortion. We are requested by the legislation - that, hopefully, will be enacted - to see whether or not this woman lawfully meets those criteria. While we do one, it does not mean that we do not provide care.

Dr. Peadar O'Grady:

It may help to clarify this area from the point of view of doctors for choice. We are being very clear. The alternative to this legislation is to allow women to decide for themselves and not to require certification by doctors about their eligibility. That is what they do in Canada where there is no criminal sanction in making this decision. There is lots of good practice. If one wants doctors to certify, one cannot also tell them that they think it is a good idea. All one can ask them is whether they can carry out that certification. This is what we are trying to advise today. Does Doctors for Choice, for example, think it is a good idea? No. One does not need certification for eligibility for abortion. One only needs it where legislators put that requirement on one. On Friday, we heard from the Medical Council and the Irish College of General Practitioners. This morning we heard from the College of Psychiatrists. Can we do it? Of course we can do it.

Legislators will have to own some of the complications that arise from the legislation. What we can do is to be as helpful as we can. Do the cases occur? Yes, they do, as Senator Bacik has pointed out. They arise episodically. Why they might arise again the future, why there might be a restriction on travel, or why there might be concerns about whether or not consent is adequately given - we cannot predict in what way they will present.

I will not go into the 16 versus 18 issue in detail. That was well argued in terms of the whole capacity debate, which I really think is a separate issue. Does it apply to this area? Absolutely, it applies to this area, but not differently than it applies to any other area of medicine. Where a question arises around consent with a young person or someone, for example, with an intellectual disability, we do need a resolution concerning access to medical treatment. Whether they can give consent, but also whether they can refuse consent, is a whole other debate.

I would favour one GP plus one psychiatrist instead of an obstetrician and two psychiatrists. Obviously, the second doctor should be optional, in my view. As I have been at pains to point out, the first doctor is and should be optional also, in terms of eligibility - not in terms of advice, but in terms of counselling and helping someone to come to a decision, but not making that decision for them.

Deputy Naughten raised a point about suicidal ideation and pregnancy, which is absolutely correct and is often overlooked. Professor Kendall's study pointed out that, years ago, there was a coincidence between suicides and pregnancy, particularly before the Second World War and before the 1950s and 1960s when abortion was made more available in terms of being free, legal and safe. It very much coincided with missing the second menstrual period, which is literally when a woman starts to realise that she is pregnant. That is when the clusters of suicide in pregnancy occurred.

As the Deputy points out, one is likely to get those cases where suicide risk arises - not all of them, but the vast majority - in the first trimester, i.e. before ten to 12 weeks which is early. Medical abortions would be carried out predominantly in that period and a delay would lead to more surgical abortions. I am not sure what advice was given on Friday. I am not an obstetrician or a general practitioner. It is not my area of expertise but I am 100% certain on that point, that medical abortions are early, including the morning-after pill if one is of the persuasion that believes that is abortion.

As regards reasonable opinion, I think the issues of viability are best referred to obstetricians. It concerns that point in time. It is not that general practitioners will not be involved, but any decision about prolonging pregnancy in order to deliver a viable baby at that stage, rather than a foetus - that is, decisions about viability and the discussion with the parent about that - is an issue for an obstetrician. There is really no role in psychiatrists. In the same way as we might object to an obstetrician advising about the risk of suicide, I think that obstetricians would quite properly object to any psychiatrists giving their opinions about viability.

As the Deputy indicated, for most people, the word "fatal" in fatal foetal anomalies implies that viability is very much the moot point. It is the point around which the heartache of parents arises. The diagnosis of fatal foetal abnormalities often does not happen until the second trimester and, sadly, sometimes not even until the third trimester. The Deputy is correct in saying that these are the more difficult situations where someone had a wanted pregnancy. These are the changes that all of us are very sensitive to. There is nothing more

tragic than wanting to have had a baby and where the mother decides she will call this a baby rather than calling it a pregnancy. Nobody, except doctors, really talks about a foetus. People either have a pregnancy or decide that they are going to have a baby. That is changed where that is not going to happen and it is a tragedy for all of us.

To come back to the issue of treatment, anyone involved in certification should never lose track of the fact that they are dealing with a human being. I do not care whether one is certifying that they need to be off work or off school, in my case - one is not just certifying and saying "Next".

One is looking at a person and asking what else, besides the certificate, is going on with that person and whether one is missing something because primarily, one's role is as a doctor, and not as a form stamper and certifier. In jurisdictions where some of that is lost, stuff like advising someone to go for the suicidal option, about which people keep talking, can only occur in a situation in which there is a legal obstacle to access to abortion. Again, it is neither within the ability nor the job of doctors to deal with that. It is the job of the public and its relationship with the legislators. In the same way that doctors get accused of trying to open some kind of floodgate - I really object to the notion of women being like water flooding through a gap, which simply is objectionable - the notion that doctors might facilitate this is as objectionable as doctors who might obstruct the process. This is a social process and attitudes to abortion in Ireland have changed fundamentally. In the most recent poll, 92% of Irish people agreed with abortion in at least some circumstances. The change this causes from a legislative point of view is between the population and your good selves.

Finally, in response to the last question raised regarding suicide, I believe Professor O'Keane has dealt with that very well. On the issue of women being hurt by abortion, I reiterate the need to get rid of coercion. It is a poignant fact that people who have a personal ethical objection to abortion are a group to which we must pay particular attention. If they came under coercion to have an abortion, rather than feeling more free to follow through with their own ethical ideals and carry through a pregnancy, and if they chose to have an abortion, they would be a group of people we would be obliged to follow up very carefully. They would be likely to suffer feelings of regret, guilt, anxiety and so on. This means we should not be idle certifiers. We should detect, engage with and follow up risk and support people, no matter what their viewpoint. Again, this is the point made by Doctors for Choice Ireland. We are for choice, not for forcing our views on anyone else. I will leave it at that.

Dr. Eamonn Moloney:

Many points already have been covered but I reiterate my opinion that just two medical opinions would be sufficient, one from a general practitioner and one from a consultant psychiatrist. We really are addressing the legislation before us here and are not really addressing the totality of care women need and obviously, to address Deputy Dowds's concerns, that would continue. Someone in distress, someone who was suicidal, will get the care she needs regardless and the certification procedure can go on. In order to reduce the need for a woman to see more and more psychiatrists, ideally the people who provide the treatment also could do the certification. This is the reason a process which mirrors the Mental Health Act would reduce the number of assessments through which a woman would be obliged to go. However, the woman at all times will get access to the health and care she needs at that point.

Similarly, most situations will arise early in the first trimester. Outside of that, when there are issues with regard to foetal abnormality or foetal viability, obviously there would be discussions as best medical practice would dictate there should be consultation, liaison and discussion with our obstetric colleagues. As for stating repeatedly that abortion is no treatment for suicide, the latter is associated with certain conditions for which treatment is available. Consequently, what we are talking about is not treatment but is about eligibility for someone to have an abortion. There certainly have been and again will be, rare circumstances in which a termination is essential to deal with a pregnant woman's suicidality associated with a crisis pregnancy. The use of extravagant language and exaggerated claims of some sort of conspiracy involving consultant psychiatrists, general practitioners, GPs, and obstetricians to open the floodgates of abortion are simply exaggerations. They are what they are, namely, exaggerated claims.

Dr. Yolande Ferguson:

To clarify for Senator Bacik, I do not mean a woman should be seen by three different doctors. The whole thrust of my opening statement was that it is not acceptable to put a woman through that. Professor O'Keane has highlighted that it is traumatic to tell one's story again and again. The Senator's other question was, if there is no GP, then what? Again, that pathway of care is different. One might see this happening a little more in the case of child and adolescent psychiatrists, where one might get referrals from school counsellors, for instance. In that case, the second doctor could be a psychiatrist or a GP because that girl should have a GP. If she did not have one before, she certainly should have one afterwards.

On Deputy Naughten's concerns about the obstetrician not being involved, I do not think any of us is suggesting the obstetrician is not involved at all. We simply are saying that when making a decision as regards to suicidal ideation, their role is a consultative one. While Deputy Dowds addressed his question to Professor O'Keane, it is really important to highlight something I mentioned in my submission at the outset, which is that as much as possible, we should follow normal pathways of care. This process should be best medical practice and best medical practice means following normal pathways of care. This means the woman is eligible for all treatments that are available to anyone who is in any situation in which he or she meets a psychiatrist.

Finally, in response to Senator Walsh, when I think of the United States, I do not think of it as a liberal abortion state but as somewhere that has very mixed and certainly very divided attitudes towards abortion. The Senator again talks about - I will not even repeat the word because my colleagues have referred to it - how psychiatrists somehow would facilitate an increase or allow an entryway into abortion on demand, which is another dreadful expression. I am a psychiatrist and I have spoken previously about how proud I am of my profession and how important it is to me that psychiatry is regarded with the same esteem as any other medical profession. This morning, Dr. Anthony McCarthy mentioned Ireland's sad history with women and pregnancy, both with the Magdalen laundries and, sadly, psychiatric institutions. None of us wishes to see a return to those days. None of us wishes to see our profession discredited.

Chairman:

I thank the witnesses. The time for members-----

Senator Jim Walsh:

May I comment?

Chairman:

No, the time for members' questions has been exceeded. I apologise to members who cannot get in but the 70 minutes are up. I now wish to turn to the time allocated for non-members. Although ten people have indicated, because of the time allowed not all ten will get in and consequently, I apologise again. However, I ask people to be brief in the questions, rather then giving full exposure to their views. Deputies Terence Flanagan, Mathews, Durkan and Creed, in that order, will be the first four questioners.

Deputy Terence Flanagan:

I have three brief questions and would appreciate it were the panel to answer them, because I posed other questions in previous sessions that did not appear to be answered. In light of the X case judgment that a termination of pregnancy is the only means of averting the risk to the life of the mother, does it follow that abortion becomes the only means available if the woman simply refuses all alternatives? Second, where a woman who is suicidal presents to the witnesses as treating psychiatrists and she refuses whatever treatments they offer, as she is entitled to do, at that point they will certify that a termination is the appropriate treatment, despite the fact there is no evidence that a termination will have any beneficial effect for that woman in a suicidal crisis. Is it not fair to state that the law's operation, as the witnesses envisage it, will be inherently open to abuse as it will rely primarily on the will of the pregnant woman?

Third, how accurate do the witnesses expect to be in determining whether someone is actually suicidal and the only treatment is abortion? Were we to legislate on suicide as grounds for abortion, are we not legislating for a condition that has an incidence rate of one per 500,000 of population, as per Dr. Anthony McCarthy, with a positive predictive value of 3%, as per Professor Casey? Moreover, findings published in the *American Journal of Psychiatry* in 1997, state that as a treatment, abortion is not effective.

The Finnish study which looked at all the registers between 1987 and 1994 found no cases of suicide in pregnancy but a threefold increase in the rate of suicide after abortion. Could the panel comment on whether abortion could make a woman suicidal? Recent media reports on the Miss C case indicated she had made further suicide attempts post-abortion.

Deputy Peter Mathews:

I thank the doctors who have come before the committee today. I have been present on Friday and today. We are all agreed that what we want – whether professionally qualified or non-qualified citizens – is a good, ethical society, one that respects life. In essence, that is what we are here for.

This is not a debate in a vacuum. It is a debate about realities. The witnesses have told us of their experience. The gaping hole in the hearings, both the earlier ones in January and the ones today, are the women and girls who have had the experience. Perhaps they have been

patients of the witnesses. They requested to be present to give their testimony and their offer was declined. By any measure, that is essentially wrong.

I am afraid that we might be rushing because of the approach to the issue. The professionals are reacting. Even on Friday, Dr. Boylan, one of the obstetricians and gynaecologists, said life is messy. Today, again, we hear that life is tough and life is messy, which it is. That is why care, compassion and supports are necessary, and all those things that eliminate the fear because no poor girl or woman who has had the unhappy experience of an abortion wants the experience. They have been motivated by fear, coercion or oppression. Even if it is imagined, the way to address the situation and eliminate the crisis is to get rid of what caused the fear. Dr. John Monaghan from Portiuncula Hospital pointed out on Friday that when he was working in the English midlands in the Liverpool area as a trainee obstetrician and gynaecologist, the number of medically-qualified people going into the profession started to decline seriously to 50% levels because of the ethical considerations of what was happening in the United Kingdom in the context of delivering medical care. Doctors undertake to do no harm. The five women who were declined an invitation to the committee were harmed and they said so.

Chairman:

I thank the Deputy. His time is up.

Deputy Peter Mathews:

It is a big omission if one fails to deliver necessary care by omission when one is young, vulnerable and in crisis.

Chairman:

Go raibh maith agat.

Deputy Peter Mathews:

I do not set out blame but I urge that we do not rush the legislation. We must think about it and look at the realities of the 7 million abortions in England and the 55 million abortions in America. We talked about children. There is a law in France-----

Chairman:

I thank the Deputy.

Deputy Peter Mathews:

-----that allows under-age girls to go to their GP and have an abortion without their parents knowledge. They are realities.

Deputy Bernard J. Durkan:

I thank the expert witnesses for their attendance today and their clear responses. I wish to comment on the Women Hurt group. It was suggested on Friday that in many cases women

who had abortions outside of this jurisdiction and had feelings of guilt afterwards had a prior psychiatric condition. Is that generally accepted? To what extent has the evidence of the Women Hurt group, who came before another group in the House, been adduced, if at all?

Given the tendency in this country to have an Irish solution to an Irish problem, is there evidence to suggest that in certain circumstances, by virtue of the existence of conscientious objection, there is a possibility that some women presenting with a crisis pregnancy might find themselves unable to access treatment appropriate to their condition, either from a psychiatric point of view or medical point of view?

Is time a critical factor in determination of access to suitable treatment in the course of an examination of a case presented by a woman in certain circumstances with specific reference to suicidality?

My final question is an important one. We have heard both in January and in recent days considerable evidence on what has happened in other jurisdictions. Could I have clarification on whether it is clearly understood by all that the situation in this country is controlled by the written Constitution, as amended by the people, with the exception of the situation as determined by the Supreme Court? Reference to extreme treatments prescribed in other jurisdictions is not relevant.

Deputy Michael Creed:

I thank the witnesses for their enlightening presentations. If memory serves me correctly, on Friday Dr. Tony Holohan, the chief medical officer in the Department of Health, said the Department did not have access to figures in respect of adolescents in care who might have access and entitlement to a termination on the basis of the circumstances of the X case.

In that context I will address my questions to Dr. Peadar O'Grady because in his cover note he states that he has experience of certifying permission for terminations in those circumstances. It would be wrong to distil this complex issue of trying to reconcile a Supreme Court judgment with the legislative intent of the people in 40.3.3°. I refer to evidence given by a consultant psychiatrist, Dr. McCarthy, this morning and a figure which has come up previously, although I cannot vouch for its authenticity. It suggests that the incidence of suicide in pregnancy is a rare phenomenon – one in 500,000 pregnancies - which would suggest that on the basis of the X case ruling in 1992, on the basis of approximately 100,000 pregnancies a year we would be looking at four to five similar cases in this jurisdiction. In his professional experience, how many times did Dr. O'Grady provide such certifications during his employment and the circumstances in which he might have been requested but declined to authorise entitlement under X case criteria?

I have a second brief question on the issue, namely, on the doctors who will make the determination. It is proposed under the heads that it would be two consultant psychiatrists and an obstetrician and gynaecologist. I do not intend to second-guess the professional view of the psychiatrists but there is another voice in the context of the complex issue that must be heard, namely, that of the obstetrician. That is something that must be taken into account. While taking on board the evidence of the psychiatrists it is also important to factor in the input of the obstetrician. I would welcome some response on those two issues.

Chairman:

The time has almost expired so I will call Senators Healy Eames and Bradford. I would appreciate it if they would be brief.

Senator Fidelma Healy Eames:

I thank the panel members for their time. What is Dr. O'Grady's professional view of the suggestion that the X case was determined by the Supreme Court without any psychiatric evidence?

Chairman:

With respect, we are dealing with the heads of the Bill. The expert group in the Supreme Court decided fadó fadó.

Senator Fidelma Healy Eames:

We are on head 4. Was that appropriate in the view of Dr. O'Grady? Dr. Veronica O'Keane made a claim that is of huge concern to me and I would like her to validate it. She said in point 5 that in situations where abortion services are not available, unwanted pregnancy is a leading cause of suicide. That is not known. Where is the evidence to support her statement? What source does she have?

In January, Dr. O'Keane said just three out of every 100 patients who attended psychiatrists and were predicted to be at risk of suicide would eventually go on to commit suicide. That is a direct quote; she did not say they were pregnant women. I am very concerned also that she says she would like a GP to make a recommendation for an abortion. Did she mean a referral to a psychiatrist? Does Dr. O'Keane believe there should be any restrictions on the provision of abortion when a woman requests it?

Senator Paul Bradford:

My first question is to Dr. O'Grady. He heard this morning, and will be aware from the evidence given on Friday and in January, that to a reasonable extent every witness has said abortion is not a treatment for suicide. The X case, which we are legislating for - I am referring to head 4 - will require certification to the extent that abortion is the only treatment available. Dr. O'Grady represents the group Doctors For Choice, an advocacy group, and is entitled to his opinion, and he has been frank and has put on the record that he has provided such certification. Can he tell me that in those certifications he was absolutely satisfied that abortion was the only treatment? Is part of his being satisfied the idea that abortion is the only suitable treatment, which legally it would have to be? Could he advise me what other treatments would be offered to those patients? We sometimes lose the importance of the language. The certification must have been that abortion is the only treatment. Was Dr. O'Grady satisfied in that regard? What other treatments had been offered? Dr. O'Grady also requested that we change the wording of the Bill to replace "unborn" with "foetus". What is his thinking on that?

Dr. O'Keane made the statement that the difficulty with evaluating suicidal ideation has been exaggerated. How can she justify that with what she said here before, along with others, about the 97% inaccuracy in that identification? She said the evaluation had been

exaggerated, but if experts like her say that in 97% of cases she is incorrect, how can she justify the statement that this is exaggerated?

Dr. Yolanda Ferguson:

I will start with that point - accuracy of assessment. There is a notion that psychiatrists do not have tools or measures to make assessments. We have clear experience and training in making assessments in all facets of people who present to our services, including suicide risk assessment. We do this every single day. We are highly trained and highly skilled in making these assessments.

Going back to the question of linking mental health issues with abortion, if we look at women who are more likely to seek abortion, it is not terribly surprising that those who have made that difficult decision did so because of a number of factors, including mental health issues. The phrase "refuses all alternatives and suicide is the only option" displays a cynical approach to women, that they are sitting there saying they will not do this, that or the other, that they only want one thing. That is not what we experience when we see women in crisis.

Deputy Mathews asked about women hurt by abortion. Support groups are usually founded by people who are dissatisfied with something. It is unlikely we would find a support group of women who are pleased with their decision.

It is important that conscientious objection be included in the Bill. That is why we suggest a panel. If a woman cannot avail of the normal pathway of care because her psychiatrist is a conscientious objector, that panel should be formed.

Dr. Eamonn Moloney:

In response to Deputy Flanagan's question about women refusing to co-operate with treatment, it is best answered by Deputy Mathews, who says that no one wants the experience of an abortion. I do not think women will come along to deceive a psychiatrist. This is why the role of the GP will be particularly important, knowing the individual and having personal knowledge, with an experience of dealing with people and being able to assess whether someone is telling the truth. We spend our working days talking to people so we have a lot of experience in this and it is cynical to suggest this is what will happen.

Several of the speakers here this afternoon and this morning, particularly by Dr. Anthony McCarthy, have addressed the positive predictive value of 3%, with one in 500,000 suicides in pregnant women. We do not know what the rates of suicide would be among pregnant women if they did not have access to abortion. We cannot make any prediction, be it 3% or 93%. As I said earlier, one cannot ethically and reasonably do those studies to work it out with that degree of accuracy. We can only say what best international practice is, not just in Ireland but throughout the world, and that we have the ability to assess suicide risk and manage that, recommending the available treatments. It is spurious to use such terms to talk about predictive values. These are in populations where people receive treatment. That obviously affects the outcome.

I would not say we are rushing into anything. It is 20 years since the X case and it is about time. I am glad we are now at the point at which where we are legislating on the X case. Deputy Mathews's reference to obstetricians' leaving upsets me because it might be due to

other factors, such as the rising rates of litigation against obstetricians. I accept we have our own Constitution but we do not live in a bubble. We are part of Europe and a wider global community. If it is the reality that women are leaving Ireland to get terminations in other jurisdictions, it is relevant to mention that.

Many of the other questions were related specifically to Dr. O'Grady's area, so I will let him address them.

Dr. Peadar O'Grady:

I will try to focus on the procedure's being open to abuse if it is left to the will of the pregnant woman. I hope I am not being unfair to the person who asked this question, but that is precisely the view of Doctors For Choice - that it is women to whom we should leave the final decision, having given all the advice and looked at all the possibilities and options. The final decision on whether to have an abortion is most safely left in the hands of a woman, and I do not consider that abuse; I consider it best practice.

I absolutely agree that a prior history of mental health problems and a history of violence, particularly sexual violence, are very important factors, and in many of the debates that have taken place about the connection between mental health and abortion, it has often been overlooked that women who suffer from mental health problems and violence are more likely to be in a situation in which they consider having an abortion. The connection is not with abortion; it is with the previous history. Deputy Durkan is correct in that, and it is the pro-choice lobby that has drawn attention to it.

The most recent studies, a report by the American Psychological Association and a review done by the Academy of Medical Royal Colleges, have clearly stated there is no evidence of abortion causing mental health problems. There is controversy around this and, as I noted earlier, we are very conscious of a subgroup of women who have a negative response to an abortion. This very often occurs for the two reasons I mentioned - namely, the women feel coerced into having an abortion, or they strongly object to abortion from an ethical point of view but feel coerced into having an abortion. It is common sense that this subgroup may experience an increase in mental health problems after having an abortion. It is definitely a subgroup to which we should pay attention.

Speaking live on the "Morning Ireland" programme, Dr. David Fergusson, a New Zealand researcher, who was cited by the anti-choice, pro-life groups, blatantly contradicted the interpretation of his research and put Professor Casey right on it, when he stated he did not deal-----

Senator Fidelma Healy Eames:

RTE issued an apology two or three days later.

Chairman:

Please do not interrupt.

Dr. Peadar O'Grady:

Dr. Fergusson pointed to three facts that are written in his paper. First, he did not do any research on women who are suicidal. Second, he did not believe the evidence he presented in his paper was strong and, therefore, it should not be used emphatically. Third, he argued in his paper for an easing rather than a tightening of the eligibility restrictions as a result of his research.

On the issue of women who have been hurt by abortion, I referred to the 47,000 women who die as a result of unsafe abortions and those who are disabled by their experience. I also spoke of the women who are at risk through coercion and stigma. It is also worth speaking of the women who are not hurt by abortion.

Deputy Peter Mathews:

It would be useful to hear that from the women themselves.

Chairman:

Deputy Mathews does not allow interruptions when he chairs the Dáil. He should respect the same rule in this Chamber.

Dr. Peadar O'Grady:

I concur with Deputy Mathews that it would have been useful to hear representative groups of women explain the negative and positive experiences they have had in order that all of us can draw conclusions about how to make this experience better for everyone, allow women to make the best decision for themselves and ensure they are not coerced into having an abortion or stigmatised afterwards. These are the two major causes of distress. We should get rid of this fear, as Deputy Mathews outlined. The voices of these women can be heard at a later date.

As to whether conscientious objection would disrupt access, that could be the case, and the issue will have to be monitored. It has been noted in ethical papers that there is a conscientious objection to the restriction of abortion. Doctors such as me would face criminal sanction if we were to exercise our right to assist a woman in following up and having an abortion on the basis of her decision of informed consent. This in contrast to those who wish to have a conscientious objection not to take part in the process. While I believe people should have every right not to take part, this right should not be an institutional one.

I was asked whether time was critical. That is absolutely the case. Around eight or nine weeks is the most critical period, as a delay at that point will make the difference between a medical and a surgical abortion. The latter increases complications for the person involved.

As to whether the jurisdiction is relevant, it is absolutely relevant. People have forgotten that the 1861 Act was not passed in an Irish Parliament but in the British Parliament and it is a British law. While we can blame the Catholic Church for many things, we cannot blame it for the 1861 Act. Jurisdiction is also relevant because the services that between 4,000 and 5,000 women from Ireland engage every year are in the United Kingdom. It is medically, if not legally, relevant.

I fully agree that no psychiatric evidence was presented in the X case. The key question for psychiatrists is whether they agree with the decision by the Supreme Court justices in that case to certify eligibility for access to an abortion. While opinions on that issue may differ among psychiatrists, in my view the Supreme Court made the right decision. For many of us, the alternative of restricting travel and access to an abortion and forcing a 14-year-old rape victim through a pregnancy was intolerable. Given our tendency to become too abstract, we should always consider what alternative options are available. Most people who examined the case at the time, including psychiatrists, concluded that the Supreme Court justices were correct and the alternative was appalling.

As to whether abortion is the only treatment available, I am fascinated by the current interest in the certification. I cannot even remember if it was the High Court or some other court because the issue was not brought before the court. The certification was straightforward and obvious at the time. The children in question had decided that abortion was the best option for them. What I had to do was ensure they had the best chance to engage in non-directive counselling and that any mental health complications that were current or might follow would be adequately dealt with. In the midst of that, the nature of my certification was not really at the top of anyone's agenda. I am in some respects glad that was the case. All of those involved in that process, including the social workers, mental health workers - due credit must be given to the Irish Family Planning Association, which dealt with the request for certification - and the judge in question, behaved rather well and did the needful in a good, thoughtful and timely manner. If anyone wishes to ask me any particular or specific questions about that, I will be pleased to answer them outside the room.

Professor Veronica O'Keane:

Deputy Terence Flanagan indicated that some questions had not been answered and requested that some of his questions be answered. I am afraid I did not catch several of the Deputy's questions. He asked what we would do in the case of a woman who refused treatment and hung on, as it were, for an abortion. We would act in the same manner as we act in respect of all individuals who refuse treatment. If a person is refusing treatment in the context of a serious mental illness and we believe he or she requires this treatment, we would involuntary detain the individual in question and, if possible, give him or her the treatment we believe he or she requires. If, on the other hand, the person did not have a mental illness, as a free citizen it is entirely his or her right to refuse psychiatric treatment.

Another point was raised regarding the system being open to abuse. I cannot emphasise enough that we, the College of Psychiatrists of Ireland, the Irish College of General Practitioners and the Medical Council, have come before the committee to help legislators bring in a law that will be effective and accessible to women. No one, as far as I know, has come before the committee to break the law. We want to co-operate. We do not want to abuse the law or help individuals we may be seeing to abuse the law. It is the individuals who do not agree with the legislation who are objecting to the law.

I am at one with Deputy Mathews in wanting to have a good and ethical society. I believe that providing for the protection of women's lives during pregnancy is providing for a good and ethical society.

Deputy Peter Mathews:

We should protect both lives.

Professor Veronica O'Keane:

It is very regrettable that some women are hurt by abortion. The majority of the more than 150,000 women in Ireland who have had abortions are not hurt because they are not coming forward; nor is that the experience in other countries where abortion is available.

We cannot be said to be rushing this legislation, given that we have waited for it for 21 years.

It is patronising to assume that women are being pressurised into having abortions. This service is a service for women and I am paid by the good taxpayers of this country to facilitate it. I will not pressurise anyone. Women are not being pressurised but are making their own choices, against the odds, to travel abroad to have abortions.

On conscientious objectors, it is important to ask whether it will delay a woman's access to an abortion if her local psychiatrist is a conscientious objector. This is an incredibly important point and it is the reason I and others have proposed the establishment of a national panel. We could screen the panel for people who are prepared to co-operate in the full spirit of the law. If the local psychiatrist is on the panel, that is fine, and he or she can be requested to determine eligibility. However, if he or she is not on the panel, the woman would be poorly served by seeing somebody who did not want to comply with the legislation. For this reason, it is important to have a panel where it is stated that specific psychiatrists are happy to work within the legislative framework.

In response to Senator Healy Eames, she is correct - that is what I said and I will repeat it again. In situations where abortion is not available, unwanted pregnancy is a leading cause of suicide. The studies come from countries not just where abortion is not legally available but also from countries where women are too poor and abortion is not economically available to them. These countries include the Caribbean states and countries in sub-Saharan Africa. I would be very happy to supply the references to the Senator.

Senator Fidelma Healy Eames:

I would be delighted to receive them.

Professor Veronica O'Keane:

Perhaps I could refer the Senator to some more general reading in this area. Clíona Rattigan's book, *What Else Could I Do?: Single Mothers and Infanticide, Ireland, 1900 - 1950* deals with about ten years in 1950s Ireland and the rates of infanticide and maternal morbidity associated with unwanted pregnancies. It is a horrible thing to say and I do not like the reality but before abortion services were introduced, infanticide was a common means of controlling one's reproduction. None of us likes this fact. We did have the Kerry babies case in Ireland and we have had situations like that within the last 50 years. Another book that the Senator should read if she is interested in this topic is Germaine Greer's book, *Sex and Destiny: The Politics of Human Fertility*, in which the author refers to the history of infanticide and injury which preceded the legalisation of abortion.

On the question of whether I personally favour any restrictions, it is not down to me. I am

here because I have been requested to be here to advise on this particular legislation. My only concern with this legislation is that if we are going to introduce a service, that such a service would be accessible, humane and will not involve unnecessary delays.

The last point I want to make relates to the difficulty of identifying the 97% of people correctly. Obviously if somebody is referred to the psychiatry services, we do every single thing we can to prevent that person from killing himself or herself. If somebody comes to us, of course, he or she is at risk of suicide. Nearly everybody who comes to us is at risk of killing himself or herself. The fact that 97% do not go on to kill themselves is exactly what we are trying to do. It is exactly the same with the abortion issue. What we want to do is prevent the suicide of the mother and the death of the foetus, baby, embryo. That is what we are here for.

Deputy Michael Creed:

Dr. O'Grady did not answer one of my questions regarding the numbers of patients he may have certified and the numbers that may have been declined, as well as why cases may have been declined.

Dr. Peadar O'Grady:

As I said earlier, I am a little loth to go through a series of my patients and talk about them publicly. Certainly I am very happy to share ---

Deputy Michael Creed:

I am not looking for the individual details. I am just looking for the overall numbers.

Dr. Peadar O'Grady:

I have not really done a study on that. What I am a little amazed by - and I am not dodging the question but pointing out another missing question - is that no-one has asked how many of them actually committed suicide, how many of them actually went through with the pregnancy and how many of them had an abortion. These are the kinds of statistics ---

Deputy Michael Creed:

I am looking for all of that data, if Dr. O'Grady could provide it.

Dr. Peadar O'Grady:

I would be glad, at a later stage, to collect that data and provide it to the Deputy.

Chairman:

The 30 minutes allotted for non-members has expired. In fact, we have run over by five minutes and ---

Deputy Billy Timmins:

On a point of order, Chairman ---

Chairman:

No. I am chairing this meeting ---

Deputy Billy Timmins:

I wish to refer to part of the written statement by Professor O'Keane about suicide in general ---

Chairman:

I ask Deputy Timmins to respect the Chair.

Deputy Billy Timmins:

I will address it in the next session.

Chairman:

I will chair the meeting.

Deputy Billy Timmins:

I will seek a response from Professor O'Keane in the next session. It is really important.

Chairman:

I will chair the meeting and if I want the assistance of Deputy Timmins, I will ask for it. The time for non-members has expired and we are actually more than five minutes over time. I thank the expert panel, Dr. Ferguson, Dr. Moloney, Dr. O'Grady and Professor O'Keane. I apologise to Deputies and Senators who could not contribute but the 30 minutes allowed has expired. We will suspend the meeting now and resume at 3.30 p.m..

Sitting suspended at 2.55 p.m. and resumed at 3.35 p.m.

Chairman:

I again welcome everybody to our deliberations and discussions. This is the seventh session in the series of meetings to discuss the heads of the protection of life during pregnancy Bill. I appeal to all Members to be balanced, fair and calm and to focus on the heads of the Bill. I again apologise to people who did not get to contribute in the sessions this morning. There is a time allocation of 70 minutes for members of the committee and 30 minutes for non-members of the committee. Members are requested to be as brief as three minutes - they need not take that much time. Members should ask questions on the heads of the Bill rather than giving statements of opinion, as that would assist us all.

Deputy Eamonn Maloney:

I ask the Chairman to repeat that.

Chairman:

I hope that people will ask questions and not give Second Stage speeches.

Deputy Eamonn Maloney:

Say it louder.

Chairman:

I again apologise to those who did not get in this morning. For the sake of fairness I will endeavour to call people who have not yet spoken in the committee hearings, be they members or non-members of the committee. I know a number of members were disappointed that they did not get in and I apologise to them for that.

I welcome most sincerely to our hearings this afternoon Dr. Jacqueline Montwill, Dr. Bernie McCabe, Professor Kevin Malone and Dr. Seán Ó Domhnaill. I thank them for coming here and assisting us. As I said to the witnesses this morning and on Friday, they are coming here voluntarily to give of their time to assist us, which we appreciate. I hope members respect that the witnesses have come here as experts to assist us.

Before beginning I remind members and witnesses that witnesses are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to do so, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of the proceedings is to be given and they are asked to respect the parliamentary practice to the effect that where possible they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice and ruling of the Chair to the effect that they should not criticise, comment on or make charges against either a person or persons outside the House or an official either by name or in such a way as to make him or her identifiable.

I ask Professor Malone to make his opening remarks. There are 50 minutes for all the witnesses to speak and they may split it 12 minutes each to be fair to the witnesses.

Professor Kevin Malone:

I thank members of the committee for inviting me to make a submission, as I did earlier this year. In the interest of brevity, focus and, hopefully, clarity, I sent a more brief submission, which I will present now and which I believe relates to the heads of the Bill.

I made a previous submission to the Oireachtas earlier this year. The legislation, which is based on the outcome of a 20-year-old risk assessment of suicidality, excludes 50% of the population - males. Such a focus in excluding men when dealing with legislation on suicidality further eclipses the problem of male suicide in Ireland. This morning I published a research report on suicide at the Royal College of Physicians of Ireland - I have only three copies left, but the Chairman may have the three - wherein the question of marginalisation

and normalisation of suicide among young males is analysed. Members should note that suicidality is already a significant problem in Ireland, accounting for more than 12,000 emergency department presentations annually and more than 2,500 presentations to voluntary organisations. The rates for males attempting suicide are climbing all the time.

Based on the research evidence from my studies on this problem in Ireland for the past ten years - Ireland is unique and somewhat different from other countries with regard to this type of research - it is possible that this legislation could inadvertently accelerate suicide rates in younger men, where the real problem lies. Members should note that the problem of male suicide in Ireland is at least sixfold that of the theoretical problem of female suicide, which is rare.

Contrary to the notion of it saving the lives of an extremely small number of females it may be placing a greater number of young male lives at risk. In terms of legislating for the whole of society, I bring this to the committee's attention. Overall, at a macro level the effect of legislation may be a greater loss of life in Ireland than life saving. Surely, that would be a law of unintended consequences. I wonder how mental health literacy will be taught in schools, in terms of explaining that suicidality is legitimised for women in certain circumstances, in respect of which the rate for pregnant females is 2 per million, but not for young men in respect of which the rate is 350 per million, or 150-fold.

My second point is whether abortion is an evidenced based treatment for mental illness in Ireland. My understanding - again I highlight this problem not from the point of view of either side of the debate but based on my clinical research experience - is that four psychiatrists in Ireland have been looking after perinatal psychiatry in Dublin for the past 30 years, including Dr. McCarthy, Dr. Joanne Fenton, Dr. John Sheehan and my late father, Professor Sean Malone who cumulatively have been in clinical perinatal practice in Dublin for close to 30 years. My father was consultant psychiatrist for 40 years at two maternity hospitals, the Coombe Hospital and Holles Street Hospital. They are all on record as saying that they have not observed one clinical case where abortion was the recommended psychiatric treatment. As a clinician, I wonder how then it can overnight become a recommended psychiatric treatment in Ireland.

My third point is more for the profession but I will bring it to the committee's attention, namely, therapeutic alliance, which is the cornerstone of our clinical practice with regard to our "relationship" - I use that word in the professional sense - with patients. If the therapeutic alliance is to be preserved for psychiatrists and their patients becoming clinically involved in a decision on abortion one way or the other - again I stress "one way or the other" - in my clinical professional point of view, that comprises the therapeutic alliance and is therefore clinically contraindicated. Any kind of fee in such a situation further comprises this position.

While my submission runs to another page I will pause at this point in the interests of clarity and brevity.

Dr. Jacqueline Montwill:

Chairman, members of the joint committee, ladies and gentlemen I welcome the opportunity to address you on this important issue. My understanding of this law is that it is to reassure the Irish people that no pregnant woman will be denied life-saving treatment because of her pregnancy. In my opinion, we do not need this law in psychiatry. We already have full clarity

in terms of our assessment and treatment for patients. There will be no situation where the welfare of the foetus will eclipse the welfare of the woman.

Head 4 of the Bill is seriously flawed for three reasons. First, the treatment it proposes is not a treatment. Second, the treatment it proposes is never the only treatment. Third, if truly suicidal with mental illness the patient may not be able to give a valid consent. We have already heard that abortion is not an evidenced-based treatment for suicidality. Unfortunately, this Government is proceeding as if it is. There is no evidence to support the view that the abortion has any mental health benefits. There is evidence to support the view that in some women, abortion may be associated with small to moderate increases in risks of mental health problems, including suicidality. There is an ethical problem in offering a procedure as a life-saving treatment to a suicidal woman where that very intervention also poses suicidality as an outcome.

It is incorrect to say that abortion could ever be the only treatment for suicidal ideation. Suicidality is multifactorial. It is important the people of Ireland understand this. Our treatment packages take this into account. We work in multidisciplinary teams because we believe that the skills of each member of our team are essential for the proper and full assessment and treatment of our patients. Best practice treatment for mental illness is and always will be appropriate full assessment, psychological support and intervention and medication, if needed. It must be remembered that we have social workers, occupational therapists and psychiatric nurses who work with people in their homes and communities. We will work with patients in the community for as long as needed following discharge from hospital. The proper care of a suicidal pregnant woman would entail proper assessment, support and treatment throughout her pregnancy, delivery and postpartum. Longer term intervention may be required, depending on the circumstances. The point is that the woman will not be abandoned.

We are very aware that mental health intervention must include the assessment of all the stresses in the patient's life at the time in question. These stresses can include relationship difficulties, poverty, unemployment or lack of occupation during the day, accommodation issues, difficult current or past family dynamics and lack of other supportive relationships. These also are an indicator of very poor outcome post-abortion. It is within this holistic view that the treatment package for a suicidal pregnant woman would be appropriately assessed and delivered. Therefore, it is illogical to say that the only treatment for suicidal intent during pregnancy could be an abortion.

Valid consent to an abortion may not be possible while a patient is acutely suicidal due to mental illness or distress. This is important. It is important to note that a psychiatric emergency or crisis is fundamentally different to any other medical or surgical emergency. This is because of the nature of the disorder. In a true psychiatric emergency, the patient's judgment is frequently impaired. Our role at that time is to administer the most appropriate psychiatric treatment and support. It would be highly inappropriate and unethical to impose an irrevocable intervention at that time when the patient may not have sufficient mental capacity to give a valid consent to that intervention. We would in such circumstances be failing our patients. The patient's right to bodily integrity is paramount. It is my view that if a termination were prescribed and given at the time when a patient is in crisis, has an acute crisis adjustment reaction or is mentally ill, the patient would be in a strong position to accuse the treating team of failure in their duty of care. It could be rightly claimed that we as psychiatrists failed in our duty to adequately protect the patient during a period of mental

illness. It should not be forgotten that mental illness responds to treatment. Acute crises respond to treatment. They settle down, often in a short period. Any impairment of judgment in these situations will resolve with treatment.

With this law, the focus will be directed away from a full and proper assessment of the patient towards an assessment for a direct abortion. As treating psychiatrists we do not assess suicidality for any reason other than to prescribe the appropriate psychiatric treatment. Society should do the same. Society should validate rather than normalise an expression of extreme psychological distress. Mental illness is just as important as physical illness. Perhaps even more so. It affects a person's thinking, the ability to relate and relationships and the ability to function. It is exceptionally important to state that the proper response to stated suicidal intent should always be the appropriate evidenced based clinical treatment. That is what we do when we assess patients who threaten suicide. Direct abortion is not a clinical treatment. It is a social solution. This law will do damage way beyond the boundaries of simply legislating for a medical treatment that is without the foundation of medical evidence and good clinical practice.

It will directly target and profoundly damage the very nature of the doctor-patient relationship. The interaction for a woman who is suicidal and pregnant will change from therapy to judgment and an adjudication interview for abortion. This will put her in an impossible situation, with outside demands impacting on her treatment and taking her out of the proper therapeutic alliance with her psychiatrist and treatment team.

For patients with mental illness, there is no evidence that abortion is a treatment for suicidal intent or threats. There is no situation in which it could be the only treatment indicated and the issue of valid consent to an abortion for someone who is truly suicidal due to mental illness poses serious ethical concerns. We have heard that the incidence of suicide in pregnancy is extremely rare and some people believe this law is going to relate to those patients. I do not believe that is true. In my opinion, the patients who will avail of terminations of pregnancy through this law are most likely to be those we discussed in earlier sessions, who have no mental illness but do not wish to be pregnant. What difficulties will this pose? Unfortunately, we cannot tell who is going to commit suicide. A study of patients in an acute psychiatric ward found that out of 100 patients who were seriously psychiatrically unwell and who psychiatrists thought would commit suicide, only three did so. We have no way of predicting who will commit suicide but in our assessments we treat everybody as if they will and we provide the appropriate treatment package for each patient on an individual basis.

Chairman:

Our next speaker is Dr. Bernie McCabe, who is most welcome.

Dr. Bernie McCabe:

I thank the committee for providing me an opportunity to present my concerns about this legislation in the absence of Professor Patricia Casey. As a consultant psychiatrist, it is my duty of care to my patients to provide them with a non-judgmental and evidence based treatment programme in accordance with their needs. It is my opinion that such treatment is their right and, in the absence of an evidence base, I am in breach of my duty of care to them and their rights. These ideals are reflected in the guidelines of my governing bodies, the

Medical Council of Ireland and the College of Psychiatrists of Ireland. In view of the submission made earlier on behalf of the college, I now have to report to the committee that the text of its submission was sought last week by members but the request was refused until today. A growing number of members of the college no longer feel the speaker from the college is representing their views. The college has been informed of this in writing, as of Friday, 17 May.

It has been stated by a number of speakers at various Oireachtas hearings that evidence is not available for the use of abortion as a treatment in suicidality. Suicidality is a dynamic state which varies from suicidal intent, where a person has no hope and does not plan for his or her future beyond his or her death, through suicidal ideas, to a crisis state where a person becomes aware of a sudden change in circumstances - in this case we are referring to an unplanned or unwanted pregnancy - and is now fearful or negative about the future. Clearly these are fearful, distressing and despairing states and have many underlying causes requiring a full multidisciplinary assessment of needs. It must also be emphasised that we have, as a scientific professional body, a number of evidence based treatments that work in terms of helping to remove a person from a despairing, distressing or mentally ill state to one where judgment is more robust and the person is again in a position to consider options for the future.

For those individuals who do not fall into the aforementioned categories, that is, people who do not have mental illness, are not despairing or distressed or have needs that cannot be met by a multidisciplinary psychiatric service, such as those who present to psychiatric services with social issues, it is important to accept that psychiatry has nothing to offer over and above those who are not trained as mental health professionals. These are social issues and, accordingly, psychiatry should not be involved. It must also be accepted that the prediction of suicide is recognised to be poor. This is a worldwide and evidence based view held by the profession. The test of whether there is a real and substantial risk to the life of the woman that can only be avoided by abortion cannot be met given that suicide cannot be predicted even among those with mental illness. Offering a pregnant suicidal woman an abortion if she says her pregnancy is the reason may seem like common sense. However, caution is required in this regard. Interventions that seem intuitively correct may turn out not to be so. Intuition is not enough. An evidence base is required. As we are members of a scientific profession which uses an evidence base for the planning of treatment, to expect psychiatrists to recommend abortion as a treatment for an unwanted pregnancy in the group I have just described is an abuse of the profession in order to facilitate the requirements of the State. The psychiatric profession has no role beyond saying that a person has no mental illness and we must not be used by the State to duck the ethical and constitutional debate that must take place or else the profession will once again fall into disrepute under the current proposals.

As it is currently constructed, head 4 should not be included in the legislation. It should be replaced by an evidence based clinical care pathway that would assist women who are suicidal in accessing psychiatric assistance because abortion as a treatment for suicidality is not evidence based. This view is supported by a growing number of professional colleagues. Of 302 consultant colleagues who received a postal questionnaire, over 130 responded and this number continues to grow. Some 90% of the respondents were in agreement with the aforementioned view. Some have sought to criticise this work but it must be made clear that respondents were asked to put aside their personal views and answer solely based on their clinical experience. It remains the only piece of work to consider the level of concern among practising consultant psychiatrists and it is worthy of consideration for that reason. In the

event that the Government disregards these concerns and the recommendations expressed more thoroughly in Professor Casey's submission and proceeds with legislation, a number of concerns have been set out in the website submissions and are beyond the scope of this presentation.

There is a dearth of information on the value of abortion among suicidal pregnant women. It has never been studied. The Government is acting as though evidence is available to support this. Psychiatrists should not be involved except in so far as we can treat women with mental illness, which must be evidence based.

Chairman:

Our final speaker is Dr. Seán Ó Domhnaill. I thank the witnesses once again for attending. I recognise that they only received short notice.

Dr. Seán Ó Domhnaill:

I thank the committee for giving me the opportunity to address it. I am a consultant psychiatrist in general adult psychiatry employed by the Health Service Executive. I also work on a pro bono basis with Cuan Mhuire addiction treatment services. I have worked exclusively in psychiatry since 1997, having graduated form the Royal College of Surgeons in Ireland in 1994.

I will address my comments to head 4 in particular. I share some of the concerns expressed by Deputy Timmins and others in regard to whether this consultation can be truly meaningful if the Government is not prepared to take the expert evidence into account with regard to abortion and suicidality. There was almost complete agreement among the psychiatric experts who gave evidence in January that abortion - the direct and intentional killing of the unborn child - is not a treatment for suicidality. It is extraordinary that the Government has seen fit to disregard all the accrued evidence in proposing legalising abortion on the grounds of suicide. I draw the committee's attention to recent votes at the conferences of the Irish Medical Organisation and the Irish College of General Practitioners rejecting motions in support of abortion, even within the limitations envisaged in the X case ruling. It clearly emerged that the majority of doctors do not support legalising abortion on the grounds of suicidality.

Our profession is very much evidence-based in its approach to its work. There is no evidence base for the proposal to allow abortion for suicidality, regardless of any attempts to restrict the scope of the proposal. If there is no case for treatment of suicidal intent using abortion, then there is no point in proceeding with this legislation. We should nail the lie at this point that Ireland has any obligation, imposed by the European Court of Human Rights, to legislate for abortion. The European Court of Human Rights has requested that we clarify our law, not that we write new law.

I will now turn to the Bill, which, I believe, has been misnamed. While every person wishes to protect women in pregnancy - I would support absolute clarity for those medical practitioners, including me, caring for pregnant women - the primary purpose of this proposal is not the protection of life during pregnancy but to provide a legal basis upon which the deliberate ending of one life may be carried out. It would have been possible to provide further clarity for the protection of women in pregnancy without legalising abortion, as the Bill aims to do. The Government appears to have chosen instead to include the deliberate

destruction of unborn human life. This is an enormous change for Irish medical practice and, in my view, it is a hugely retrograde step. Abortion has no place in modern medicine. It is a medieval solution to crisis pregnancy. This Bill is not about saving lives because it allows for the killing of a physically healthy baby being carried by a physically healthy mother. All of this is despite the evidence which shows that abortion does not reduce mental health risks and may be associated with an increased risk of mental health problems.

There are five key points I wish to make about the Bill. First, how would this proposal operate in practice? Again, it is time for a reality check. I have enormous respect for Irish medical practitioners, particularly during these difficult recessionary times, who are invariably working under extremely difficult conditions and in under-resourced hospitals. However, I would like to introduce some clarity in respect of head 4 of the Bill. It is a fact that there are some psychiatrists who are ideologically supportive of abortion and who believe it should be available on request or on demand to Irish women. It stretches the boundaries of credibility to suggest that those psychiatrists would not be more likely to approve abortions if the Bill becomes law. As matters stand and from the submissions that have already been made, they are demanding that only psychiatrists who are in agreement with them ideologically should be allowed to participate in the assessment panels outlined in the heads of the Bill.

We have seen this play out in practice in many other jurisdictions. I remind the committee of the experience in California, where abortion was legalised in 1967 on several grounds. One of those grounds was to preserve the mental health of the pregnant woman under supposedly very restrictive conditions. There was a genuine effort to make these conditions as restrictive as possible so as not to open the floodgates. It was required that a hospital committee would be obliged to unanimously agree that the pregnancy was causing such an extreme mental health risk to the pregnant woman that she would be required to be committed to a psychiatric institution. Despite this, in 1970 more than 65,000 abortions were approved and almost 63,000 of these were performed. Some 98% of these were for reasons of mental health. Did all 63,000 abortions take place according to the spirit of the law? The notion is ridiculous. The California Supreme Court questioned the integrity of the process and stated that "Serious doubt must exist that such a considerable number of pregnant women could have been committed to a mental institution." That was the criterion that needed to be met in order to meet the conditions of the law. Evidently, some doctors who believed that women had a right to access abortion used the subjectivity of making a judgment on mental health grounds for abortion in order to make abortion freely available.

We all know of the experience in Britain. It mirrors almost exactly that of California and occurred in the same year. We need to be honest - something which has been lacking to a large degree in this debate so far - and stop fooling ourselves that matters in Ireland will be different than has proven to be the case in every other country that has sought to take this particular route.

My own experience in psychiatry has been that abortion can be harmful to women and that this is largely ignored by those supporting abortion legislation. It is most unfortunate that women hurt by abortion, many of whom have been in contact with me in recent months, have been excluded from giving evidence at these hearings. This is a broad-based consultative process, not simply a professional forum. Abortion is not primarily about medical or psychiatric emergencies; it is usually about psychosocial stressors and the choices people make in response to them. We have all heard or read about the tragic story of Miss C, who

was forcibly taken abroad for an abortion by this State - into the care of which she had been placed - and which she says quite categorically left her suicidal and caused her to attempt to take her own life many times. The distress is very real and the loss felt by these women is extremely acute. The harshness and lack of sympathy expressed by abortion supporters for women hurt by abortion and Miss C is, quite frankly, breathtaking.

I am in full agreement with Dr. Coulter-Smith, who spoke for many of this colleagues when he said:

> ... our psychiatric colleagues tell us that there is currently no available evidence to show that termination of pregnancy is a treatment for suicidal ideation or intent and, as obstetricians, we are required to provide and practice evidence-based treatment ... It, therefore, creates an ethical dilemma for any obstetrician who has requested to perform a termination of pregnancy for the treatment of someone with either suicidal ideation or intent.

It is my opinion that psychiatry cannot support a provision which obliges obstetricians to deliberately end the life of a child being born to a physically healthy mother when the evidence that abortion is a treatment for suicidality simply does not exist. I noted, as did many others, that two obstetricians from the National Maternity Hospital gave evidence on Friday. I would have been most interested to hear the opinion of the master of the Coombe Women & Infants University Hospital, which is one of the largest and busiest maternity hospitals in western Europe, or that of a representative of the master.

The reality of abortion is being ignored at these hearings and in the wider debate in general. The idea that abortion is a political issue or is a matter for discussion in back rooms or in television stations is something really that we do not have the right to do. Abortion is a reality and anybody like me who has actually witnessed the corpses left behind by the victims of abortion would certainly not want that reality to be ignored. This Bill seeks to turn doctors into abortionists. We know from the website of the British National Health Service that unborn children before 12 weeks gestation will be sucked from the womb by a razor vacuum aspiration process, while after 15 weeks of pregnancy the doctor will have to cause a fatal heart attack and deliver the baby whole or piece by piece. We must not be fooled.

The suicide clause in this Bill is not about early delivery; it is about ending the life of children in the womb.

Finally, the evidence of medical experts has been remarkably consistent during these hearings. The committee has heard from a representative of St. Patrick's University Hospital, one of Ireland's leading psychiatric hospitals, who said that there is "no evidence either in literature or from the work of St. Patrick's University Hospital that indicates that termination of pregnancy is an effective treatment for any mental health disorder or difficulty." The committee has heard from Professor Kevin Malone, who stated that abortion is not a treatment for mental illness and in his written submission referred to a textbook of psychiatry and asked how it can suddenly become a recommended psychiatric treatment in this legislation. These are the words of one of the world's leading suicide researchers, who comes from Ireland. He must be listened to.

This committee and the Government have heard much of this evidence before. I sincerely hope that they display the integrity expected of them by the people of this nation and that

they respond to what they have heard on this occasion. Mothers and babies deserve far more than an ideologically-driven Bill which seeks to end rather than protect human life in pregnancy.

Chairman:

Thank you very much, Dr. Ó Domhnaill. For the record, you made reference to the Master of the Coombe Women & Infants University Hospital. She was invited in and she communicated to the committee that the views she holds would be represented by the institute. That is for the record.

We now have 70 minutes for members of the committee. Again, I apologise to both members and non-members of the committee who did not get in earlier. To assist, I ask if members could be brief. It would allow for more people to be able to participate.

Deputy Billy Kelleher:

I suppose we will speak on head four initially. At the outset, may I say that we are not ignoring the issue of abortion. The fact is that more than 4,000 Irish girls and women go abroad every year to Britain for whatever reason, and there are a variety of reasons. In that context, can I ask the witnesses, in their professional opinion, are they saying that there has ever been a case in which a woman has actually taken her own life because, for whatever reason, she was in a crisis pregnancy? There could be myriad reasons, but she was in a crisis pregnancy in her mind at the time. Has there ever been such a case? We are legislating for the fact that the X case obliges us to look at the issue of suicide because of the constitutional imperative that is there. I want to get clarity on that issue.

It has been stated by other psychiatrists who are eminently qualified that termination of a pregnancy is not in itself a treatment for suicide. That was said quite openly here by many people today. Equally, they say that in a very rare circumstance it may be the only option left to save the life of the woman. That was stated but in the context of extreme circumstances. If the witnesses are saying that there is no evidential or clinical-based research data to suggest that termination is a treatment for suicide, why would it ever be prescribed? Why would psychiatrists ever prescribe a termination if the witnesses maintain that the clinical evidence is that it is never a treatment for suicide? In other words, why would the witnesses be concerned that this legislation would open up a more liberal form of abortion in this country if all the clinical evidence is that it is not a treatment for suicide? I am just asking that question.

We are aware that women go to extraordinary lengths when they are in crisis pregnancies, including self-abortion and self-imposed surgical interventions. We know what has happened with women in previous times; because they could not access abortion for whatever reason, they have done things and made interventions. That is still happening as we speak in this country, with abortive pills and so on. We know that women will go to extraordinary lengths. I am just asking the question. Is it possible that a woman would ever go to the most extraordinary length of all and take her own life?

On the issue of whether psychiatrists can decide whether a person would commit suicide, the witnesses say that of 100 people who were potentially suicidal, only three went on to actually commit suicide. Surely that shows that intervention, counselling and treatment actually work,

in view of the fact that the witnesses have proscribed 100 people that in probability could have committed suicide, but only three actually did so. I assume it is because they all got treatment and because they were in a controlled environment. I assume they would have been assisted, assessed and counselled, so that treatment does work. The point I am making is this: if we have women who are at present going abroad, would it not be the case that instead of going abroad they might present themselves to the system here and that there could actually be interventions other than the extreme of actually going to England for a termination?

Deputy Caoimhghín Ó Caoláin:

I welcome our guests here this afternoon. It is very important to say at the outset that despite the scepticism of some of the voices this afternoon in respect of the worth, value or legitimacy, even, of this set of hearings, whatever the respective views of Government, as an opposition voice I am accepting the bona fides of it, and it is hugely important that this is understood. That is why we are here: to listen to a wide variety of views, each of them equally respected. I welcome the respective contributions of the witnesses, as I have those that I have already heard.

To try to help us fully understand the position that each of the contributors has given, I wish to clarify a point in Dr. Montwill's contribution on consent. All I am asking is for is an elaboration and an explanation. She stated, under point five on consent, that a patient must give her consent for any medical procedure. It is accepted that ultimately it is the woman who will decide, if a determination is made in respect of legality or if this Bill were to pass. Dr. Montwell went on to state that it would be unethical to impose a procedure on a patient when the patient may not have full mental capacity or be able to give a valid consent to such a procedure. She went on to say that impaired judgment could be seen to affect the patient's capacity to consent to the procedure and her right to bodily integrity would be violated. If, ultimately, the decision is the woman's, Dr. Montwell is suggesting that in some or all cases it would be the professionals who made a decision, irrespective of the woman's view. It is open to that interpretation. As someone who believes that, in the event of the passing of this legislation, it is absolutely the case that the woman must have the final say - she cannot be compelled - then I believe we need an elaboration in respect of point five, please. That is the only reason I highlight it.

Dr. McCabe's executive summary states that claims have been made that some women are suicidal because of the pregnancy only. She goes on in the same paragraph to say that psychiatry has little to offer this group. Given the contribution of my colleague one moment ago I would have thought that psychiatry certainly has a role to play and that the whole purpose and intent of the intervention is to assist, to help and to prevent the woman from taking that course of action, and that this is where we would work from at all times. Fully 0% is what we want to see, not any percentage. I find that a most unusual point in Dr. McCabe's executive summary.

Not to pass on Doctor Malone's contribution, but I wish to ask a question in respect of Dr. Ó Domhnaill's submission. One sentence of his stretches the boundaries of credibility - that is, his suggestion that those psychiatrists would be more likely to approve abortions if this Bill becomes law. In the context of Article 40.3.3° still standing, in the context of the extent of the wider interest in and the requirement to report all such decisions directly to the Minister of the day and in the context of the legal measures that many are uncomfortable about and that could be taken in the event of any abuse, does Dr. McCabe really believe that there are

professionals in our psychiatric services in this country who would do as she has suggested and would take the risk if were only from a selfish point of view?

Deputy Mattie McGrath:

I welcome our guests and thank them for the frankness and honesty of their approach. I will ask them a question I asked earlier. The X case judgment stated that abortion could be the only way of treating suicidal ideation. Is there psychiatric evidence for what that judgment presupposed, namely, that abortion is a form of necessary mental health treatment? The heads of the Bill also provide for abortion where it is the only way of avoiding a real and substantial threat that a pregnant woman will commit suicide. Are the guests aware of any in-depth studies that indicate that abortion can be the only way of avoiding the real and substantial threat of a pregnant woman's committing suicide or even that abortion can be a form of genuine mental health treatment? I think the guests have already made their position on this clear.

Unlike Deputy Ó Caoláin, I do not have the confidence that he expressed in the hearings that took place in January. The guests might expand on their view that the Government has ignored the evidence presented here last January. They believe there is clarity on the position already in the guidelines and that the guidelines would have sufficed.

Chairman:

Does Dr. Montwill wish to reply?

Dr. Jacqueline Montwill:

Deputy Kelleher asked if there had ever been a case of suicide in a crisis pregnancy. That is the difficulty, in that there is no data. What we are probably assuming is that some of the 5,000 women who go abroad are suicidal at the time they make that decision but we do not know if they are suicidal when they have a termination. We do not know, for example, if they bought their airline tickets and then changed their minds. We do not know how many women are suicidal on returning home. We also do not know how many women regret the procedure or would say they have no regrets. We have no data and that is the problem.

Many assumptions have been made. For example, Professor O'Keane described a 20% suicide rate in women of childbearing age, but that does not mean that is in any way related to crisis pregnancy, just because the women are of childbearing age. How can we not say that perhaps some of those women who committed suicide were women who had a suicidal reaction to an abortion? There is no data. A great many assumptions are being made. If members look through the submissions, they will note that many of them have no evidence or references in this respect.

The Deputy's second question was why a psychiatrist would ever prescribe a treatment that is not a treatment. I agree, but the problem is that we do not think we are prescribing this treatment; rather, as was said earlier, we will be certifying eligibility. Let us see if can we certify eligibility and what the eligibility criteria are. There are no such criteria, because if a woman has mental illness or an acute crisis reaction, she will be in a state of crisis and people will recognise that. Even when people have a simple crisis in their lives, they will not be able to think straight. That is okay and can settle down within a day or two. If people are in that

state, their capacity will be affected. We have to make, supposedly, in this law, a judgment that the woman still fully understands what is going on, has full capacity, is saying she is suicidal and meets the criteria that suicidality will mean that abortion is indicated when there is no evidence that it is, but we also have to make sure the woman is not so distressed that her judgment is impaired. As we know in our mental health practices as consultant psychiatrists, those patients' judgments are impaired and we never impose any life decisions on those patients at such times. We say to them: "Please wait; you are not in the right frame of mind, and in a day or two, or when the medication takes effect, things will be different." We have no criteria by which to apply a test for this law. It does not exist.

The research that Professor Casey talks about involves the worst cases we can think of - patients who are extremely unwell, in a psychiatric unit, and all, as far as a consultant psychiatrist is concerned, at the highest risk possible for committing suicide. In that situation, in which one would think we would have a very good prediction rate, we do not; we can only predict 3% of suicides. In all our assessment cases we make a full assessment and examine all the pressures surrounding the patient and why he or she is suicidal at this time. For example, we examine what has happened to this woman who is pregnant, what are her supports, whether she had mental illness previously and whether there was a risk of suicide. That is all part of our assessment.

Deputy Ó Caoláin asked for an elaboration on consent. That is the issue. We have three broad groups of women. The first group is women who have severe mental illness, which could include psychosis or depression. The definition of psychosis is that people can have strange ideas that are not true but they resolve with treatment. The second group consists of those with adjustment reactions. One can have a depressive reaction with suicidal ideation. This is in the psychiatric classification of diagnosis, and it settles with treatment. Both of those are classified in terms of mental illness. The third category includes people who are in a life crisis but have no mental illness. It could be rightly assumed that valid consent to an abortion must be given when there is no impairment of judgment and the person has the capacity to make that decision.

Moving on to Deputy Mattie McGrath's question, in terms of the X case judgment, the problem is that there is no study indicating that abortion can ever alleviate a real and substantial risk to the life of the mother. Professor Fergusson's research is incredibly important in this regard. In his hypothesis he examined whether abortion reduces rates of mental health problems in women with unwanted or unintended pregnancies, and for this reason he looked at all the research. When he was contacted he rightly said, with regard to the explicit question of a woman being offered an abortion when she is suicidal, that research had not been done. One could understand why that would happen because no doctor will offer a woman an abortion when she is acutely suicidal. I have grave reservations about colleagues stating that they think the timeframe should be reduced. If one had a woman who was acutely suicidal, one would help her get better so that she had a good capacity to make judgments about what she wanted in her life. That is all we are saying. When somebody is acutely suicidal the particular issue is that the person cannot make judgments and the person is not looking to the future. If somebody is truly suicidal, the person sees no future.

Dr. Bernie McCabe:

I find it difficult to follow on in answering a number of those questions because Dr. Montwill has answered many of them. I emphasise that there is a difference in the groups of people

about whom I have specifically talked. I have talked about the mentally unwell, including people who have suicidal ideation and people with crisis pregnancies who are despairing and distressed. One can imagine one's self in a crisis. If one crashed one's car into a bollard, one would not be able to think straight for the next five minutes. Imagine how a woman would feel on discovering she is pregnant. It may take her a week, two weeks, three weeks or a day - it depends - to come to terms with it, but there are many problems in terms of her thinking processes during that time. I have dealt with those. We can help in those situations.

The situation in which we cannot help and in which we have no role is that of a woman who does not have any of those thoughts. A person can drive into a bollard and say to himself or herself, "I drove into a bollard - no problem." One can have a person with a crisis pregnancy who is a little bit more resilient and who does not get upset but finds herself before a psychiatrist because her GP is not quite sure what to do. The woman may say: "I am pregnant and I do not want to be. I have been told to come here, so here I am." Our job is to assess that woman and determine whether she has a mental illness and whether she has psychiatric or psychological sequelae with which we can or cannot help. If we cannot find anything to help her with, then we have no role.

We have people coming to us all the time as a result of the recession, as Dr. Seán Ó Domhnaill mentioned. We have a number of people coming and going. A person will present and say, "I cannot pay my mortgage. I am not depressed but I am distressed and I do not know what to do. I was sent here; what can you do for me?" As a psychiatrist, I can make sure the person is not ill. My psychiatric services are multidisciplinary, thanks to the junior Minister for Health, and I can make sure that my multidisciplinary team have nothing to offer the person. If we do have something to offer the person, then we do so, but if we do not, I can direct that person to outside services such as MABS, the bank or the social welfare officer. That is what I mean by that statement. There is a different group whose situation was not addressed earlier, and I am trying to address that.

Chairman:

Does Professor Malone wish to make a comment?

Professor Kevin Malone:

I was asked if there was evidence in this respect.

With regard to Ireland, we have heard of four perinatal psychiatrists. It is important to bear in mind that consultant psychiatrists throughout Ireland manage the bulk of pregnant women. They refer to perinatal psychiatry if there is a particular problem around childbirth and for a period after but for the vast majority of the time it is the consultant psychiatrists of Ireland who are looking after women in pregnancy with any type of mental health difficulty.

This may be related to Deputy Kelleher's question. There is a challenge in predicting the future. Once that question is asked, one will never be certain about how one will predict the future. That is true of any clinical medicine; it is not just related to psychiatry.

In relation to the X case, to which I referred at the start of my presentation, that psychological evidence is 20 years old and we do not know how it would relate to modern psychiatric practice, but it is worth bearing in mind.

Dr. Seán Ó Domhnaill:

I had better respond to the question about why I might have concerns about head 4 in relation to the assessment of colleagues who might deem people as being suicidal and who might be prepared to sign off on forms that would allow them to travel for abortions or to have abortions because of mental health issues. Quite honestly, the reason is that I have worked in other jurisdictions and in the very first jurisdiction in which I worked where abortion was legal, which was Jersey in 1997, I saw consultant colleagues at that time who signed off in advance. I remember one particular individual who had a pile of forms pre-signed, and the reason for that simply was that the ideology of that individual was completely pro-choice and they had so little regard for the unborn child or for the rights of the unborn child. My concern is that we would reduce the value of the life of the unborn, as this Bill seeks to do for the first time ever. This is the first time a piece of legislation seeks to allow any human being in this country to be killed. That is how serious this is. We outlawed the death penalty. The only person at risk in this country at the moment of having a death warrant signed is an unborn child.

Deputy Ciara Conway:

I thank our panellists. I have a number of questions arising from the previous questions of my colleagues and the witnesses' subsequent answers. Dr. Montwill spoke about abortion being a social solution and her colleague, Dr. Bernie McCabe, articulated that there are often social solutions to problems that confront people with mental health difficulties, that they work in a multidisciplinary way, that it is not always just a question of medication or some intervention, and that there can be social stressors. By that very deduction, is abortion not a solution to somebody who is facing a crisis and who is suicidal? If the person does not get that intervention, what do we do with them? What is the alternative? I would like to know the witnesses' thinking on that.

I raise a second issue. We have had 13 consultants before us today. I asked a question this morning and I will ask it again of the witnesses. If I was in crisis today, how long would it take me to get to the services provided by the witnesses? That is a crucial question in terms of the pathway and engagement for women who are in crisis. It is very important because no woman would be lucky enough to have the access we have had today to 13 consultant psychiatrists. That is a point worth making.

In terms of the evidence we have heard from some of the other psychiatrists who were before us today, Dr. Anthony McCarthy said that suicide in pregnancy is a real risk and that there will never be evidence because it is such a rare event. I would like to hear the witnesses' views on that because it is very important. For me personally, as a legislator, that struck a chord in that even if it is only one, that is one too many.

Senator Jillian van Turnhout:

To take up where Deputy Conway concluded, Dr. McCarthy told us this morning that suicide in pregnancy is a real risk. He concluded by saying, "It does happen." Professor Malone

spoke about the therapeutic alliance. My question is: has he ever involuntarily admitted a patient? Surely it could be argued that involuntarily admitting patients is in breach of a therapeutic alliance. Earlier, Dr. McCabe stated that these are social issues and, accordingly, psychiatry should not be involved. There is not always one pathway. With the current financial backdrop we know that many other social issues are a factor when people end up availing of the witnesses' services. Life is messy and interlinked.

Earlier today we heard compelling examples of children in the care of the State who were impregnated by their fathers and sought psychiatrists in those situations. We heard about a woman with anorexia, and the X case. We know that very often there is distress, stress, and mental disorder, and that is what we have heard already today. I am trying to put myself in the shoes of that one in 500,000. I listened to Dr. Malone give figures on male and female suicide. My role as a legislator is to protect everyone and not to say that that is not a sufficiently large figure for us to examine. If I am that one in 500,000, what happens in those situations? Do we put our heads in the sand, knowing they will go to the United Kingdom? Is that the solution we are proposing, or do we ensure that the treatment is available for them and not tell them to wait two weeks? This one in 500,000 is a rare, extremely stressful case. These women are not in a logical, rational place. If I am that one in 500,000, what would the witnesses say to me? It does happen.

Deputy Mary Mitchell O'Connor:

I thank the expert witnesses. I refer to Dr. Anthony McCarthy's contribution earlier. We heard he was the president of the College of Psychiatrists of Ireland and that he was also an assessor on the confidential inquiry into maternal deaths in Ireland. I find it difficult. The witnesses are the experts and we are here genuinely trying to go through the information. Dr. Ó Domhnaill stated that it is extraordinary that the Government has seen fit to disregard all the accrued evidence in proposing legalising abortion on the grounds of suicide, yet we have heard different views from the psychiatrists, not just from masters of hospitals or anyone else. I assure the witnesses that we are genuinely trying to go through this information and take on board what is being said.

Dr. McCarthy said earlier that women should be able to avail of assessment which is individual, comprehensive, compassionate - that is very important - and not prejudged. I ask the psychiatrists before us if women coming to them will be prejudged.

Dr. McCarthy asked us to ask all the witnesses if they had ever signed a form under the Mental Health Act for the involuntary detention of a patient because he or she was at risk of endangering himself or herself.

Could it be foreseen that this might have to be done for a pregnant woman? If so, how would the case be managed? The witnesses mentioned the three in 100 that they are unsure of and I would like to know how they can be dealt with.

Senator Colm Burke:

It is important to clarify that the master of the Coombe hospital was invited before us together with the representatives of the other hospitals on Friday.

Chairman:

I did so.

Senator Colm Burke:

People from six hospitals gave evidence on Friday. There has been criticism about the lack of legislation and it is important to refer to the judgment in the X case, particularly on page 82 of the judgment, where Mr. Justice McCarthy criticised the Legislature for not putting in place laws. The eighth amendment to the Constitution "guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right." The Supreme Court judgment criticised the Oireachtas for not putting in place laws to fully implement the amendment to the Constitution at Article 40.3.3°. It was 20 years ago that the Oireachtas was criticised in this respect and the courts indicated a need for legislation. In the judgment the courts relied on just one medical report, but the system we are discussing would have a requirement for reports from three medical practitioners. Which is the better option? There is nothing preventing the courts, in the absence of legislation, from putting their own interpretation on the Constitution at a future date, so legislation may clarify the issue.

Dr. Montwill referred to the need for support services in hospitals. In the 19 maternity units around the country, does she feel there is adequate support from psychological and counselling sources? Is there a need for a more structured procedure to be established in units around the country?

Chairman:

Five other speakers are indicating so I would appreciate if the witnesses would give their replies now.

Dr. Jacqueline Montwill:

Deputy Conway spoke about abortion being a social solution and asked about the alternative. We must be very honest. There are only two options: the woman either will have her baby or she will not. The issue is whether we can accurately assess and diagnose somebody as suicidal so as to be eligible, under this law, for an abortion. The problem is that we cannot do so. We cannot say which woman will commit suicide and, more broadly, we cannot say which patient will commit suicide. It is important to understand that research has shown that we should be considering why the woman is seeking an abortion. Is the partner or boyfriend gone and is the woman on her own? Does the family know she is pregnant or is she on her own there as well? What are the pressures with regard to study and work? What coercive pressures will be placed on the woman in making her choice?

The alternative is a proper support care pathway for the woman when she presents and indicates she has an unwanted pregnancy and does not know what to do. That is if she feels suicidal. When we do our assessment, we must assess - as we do with every suicidal patient - whether immediate treatment is required, if the person must come to the hospital or if she can be treated in the community, if medication is required and if there is evidence of a depressive illness. We must consider whether there is evidence of an illness that leads people to commit suicide when pregnant, such as severe mental illness or psychosis. The two women in a million are not women with crisis pregnancies but with severe mental illness.

Considering maternity rates in the UK, it has been indicated in research that the women committing suicide have severe mental illnesses that are either under-diagnosed or inappropriately diagnosed. There is no reduction where abortion is freely available. They are not getting full and proper treatment, which is the issue. These women need best practice and full assessment. We should not skimp on that but this law will skimp on it.

A second issue is the idea that suicide in pregnancy is a real risk. It is absolutely a real risk. We deal with it all the time in pregnant women, and the highest risk is in the post-partum period. We are very aware of that, but it is not what this law is about. Listening to the four previous contributors, one can see that what we are talking about is not women with mental illness but rather women with a firm belief that they do not want to be pregnant. If a woman goes to a doctor and states that she is suicidal and will kill herself because of an unwanted pregnancy, if this Bill becomes law no psychiatrist will be able to say that this woman will not kill herself, and women will be processed through this law. They will also miss out on proper assessment, which is a problem.

Deputy Regina Doherty:

How will women miss out and not get a full assessment?

Dr. Jacqueline Montwill:

That is what I am concerned about. For example, I have heard that there is a reduction in time to 72 hours. The Bill is proposing that the period be seven days. If a person presents as being acutely suicidal, mental illness will respond to treatment, but only over time. If the person has severe depression or psychosis, antidepressants normally take four to six weeks to take effect. That is the nature of the disorder. We do not know how long acute crisis and adjustment reactions take, as it depends on a person's circumstances and how they present. Sometimes patients present with acute adjustment reaction on Friday evening and by Saturday morning, if they are in hospital with one-to-one support from nurses, they feel much better. It can be a wonderful thing. A young female came to me one morning and said she could not believe she was not suicidal. I had told her the treatment would work but she did not believe it at the time, although it worked. We have to hold with our patients while the treatment works. That is what we do. If a woman is acutely suicidal, she should get full and proper assessment and she should have the full assessment of the team. She should be admitted to hospital only if she needs to be admitted, as she may have psychosis or severe depression. She may have overwhelming anxiety or a partner who is abusive or violent or is coercing her to have an abortion. This assessment must provide that knowledge to her treating doctor, or else she is being skimped on and is not receiving proper assessment. That is the issue.

There are no different views in how we deal with patients. We always deal with patients in a non-judgmental way, and a psychiatrist cannot be shocked, as we have heard it all before. There is no problem at all in hearing alternative life views or choices, as it does not matter. Our only role is to see whether there is a treatable psychiatric illness and to ensure it is treated promptly and appropriately.

Senator Burke spoke about the X case judgment. The problem is that the judgment was made with full integrity because the worst-case scenario presented itself. This was a 14-year-old girl who had been violated and raped and who stated she was suicidal, which is completely understandable. The girl went on to have a miscarriage, but the X case legislation was

enacted for the C case, which was again a worst-case scenario of a suicidal girl. Our immediate instinct is to make it better; we say to junior doctors that they should not treat their own anxiety but rather that of the patient. What, in hindsight, was the best treatment for the patient? It was to manage her pregnancy in a safe and protected place, probably a hospital but perhaps a supported house or with her family. We now have the evidence, in hindsight, that she stated she never wanted an abortion and was never told about it. It happened, and she has been suicidal since. We must stick to best practice clinical guidelines and medicine, regardless of how distressing is the presenting complaint.

Dr. Bernie McCabe:

I repeat that what seems to be intuitively correct may not be so. In the past we have had debriefings for people who were involved in crises *en masse*, which has proven to be damaging. It looked good and sounded right but it was damaging. We now offer that service to people who want it. If we offer abortion when we know there is no evidence base, we are not being fair, right or just to our patients. Our patients deserve that we be just.

The members are asking us why we are not offering these people these things: because it is not the right thing to do. We do not have the evidence base. Do the members want to receive a treatment that is not evidence-based, that has not been proven? I would not think so. I think that is okay; I am happy to go along with it. I will wait for the evidence. It may come.

The question about a pathway to services is a bit unfair. In fairness, services differ across the country. Efforts are being made to regularise those services and I again compliment the junior Minister for Health on her efforts in that regard.

Deputy Ciara Conway:

How long does it take?

Dr. Bernie McCabe:

At the moment patients have access to casualty and to any psychiatric service upon referral from their GP. If Deputy Conway is asking me my times, that is unfair. I can give them, and they are good, but it is unfair to other people who operate under different circumstances with different difficulties, so I will not.

On the question about social issues, I will stand over what I said before. If a cardiologist sees a patient who is having palpitations because he or she cannot pay his mortgage, the cardiologist will check that patient out, do an ECG, perhaps an angiogram and other things. If the heart is normal, the heart is normal and the cardiologist cannot deal with it. If you transfer that over to our slightly different situation, if there is no mental illness or distress, we have no role. We have outside services beyond our multidisciplinary teams to which we can refer people, and we do that. I remain adamant on that question.

Professor Kevin Malone:

I think the question about pathways to service was a good one. We are currently in Dublin 2. One would go straight to St. Vincent's University Hospital where there is a protocol under which one would be seen, assessed and triaged psychologically and psychiatrically within

eight hours. If one was identified as having a treatable mental illness one would be referred on to a community psychiatric team in Baggot Street or Irishtown and one would hopefully be afforded the full complement of clinical services. I would like to think that would be the same around the country. Unfortunately, it is not, but it is really important in all this to have evidence of good clinical practice. It gives hope and leadership. It is a good question.

The question on involuntary admission and therapeutic alliances is a fantastic one. They are both fantastic questions, but that is a particularly good one because it is a real challenge to treat somebody under an involuntary certificate and working longitudinally with a therapeutic alliance. It is something we do all the time and it is part of what we do. I would point out that there is still no evidence that abortion is a treatment for a mental illness. While Dr. McCarthy's point about suicide in pregnancy being real is correct, there is still no evidence that in those cases where a suicide death has occurred in pregnancy and there was a treatable mental illness, abortion was the right treatment for that person. Again, I come back to the four clinicians from the perinatal psychiatry service over the last 20 years, and indeed all psychiatrists around the country. I have not heard one psychiatrist say he or she has found a case in which abortion was a treatment for mental illness.

Dr. Seán Ó Domhnaill:

On the issue of pathways to care, I concur with my colleagues. Apart from the fact that we have 24-hour accident and emergency cover, I know that in the service with which I work any patients identified as posing a significant risk are seen within a matter of hours. Suicide in pregnancy is rare and, as my colleagues have pointed out, tends to be associated with the more severe manifestations of mental illness, such as psychotic depression. The treatment in that case is to treat the psychosis and depression. The patient, when she recovers, would be fairly upset if she thought a doctor had ended her pregnancy because she was depressed or psychotic. The doctor would probably be sued.

I have to make this point to Senator van Turnhout. We cannot cover all the angles. She mentioned the one case in 500,000, but how many lives is she prepared to sacrifice for that one case? Once you open the gates - once you legalise abortion on mental health or suicide grounds - they are open. If we look at Britain, where in 1967 there were just under 80,000 abortions and last year there were just under 200,000, we can see the price they paid. It is over 4 million. It is a question that is worth reflecting on. It is something that we should all reflect on, as members of society.

The question was raised of what to do when one is presented with incredibly difficult cases. I have no doubt I have been presented with some of the most difficult, bizarre, unprecedented, GUBU cases that I could ever have imagined. Thanks be to God, and my colleagues, the patients have survived. We do what we do best. We manage psychiatric emergencies. I am very confident in the service, particularly in the emergency psychiatric service provided in this country. It is excellent. It is unfortunate that the Minister for Health and other politicians might feel it necessary to impugn consultant psychiatrists, but I can honestly say that most of my colleagues work far beyond the number of hours requested in their contracts.

On the question of why have the fear that somebody is going to sign these forms if suicidality is not a ground for abortion, again, ideology is an incredibly strong thing and there are those who cannot see beyond their ideology. I believe and hope that as clinicians - many of us consider ourselves somewhat vocational in our work - we are able to go beyond our own

ideologies to provide the best possible treatment. However, the people who are watching and who will read the record of this hearing now and down the years may wonder what we were so afraid of. We read the newspapers. It is not often I get time to read them any more, but I do read the newspapers. The newspapers feed cynicism, if one is holding cynicism, and they have been particularly feeding it recently. A newspaper that I do not buy-----

Chairman:

Please do not identify it.

Dr. Seán Ó Domhnaill:

I will not. Members can take it for granted. This newspaper reported that Members of the Oireachtas were playing games in an attempt to get the Government to commit political suicide. Several hundred thousand people in this country read that report. How about dealing with that?

(Interruptions).

Chairman:

I will chair the meeting. There are six speakers and a half an hour remains in this session. I ask Members to co-operate with the Chair in speaking to the heads of the Bill. I will call Deputies Peter Fitzpatrick, Catherine Byrne, Denis Naughten and Senator Jim Walsh in that order.

Deputy Peter Fitzpatrick:

I welcome the witness and thank them for appearing before the committee. If a patient is suicidal and suffering from mental illness would that person be legally compelled to give permission for an abortion in accordance with head 4? When a patient is suicidal will the provision of full-time care, which includes close observation, reduce the risk of self-destruction to a significantly low level? I asked that question at the last session and I never got an answer. If a patient is suicidal but not suffering from mental illness which medical treatment can be given? If a patient has stated that she is suicidal but not suffering from mental illness what criteria will be used by a psychiatrist to decide that a real and substantial risk of suicide exists?

Deputy Catherine Byrne:

My questions have been asked already. I want to make one or two remarks. I found the witnesses' comments interesting and sometimes disturbing. I came here to listen and to learn. That is my job at the hearings. There is nothing dark and cynical in this room. We have been at the hearings since Friday, which will continue until tomorrow, to listen to everybody's side of the story and their views. I do not question the witnesses' integrity and it is wrong to question ours. In his last statement Dr. Seán Ó Domhnaill said, "I sincerely hope that they display the integrity expected of them by the people of this nation". I take offence to that statement. Many of the women sitting here are mothers. I have beautiful children and, unfortunately, had five miscarriages. I know what it is like to lose a baby at 23 weeks and what it is like to hold a baby in my hands when it is born naturally. I can only imagine the

dismay women go through when they have to go down the line of having an abortion or a termination of pregnancy. I do not think it is something that any woman does lightly.

Deputy Denis Naughten:

May I pick up from Deputy Peter Fitzpatrick's last question. If a woman does not have medical or mental health issues what advice can be given to her if she is suicidal or how should be treated or should she come under the category as provided for in head 4? I want to ask Professor Kevin Malone about comments made on Friday about bad science by Dr. Peter Boylan and Professor John Crown. Professor Kevin Malone stated in his written evidence that the field of clinical assessment of suicidality in psychiatry has not reached any kind of validity or reliability in relation to predicting suicide. How then can the legislation, which clearly states in regard to suicide intent that it can be the only mechanism for treating a person with suicidal ideation, be implemented based on the report he has given to the committee? What are the psychiatric clinical procedures for the assessment of suicidal risk? We were told this morning that an assessment can be made in two to three hours. Dr. Seán Ó Domhnaill said it is a subjective assessment but we were told here this morning by his own college that there are many clinical markers which are reliably used, while not absolute, to assess suicidal intent. His college is telling us one thing and he is telling us something different. Perhaps he will clarify that. Dr. Jacqueline Montwill made the point that women in this situation need help and support from psychiatrists but will they go to the psychiatrists if provision is not made in head 4 or some other head or will they not just travel to the UK? By going to the psychiatrists here, does it mean that more of those women will not have a termination and will see that pregnancy through?

Senator Jim Walsh:

I will individualise my questions which may make for shorter answers. My first question is to Dr. Jacqueline Montwill. She states that suicidal feelings and thoughts can change and disappear - we got this evidence previously - so that one day a patient can feel suicidal and next day the patient is not suicidal. That raises certain issues regarding the validity of certification. How does she think that should be dealt with? She also mentioned that mental illness responds to treatment. To my surprise, Dr. McCarthy said this morning - I am not a professional in this area - that there is no treatment for suicidality which astounded me. Perhaps Dr. Montwill would comment in regard to that issue.

Chairman:

To be fair, I do not think he said that.

Senator Jim Walsh:

He did say that. Dr. Bernie McCabe mentioned that, "It is not necessary for the medical practitioner to be of the view that loss of life is inevitable or immediate. This in my opinion is a very low bar". How does she think we can deal with that issue if the bar is very low? Is she saying that the Bill will lead to more liberal abortion in Ireland? Dr. Sam Coulter-Smith and some of the witnesses this morning said that may be the outcome of this legislation. I am seeking her opinion in that regard.

Dr. Kevin Malone sent us a very interesting paper on 28 December 2012, in anticipation of appearing at the January hearings. He said that based on new research, knowledge and understanding of the epidemiology of suicide in Ireland there is a greater likelihood that this legislation will contribute to an increased risk of suicide in Irish males through foregrounding suicidality within the State for females consequent to this legislation. In other words, an amplifying cultural suicide signal through a normalisation effect. He also says it will have implications for non-pregnant young females. Will he please comment on that because I found that quite alarming.

My next question is for Dr. Seán Ó Domhnaill. We met Miss C last week. I understand she was the only person whose case was taken up by the State as a consequence of the X case. With regard to the psychiatric profession, we have seen in other jurisdictions and in Britain that it given rise to a situation where abortion has become very liberal.

Chairman:

The Senator's time has expired.

Senator Jim Walsh:

What is it about the Irish profession of psychiatrists that would make it different from those and give us an assurance that will not happen here?

Chairman:

The Senator is being unfair to other colleagues. I call Deputy Regina Doherty to be followed by Senator Aideen Hayden who is replacing Senator John Gilroy.

Deputy Regina Doherty:

My first question is for Professor Kevin Malone. In his written testament - he also said it - he said he has a great concern that given that termination or abortion is not a treatment for suicide he questions how it can suddenly become a recommended psychiatric treatment overnight on the passing of this legislation. Will he explain how and why he feels it will, given that psychiatrists say they will not prescribe it because it is not treatment for suicide?

Dr. Bernie McCabe said earlier that there is no criteria to medically assess a woman in a crisis pregnancy who is suicidal. What does she do today? If a woman presents to her who is suicidal because of a crisis pregnancy is she saying there is no assessment today to actually treat her? Will she please explain what happens?

Dr. Bernie McCabe:

There is no criteria to medically assess a woman who is suicidal.

Deputy Regina Doherty:

Dr. McCabe said earlier that there is no criteria to medically assess a woman in crisis pregnancy who is suicidal. I beg your pardon, it was Dr. Jacqueline Montwill who said that.

Dr. Jacqueline Montwill:

Did I?

Deputy Regina Doherty:

Will she please explain to me what she would do if a woman who is suicidal because of a crisis pregnancy presents to her today?

Chairman:

I will take the final speaker, Senator Aideen Hayden.

Senator Aideen Hayden:

I support the comments made by my colleague, Deputy Catherine Byrne, in regard to Dr. Seán Ó Domhnaill's comments. I appreciate that the witnesses are present voluntarily but my understanding is that we are here, on a point of information, to put a legislative framework on existing medical practice as set out on foot of the constitutional amendment, on foot of the Supreme Court ruling and a requirement of the European Court of Justice on the Legislature. I was struck by a number of the categorical statements made by some of the contributors. To reiterate them - mental illness is as important as physical illness. I agree with that.

The second statement was that there is no way of predicting who will commit suicide. The third is that we do not categorically know the motivations of the 5,000 women who leave this country.

I shall return to the questions raised by my colleagues Deputies Kelleher and Ó Caoláin. Why would a psychiatric colleague prescribe a treatment that does not stem from an evidence base? The evidence that was given to the committee on Friday from other colleagues was that this was not a feature of the Irish medical profession and they did not regard it as a serious threat. There seems to be an element of mistrust among members of the medical profession; they do not trust other colleagues.

I was struck also by a comment made by speakers who suggested that the judgment of a woman who presented as suicidal was "impaired" and, as such, nothing that the woman would say, in effect, could be believed, for want of a better word. In other words, her threat of suicide could not be taken as a real threat. I was struck again by statement made by the girl at the centre of the X case, who stated that she only became suicidal after treatment was withheld from her. Can that be reconciled?

I want to ask Dr. Montwill a specific question. Given what she claims is a lack of evidence, can she guarantee - and I use the word "guarantee" in a legal sense - that a woman who presents as suicidal can be cured by her without ever having recourse to termination of a pregnancy?

Chairman:

I call on Dr. Montwill to commence. There are 20 minutes left in this session, and we will finish at 5.31 p.m.

Dr. Jacqueline Montwill:

I want to clarify the issue of impairment of judgment. If any patient presents to the psychiatric emergency department with a severe mental illness, an adjustment crisis reaction in which she is threatening suicide and saying "I am completely upset, Doctor; I can't think straight," or severe symptoms of mental illness, then, during that emergency time, her judgment is impaired. That only means that we ask the patient to come into hospital or offer to treat her at home where our nurse can go and see her. If at that time the law says that the patient has full capacity to make the decision about an abortion, then that is the issue, not whether she is suicidal. We believe that what patients say is true for them. We always believe what the patient says because that is part of the clinical presentation. The issue about capacity is this: are you suggesting that we should offer an abortion to a woman who might be seriously psychotic, who might be severely depressed or who might be suicidal in a crisis reaction, when perhaps her judgment is impaired just for that period? What we are saying is that we should treat the woman, and when her judgment is more robust, then she will be able to make that decision - not when she is acutely suicidal.

Senator Hayden asked whether I can guarantee that any woman who is suicidal can be cured. We aim to cure all our patients, but the problem with suicide is that there could be an impulsive thought that comes into the patient's mind or there could be outside circumstances that we do not know about. The tragedy of a completed suicide must be assessed completely. The most important thing is whether the person got a full and proper assessment and proper treatment, whether he or she was complying with the treatment and whether we were managing him or her as closely as possible. We can never guarantee that a person will be completely cured. We would hope to.

Senator Aideen Hayden:

The answer is "No."

Dr. Jacqueline Montwill:

It cannot be guaranteed in any element of medicine. There is one other matter, however. The criteria that the Government has put into this legislation are not true criteria to assess suicidality. They are pretend criteria that it has made up to assess eligibility for abortion, but no such criteria exist. We cannot tell who will commit suicide, but we can say to every one of our patients that we will treat them as if they are going to commit suicide and we will make it as safe as possible for them.

It was stated that I said there were no medical criteria for assessing crisis pregnancy. I am pretty sure I did not say that. If I did then I must have been nervous. No; there is no question of anybody not getting the proper assessment, and that is the issue here. The problem is that the discussion is now moving from women with mental illness to women with no mental disorder. I have a little bit of an issue here, because I wonder at what point a woman will be completely over her crisis, will be completely adjusted and will have no mental disorder. My colleagues described that scenario earlier this morning, and I can see the scenario in front of me. It is a woman who comes in and says, "Doctor, I have an unwanted pregnancy. I have a right under this law to an abortion and I am telling you now that I am going to kill myself." We say, "We will treat you anyway, but we are going to put you through the pathway to see the panels." We ask the patient if she will see our psychologist, if she will give us the full

background, and if we can talk to her partner or family. She says, "No, I don't want any of that. I just want the abortion. I am telling you now I am suicidal." In those circumstances we will continue to offer treatments, but the woman will now go through into this process. In law there is no psychiatrist on the panel - as we said, we cannot guarantee anything - who will be able to say the woman will not commit suicide, so it is a direct pathway. What is happening, though, for that woman in crisis? Why will she not allow the assessment? What are the pressures being put on her? It would not be out of the range of possibility that a partner has urged the woman to go in there and tell us she is suicidal. That is my point. She is not getting a proper assessment.

Deputy Regina Doherty:

Can I ask a question?

Dr. Jacqueline Montwill:

Yes.

Deputy Regina Doherty:

The law as it stands refers to circumstances in which all other treatments have failed and where abortion is the only option. In that scenario, it is not the only option.

Dr. Jacqueline Montwill:

Exactly. Absolutely.

Deputy Regina Doherty:

Just because I am saying "No, I do not want the other option," it does not mean the law is changed.

Dr. Jacqueline Montwill:

I agree. The problem is when, as our colleagues this morning said, the woman is refusing all treatments. The reality there is that of course there are other options, but she is refusing them. That is her right. If she has no mental illness, in our practice we have to say, "These are our treatments and we offer them to you. Come back if you want them. Can we phone you tomorrow?"

Deputy Regina Doherty:

Then the patient does not qualify for eligibility. She is not eligible.

Dr. Jacqueline Montwill:

A woman who will come in and say, "I am entitled to my abortion. I am telling you now that I am going to kill myself"-----

Deputy Regina Doherty:

She can say what she likes but she still will not qualify.

Senator Fidelma Healy Eames:

There is a very low bar.

Dr. Jacqueline Montwill:

The point is, that sentence is nonsensical. One cannot say abortion will ever be the only treatment. That is the point. This law does not make sense. That situation does not exist. There are loads of treatments.

Chairman:

Does Dr. McCabe with to reply?

Dr. Bernie McCabe:

With regard to the low bar, I think that was a reference to Professor Casey's submission online. This is a timing issue. The explanatory note to head 2 states that it is not necessary for the medical practitioner to be of the view that loss of life is "inevitable or immediate." It does not clarify how far into the future one should consider the risk to apply. Could it be six months, two years or ten years? That is the point that is being made. There is no bar. This can extend to anybody at any point in her life. I hope that I have answered the question.

With regard to having no way of predicting suicide, we do not predict suicide very well. I mentioned that specifically in my earlier speech. We are very good at risk assessment, though. We do a lot of risk assessment and we do it very well. We put a lot of people into the high-risk category and we monitor a lot of people as a result. However, we have no real way of knowing who is going to proceed to suicide. We just do not. We know this from various studies. We have done studies ourselves, and there have been actuarial studies that did not involve practitioners. They basically told us that we are not good at predicting who will commit suicide, so we should not try to do so; we should be over-cautious and keep monitoring the high-risk people. That is what we do. We will never be able to predict. If we could predict - and it would be very nice if we could - we would not have any suicides.

With regard to mistrust of colleagues, I am not quite sure what that is referring to. Does it refer to the letter that went to the college on Friday morning because some members did not have access to the text of the college's submission? I am not sure if that is what is being talked about. That is an area of concern to members that will play out.

There was a question about whether a determination that a patient was lacking in judgment meant that we did not believe the patient. That is not the case and never will be the case. A lack of judgment is not necessarily a lack of capacity. It ranges all the way from being upset to not being able to form thoughts properly because one is psychotic. It encompasses a wide range and does not mean the patient is not believed. It does need psychiatric interventions of all sorts, ranging from psychotherapeutic interventions to admission, if necessary, and medication, if necessary. It does not equal not being believed. We do not refuse to believe our patients. We have no choice but to believe them, and we want to believe them. That does not

mean we do not assess them. We will always assess them very thoroughly, and the assessment does not take two hours for every patient.

For some, it might take two hours; for others, it might take two weeks or two months, depending on the circumstances. Who is to judge? We do not decide that until we get the patient before us. That really needs to be clarified. These matters are not written in stone. I hope that is helpful.

Professor Kevin Malone:

I will try to answer two questions. The first relates to the science question. I refer the committee to a paper I wrote in the *American Journal of Psychiatry* in 1995 about clinical versus research assessment of suicidal behaviour in major psychiatric disorders which refers to the strengths and weaknesses of any type of predictive modelling, which was obviously peer-reviewed by international scientists.

The second point I make is that, because suicide in pregnancy, at 500,000:1, is such a rare event, it is statistically impossible to construct any type of predictive modelling. That is where we stand on that. One will never be able to construct a predictive model.

The third point I address relates to the question I have raised about normalisation through an amplified signal and in this legislation, writing suicidality into Irish law. I have just published a study on suicide in Ireland where the problem is very particular to young men and there is a clustering problem in young men. These young men are frequently at the margins of society and they are vulnerable. I think introducing something that makes suicidality okay for some people for certain social needs really creates a challenge for Irish society.

Then, on the second point, if one increases inadvertently male suicide - we have done a study of female suicides - there is a two-year lagged effect. When male suicide rates increase in Ireland, two years later one will get an increase in the female suicide rates. We have documented that over a 15 year period.

Dr. Seán Ó Domhnaill:

Obviously, there was a misunderstanding in relation to someone stating that there were clinical markers for suicidality. We live off clinical markers. They are what we use to carry out assessments. In fact, I contributed the piece to the college's paper specifically on this because in the Bill it refers to the fact that there are no clinical markers and I said, "No, no. There are clinical markers. The problem is that there are no laboratory tests", and that is what the Bill should actually have said.

In terms of the Irish profession and in what way is our profession different specifically to our English-speaking colleagues in Boston and Birmingham, to whom I think we are closer than Berlin, the more time I spend in Boston and Birmingham the more I realise that, really, there is very little between us. All of the evidence is there. One need only look at one's children the way I look at mine and one will see that they are mimicking what they are seeing on television from America and Britain.

I am surprised - I am sorry I missed the Deputy's name because I could not see the sign-----

Chairman:

Deputy Catherine Byrne.

Dr. Seán Ó Domhnaill:

I am surprised and, I suppose, a little disappointed that the Deputy feels insulted or upset by my, for want of a better word, cynicism. I am actually not that cynical but, unfortunately, I must be quite honest with the Deputy and tell her that I voted in the last general election as an Irish citizen and I voted for the party that told me it would not bring in this piece of legislation.

Chairman:

The heads of the Bill, if Dr. Ó Domhnaill does not mind. We are on the heads of the Bill.

Dr. Seán Ó Domhnaill:

I should respond to Deputy Catherine Byrne. It would be rude not to answer her question. I suppose, having voted for Fine Gael-----

Deputy Regina Doherty:

Apologise with impunity. Dr. Ó Domhnaill is doing it again.

Chairman:

I will Chair the meeting. I thank Deputy Regina Doherty.

Deputy Regina Doherty:

Bizarre.

Dr. Seán Ó Domhnaill:

-----I am a little bit upset that I find myself here having to speak on a Bill that they told me would never present itself before the Oireachtas.

Dr. Jacqueline Montwill:

I did not answer one question about criteria as to whether a patient with suicidal ideation would be legally compelled in terms eligibility. We will treat our patients regardless, but this pathway will ask psychiatrists to assess eligibility for an abortion process and, I suppose, we do not have criteria. The problem about that is that while I can see from earlier today that one of my colleagues described that he has already certified children, at least under the age of 16, perhaps 14, as eligible for an abortion procedure, I do not know what criteria he used. Criteria for that assessment does not exist. I am very concerned. There was no indication that any of these assessments had been monitored, there were no numbers coming out etc. That is the problem here. We do not have appropriate criteria to assess what the Government thinks we

can do, which is eligibility for abortion. We have criteria to assess for risk factors and the best practice way to treat our patients when they are suicidal.

Deputy Regina Doherty:

The question I asked Professor Malone was based on his written submission in which he asked how can it suddenly become a recommended psychiatric treatment overnight by passing this legislation. Can he explain why he thinks that it will, given that all psychiatrists have stated that it is not a treatment for suicide?

Professor Kevin Malone:

I do not think it is a treatment. If it comes into law and it is approved that psychiatrists are expected to deliver or to sign-off on it, one is proposing *de facto* that as part of a treatment plan. There is no evidence to support that.

Chairman:

We are now moving into the section of the meeting for non-members. Eight Members have indicated the wish to speak and there is half an hour available. If I could get everybody in, it would be great. However, I will not be able to and I apologise in advance. I take Members' names as I see them and as they indicate, and there is no bias on the Chair's behalf. The first three are Senator Healy Eames, Deputy Terence Flanagan, and Deputy Timmins, in that order. Deputies Mulherin and Senator Bradford are the next two after that.

Senator Fidelma Healy Eames:

I am struck today by the 13 or 14 psychiatrists we have had before us, by the care and compassion each of them has displayed and the holistic approach they use to assess their clients and patients. I am inclined to conclude, and agree with Dr. Ó Domhnaill, that abortion is a medieval solution to crisis pregnancy. How - he may have a legal opinion on this - can we clarify the law to satisfy the European Court of Human Rights without writing new law?

Chairman:

That is for tomorrow.

Senator Fidelma Healy Eames:

It is, but Dr. Ó Domhnaill may have taken legal advice on this. This was his question. How can we clarify the law to satisfy the ECHR without writing new law?

Chairman:

We are dealing with medical evidence today. To be clear, it is psychiatry in this session.

Senator Fidelma Healy Eames:

As a country we have the luxury and the benefit of looking at the evidence in so many other countries. We have the benefit of being compassionate here. While some say we have done

the wrong thing by waiting so long, I believe we have done the right thing. We are in the top five in maternal health care in the developed world.

This question is to each of the psychiatrists. Given the difficulty of predicting suicide with accuracy, how many unborn babies' lives do we have to take to save possibly one in 500,000 lives, especially when there could have been a more appropriate treatment for the pregnant woman?

I understand Professor Malone is a leading world expert in suicide. Is he gone?

Professor Kevin Malone:

I am here.

Chairman:

Senator Healy Eames did not yet scare him off.

Senator Fidelma Healy Eames:

I am sorry, I did not see him.

I am conscious of the following question. With this Bill, are we in danger of validating suicide in Irish society which is already at epidemic levels as a real option by legislating for it as a way to procure an abortion? I put that question to Dr. Sheehan this morning and he stated he has grave concerns. We must seriously look at what we are doing. We are here to look at abortion but we also may be legitimising suicide which is very dangerous.

Deputy Terence Flanagan:

I will be brief. I have three quick questions.

The first is to Dr. Montwill. I note a previous speaker, Senator Walsh, asked about indications of the extent to which suicide ideation strengthens or weakens over a given timeframe, or even disappears.

Perhaps the witness can comment on the Bill because there were calls earlier regarding the review process, to reduce it from seven days to 72 hours.

I also have two questions for Professor Malone. In this legislation psychiatrists will not only be asked to assess whether a woman is suicidal but also to certify that the only treatment is to terminate the pregnancy to address suicidality. Does Professor Malone think abortion is ever the only treatment to terminate a pregnancy? If not, what other treatments in current clinical practice in this country would be offered to someone who is suicidal? Does the Mental Health Act offer any guidance in this particular area?

Regarding the X case, part of the test for an abortion on suicide grounds is that as a matter of probability there must be a real threat posed to the life of the mother by way of self-destruction. Can psychiatrists judge as a matter of probability whether someone will commit suicide? Can Professor Malone point to any published research supporting his answer?

Would Professor Malone contend that this part of the X case test is generally unachievable from a psychiatric perspective?

Deputy Billy Timmins:

I apologise if I was trying to badger the Chairman a little bit in the last session, but I had a few important points to make. I would like to ask the panel about Women Hurt. I was deeply offended at the last session when Dr. Ferguson stated that people who are dissatisfied set up pressure groups.

Professor O'Keane said that there are 150,000 women out there who have had abortions and - I forget the exact terminology - not that many must have been affected because they have not come forward. Have any of them come forward to the witnesses? My understanding is that Women Hurt was invited in here and everybody was invited to hear them. They sent an invitation to everybody. They are still available for people to talk to. My understanding is that many of the people in that organisation have lied about the impact of their abortion and have not even told their psychiatrist about the abortion. They just recount their difficulties and look for a cure without coming up with a solution. I would like to hear the witnesses' views on that.

There appears to be a division and while it is not a clinical matter, it is important. This morning I asked Dr. McCarthy about the survey he referred to concerning 113 or 120 people. He questioned the accuracy or authenticity of it. One of the other speakers did also. Perhaps the witnesses could elaborate on that. I was surprised when I heard Dr. Sheehan. It appeared to me that he had not participated in the College of Psychiatrists survey, although I may be wrong. I would like to know if the witnesses got the one from the college, of which there are 864 members. Do we know how many people responded to that? I asked that question this morning but I did not find out. Perhaps the witnesses have that information.

I have a couple of points following Professor O'Keane's talk this morning. I will be brief but it is important. These questions are for Professor Malone. Professor O'Keane made a written submission on 9 May, which was circulated this morning.

Chairman:

We cannot deal with that now, Deputy.

Deputy Billy Timmins:

Yes, but there were slight differences in her verbal submission. I am wondering which one will go into the record. I want to clarify a few things in case the record-----

Chairman:

The record will reflect the written submission and will also reflect the testimony given at the hearing today.

Deputy Billy Timmins:

Okay, so there will be a slight difference. That is fair enough. In her written submission, Professor O'Keane states that-----

Chairman:

Your time is up.

Deputy Billy Timmins:

-----the vast majority of people who kill themselves tell someone that they intend to do so and, therefore, should be believed. I think that is a very profound statement and will have an impact. From my brief understanding of suicide and the bereaved families I deal with, very few of them in that tragic situation seem to have been told, or knew anything about it, beforehand. Is there any evidence to sustain that? Perhaps that point could be clarified.

Professor O'Keane's written submission stated that in situations where abortion services are not available, unwanted pregnancy is a leading cause of suicide. In her verbal presentation this morning, she said it was a leading cause of death.

In Ireland in the 1950s, 10% of Irish women who killed themselves were pregnant. Do we have a figure on what the number was? Of the 10% who killed themselves when pregnant, do we have any statistics on what the basis was? Was it as a result of the pregnancy or prior mental health? Perhaps Professor Malone can answer those questions.

Deputy Michelle Mulherin:

I have two questions. As regards the first one, I would appreciate it if the experts could give me a specific answer. As regards the heads of the Bill, the current position on the interpretation of the balance between the life of the mother and the life of the unborn is given in the X case. We are told by the Government that this will tighten up the situation and, in effect, make it better. As regards the tightening up and the clarification, I might guess how the experts will answer, but can they say whether they are in agreement with that, whatever they think or do not think about the X case? The current practice requires the X case with all its unknowns. The witnesses are operating under the X case at the moment concerning such matters. This legislation is supposed to provide clarification and tighten up things, as we are told, but I wonder if the witnesses agree that it does so.

The second question is a bit broader and comes back to the whole issue of treatments. A lot of us are hopeful and Dr. Montwill spoke in a very hopeful manner about addressing people who are in distress and seeing them through. That is very reassuring. We would all place a lot of significance and importance on the need for treatment. Unfortunately, I did not get a chance to speak when Professor O'Keane was here. I would like to have put the question to her to clarify it, because she is the main proponent of this position. When one treats somebody with a mental illness or psychosis, that treatment is invoked under the psychiatric services. If a person does not have a psychiatric illness or psychosis, they are not getting treated.

However, Professor O'Keane is envisaging another situation which is that a woman is suicidal because of her pregnancy, does not have psychosis or a mental illness but is in a heightened state of distress. As a lay person, I would think that if a person has a mental

illness or psychosis, that is obviously more quantifiable by the witnesses. As regards somebody who is very distressed but does not have a mental illness, can that person even be treated? We are all reassuring ourselves that people are going to get treated, but is there actually a treatment for such a person who does not have a mental illness? In that situation, and accepting what Professor O'Keane says, are the witnesses saying that this person is very upset and really believes - this is not about duping somebody or having them on - that they need to have a termination and therefore there is nothing the witnesses can do for them in that situation because there is no treatment where there is not a psychosis or a mental illness?

I would like to have some clarification. In my lay person's view, surely if I put myself in that boat, not having a psychosis or mental illness that I know of, and if I am in a heightened state because I am distressed because of an event, could the witnesses not talk me down? I would say that such people would be less likely to need suicide protection compared with a person with a mental illness. I would like to hear the witnesses comment on that.

Chairman:

I will go to the panel now and call Dr. Montwill.

Dr. Jacqueline Montwill:

I will try to answer that question first but I might need, if you do not mind, Chairman, to get-----

Chairman:

Four people have offered to ask questions so I will come back to them if the panel so allows.

Dr. Jacqueline Montwill:

I will answer that question. We are in a quandary here because some of our colleagues are describing that this law will be used for people with no mental illness. If anyone comes to my clinic or our emergency department where our junior psychiatric doctors are, and they are distressed for any reason, we will admit them. If they are suicidal and pose a risk to themselves, or if they are so distressed that we are very concerned about them, we will do a proper assessment. That sometimes takes two or three weeks and at the end of that assessment we will be able to formulate a proper diagnosis and a treatment plan. I do not know when a woman in a crisis pregnancy is going to go from having the acute adjustment reaction where she is saying, "This is the worst thing in my world; I want to kill myself; I cannot deal with this," to having no mental illness. I would follow that woman all the way through anyway if she ever had a situation where she was thinking of suicide.

However, we have to make a distinction in that, with this law, there will be women who will present with a firm belief that they are entitled to an abortion and who we can say, hand on heart, have no mental illness and will threaten suicidality. That is the issue. What do we do for those patients? I would say to them that they should not be threatening suicide, that suicidal ideation is not a good mindset to be in, and therefore let us do our assessment. However, if the woman is saying she does not want any of that, and when we have no concerns that they have a mental illness, we are in a quandary.

I will outline what we would say in our practice. In the case of a woman who came in and about whom we were absolutely sure, after a two-week assessment, that she had no mental illness, we would be able to say to her that we were terribly sorry, that we could not stop what had happened to her and that she had a crisis pregnancy. We would be able to say to her that while she was saying she was suicidal and that was not a good place in which to be, there were all these supports to which we could link her, including all the supports in the community, as well as being able to monitor her and make sure she was okay. However, after our assessment, we could tell her that she did not have a mental illness but had a crisis reaction.

The problem is it is very difficult to say, if a woman does not have mental illness and presents, in this law, that we will not be able to offer a treatment if she does not want one. This is what the people who are advocating the law are saying and we must address that issue about saying what we would do. We have situations in our practice in which people threaten suicide and do not have a mental illness. They come in and ask for different things to happen in their lives, but after our assessment, we know they do not have a mental illness. We say to such people that they do not have mental illness that would respond to treatment but they have a huge problem with their mortgages or with their partners who are being completely unreasonable or with other stresses such as bullying, etc. and we will divert them to the proper treatments and supports for those problems.

It is confusing and, to be honest, I am half-confused myself because I will treat any patient who comes to me when he or she is distressed, and while we will not send anyone home, the people who advocate this law want to get out of the way of saying the patient has a mental illness because they know abortion is not a treatment for mental illness. Consequently, they now are saying that in the case of a patient who does not have a mental illness but who is saying she intends to kill herself, surely she should be able to have an abortion for that reason. All I can say about that is we do not have a test to be able to say who can commit suicide. Consequently, the problem is we have no criteria of which we know and if the Government insists on this, there is no way any psychiatrist can state that a woman will not commit suicide. That is all we can say. I do not know if that answers the question.

Dr. Bernie McCabe:

I wish to answer Senator Healy Eames's questions as well as the question about the survey and the poll. In respect of how we predict and what must be done to predict suicide, we know we are poor predictors of suicide and I have mentioned this several times before. A number of studies show they are all over the place. While I am sure Professor Malone would add by a factor of ten what I will give to members, these studies also extend to actuarial studies. Even the latter, which were not done by psychiatric professionals and are purely statistical, have proven the prediction of suicide to be highly unpredictive, even in the high-risk groups. A paper produced in 1983 by Pokorny states the number predicted as being likely to die by suicide was 35 times greater than the number who would die. In other words, we over-predict and as a result have false positives. I hope that answers Senator Healy Eames's question. We are very poor at it. If one equates this to the number of pregnancies, that is a startling and distressing number.

Senator Fidelma Healy Eames:

May I add a tiny-----

Chairman:

No.

Senator Fidelma Healy Eames:

It is about the number.

Chairman:

No. Thank you. Dr. McCabe may proceed.

Dr. Bernie McCabe:

In respect of the survey, there are two pieces. First there is what I will call a poll, for want of a better word. Three colleagues and I, who know one another from different areas and are friends outside of work, Dr. Montwill being one, were discussing our concerns about this law and decided to ascertain how many others had concerns. We tried to identify as many working consultant psychiatrists as possible. While the Irish college has a list, we were not allowed to use it because it is not used for such purposes. We generated 302 names - I believe there are approximately 350- and sent out a postal questionnaire with a statement in respect of the evidence base. Arising from that, we received at least 130 responses. As the numbers continue to rise, I cannot really be sure precisely what number we have reached but we got 130 respondents. While 14 agreed with the proposals as indicated going through, more than 120 did not. This means that 90% of respondents to the poll did not agree with the proposals or had concerns about them. This indicates the level of concern among our consultant group.

As for the other issue regarding the college, on the Friday before the bank holiday weekend - I am unsure of the precise date - the college sent out an e-mail to more than 800 members. These included all levels of training and qualification-----

Chairman:

I ask Dr. McCabe to stick to the Bill please because-----

Dr. Bernie McCabe:

This was asked of me.

Chairman:

I know, but the joint committee is not dealing with the college because, unfortunately, that is outside our remit. It is not part of our remit.

Deputy Billy Timmins:

Chairman, I sought this information this morning from the college.

Chairman:

Okay, but I would rather Dr. McCabe did not answer because, with respect, this is not part of our remit. We are not discussing the college.

Dr. Bernie McCabe:

It relates-----

Chairman:

Thank you, I will chair the meeting.

Dr. Jacqueline Montwill:

It is important.

Chairman:

I understand that, and I am responding to the question.

Dr. Bernie McCabe:

A number of members seem to want me to answer this question.

Chairman:

No, I will chair the meeting, with respect.

Deputy Billy Timmins:

On a point of order, this information was given out this morning by Dr. McCarthy-----

Chairman:

May I make the point-----

Deputy Billy Timmins:

----- and it informs the debate.

Chairman:

With respect, may I just make the point-----

Deputy Billy Timmins:

The impression was given that-----

Chairman:

----- that our remit is not that of the college. This is the Joint Committee on Health and Children and we are not dealing with what the college does or how it does its business. That is not within our remit.

Senator Fidelma Healy Eames:

The information comes under our remit.

Chairman:

No, it does not.

Senator Rónán Mullen:

On a point of order-----

Chairman:

No, I am not taking it. The Senator will be coming in shortly.

Senator Rónán Mullen:

Yes, but there is a point of order that is outstanding.

Chairman:

You may go ahead.

Senator Rónán Mullen:

Earlier, the Chairman advised Dr. McCarthy that he might or might not answer a question as he saw fit. The same test should apply here.

Chairman:

Okay, I accept that as a fair point. However, if you do not mind, I would prefer if we did not get involved in the politics of the college.

Senator Rónán Mullen:

I understand that.

Chairman:

While I know you wish to draw us into that controversy, I do not.

Senator Rónán Mullen:

Please, that is not fair.

Dr. Bernie McCabe:

The politics are not fair.

Chairman:

I know, but I would prefer if we simply dealt with the heads of the Bill.

Senator Rónán Mullen:

I was only asking for consistency.

Chairman:

I know and understand that.

Dr. Bernie McCabe:

Okay, well I would have been prepared to answer the question.

Deputy Billy Timmins:

That is really unfair. The impression was given that the submission represented 864 members or whatever number was given by the president of the college. Let us find out. Why are we afraid of this information?

Deputy Mattie McGrath:

On a point of order-----

Chairman:

All I wish to do is to protect the joint committee from becoming involved in the issue which has no bearing for us at all.

Deputy Peter Mathews:

It has a huge bearing. It was misleading.

(Interruptions).

Dr. Bernie McCabe:

Shall I proceed with the answer?

Chairman:

In the interest of fairness, Dr. McCabe may go ahead.

Dr. Bernie McCabe:

My understanding is that 500 of these e-mails were opened and the college received 30 submissions. The problem that exists is the college did not allow a draft text to be circulated and the members of the college are uncertain that their views have been represented in full. That is the answer to that question.

Professor Kevin Malone:

I will try to answer two questions that emerged. One was a question on legitimising suicidality. The question actually was about legitimising suicide, and I do not think that is fair. However, I think it potentially is legitimising suicidality, and that has the potential of running interference at deeper levels in Irish society than those to which we are giving full thought. That would be my feedback on that question. I heard someone mention Dr. Sheehan's grave concerns, and as a result of this, I would share his concerns in that area.

The other question that came up was about communication of intent, which is a good question because communication of intent does increase the risk. In other words, people who say they are going to do something are more likely to do it. Unfortunately, one still remains in the realms of extremely rare. When one is trying to predict something that is as rare as one in 500,000, even though one can improve the odds, one will not improve them anywhere into the range of having any type of predictive validity. Consequently, the answer to communication of intent is yes, it increases the odds. For example, as I mentioned, we have more than 15,000 presentations to accident and emergency each year, many of which involve people who have made an attempt on their lives. While it may not have been of high lethality, they have made an attempt on their lives. The vast majority of these people will not take their own lives. Again, one is entering into the realms of statistical theory.

Dr. Seán Ó Domhnaill:

I will respond to three points. One pertains to the issue of proportionality of risk and I suggest this is something that probably could be brought up with the legal experts because recent Supreme Court rulings have changed the position on the measurement of proportionality and that in turn will have had an impact on the X case, in so far as it now applies in law.

Second, in regard to how one responds to somebody who looks one in the eye and threatens to do something unless one provides them with the specific treatment they seek, in the case of the Bill if someone is demanding an abortion or that they be given whatever it is they require to get an abortion, it would not be a new scenario. I have worked most of my life in inner city Dublin. I have had many hundreds of patients, at all hours of the day and night, look me in the eye and tell me that if I did not provide them with the specific treatment they wanted at the time, they would kill themselves. They usually referred to throwing themselves under a bus. The specific treatment they sought was invariably chemical and it was usually named benzodiazepine. To date, none of them went out and completed the act, despite the fact that none of them were given the specific treatment they requested. They were, however, given the treatment I would expect to give to anybody who was in an acute state of distress, which is support, counselling and time, which is probably the most important thing one would ever give to someone in psychiatry. Time allows them to come down from that heightened state and begin to look at their situation with a little more clarity so that there is more light when the heat subsides. I hope that psychiatry provides people with hope because in my experience that is probably in any age, and in particular in this recessionary interval, the best thing

psychiatry can offer, certainly not the counsel of despair which is what I would consider the recommendation of abortion as a treatment to be.

Chairman:

For the information of Deputy Timmins, I draw his attention to page 4.2 of the written submission of the College of Psychiatrists of Ireland. It states that the submission re the heads of the Bill has been agreed by the council, the elected decision-making body of the College of Psychiatrists of Ireland. It states that in a college with more than 864 members there would be a wide range of opinions with regard to the sensitive issue of abortion, reflecting the deep divisions in society about the issue and, therefore, they are confining their comments to the general scheme of the heads of the Bill rather than any overall comment about abortion.

Dr. Jacqueline Montwill:

There are no data to support Professor O'Keane's point on approximately 10% of Irish women dying. This is all supposition. In Irish society most people know of an aunt or single woman who, because of society's norms at the time, committed suicide because she was pregnant. One would hope that would not happen in modern Ireland. There are no data to suggest that such a high rate existed. Dr. Dermot Walsh wrote a letter to that effect to *The Irish Times* and he has been the inspector of mental health hospitals for many years.

The other issue I wish to clarify is that there are no data for any of the assumptions on the suicidality of women who are going to England. If women have mental illness, we hope that their first port of call, their GPs, would be able to assess it, or their family, and we have to advocate that in society so that all mental illness is treated. That is the issue at stake.

It is important to reiterate what Dr. McCabe said on the submission from the college. We received the email on Friday. There are approximately 350 consultants in the college but I am not sure about the exact numbers. We sent in our submissions and only 30 of them were received by Wednesday evening. An emergency meeting was held on Thursday and a draft was supposedly unanimously agreed. We have no idea what was in the draft. None of us saw the text of the submission. We repeatedly asked about it by e-mail on Thursday and Friday and we were told it would only be published on Monday. I have not read the submission because I did not have time today, except for two points: 72 hours is far too short to have some poor suicidal woman going through a process and being directed immediately to an abortion. That is an abomination. The second point is how the College of Psychiatrists in Ireland does not mention evidence-based treatment for suicidality. The public should be informed of the evidence base for every treatment for suicidality. I have serious concerns about the submission but I have not seen the text. That is the issue. We have not seen the submission.

Chairman:

Ten minutes remain in the session and five members have indicated. Unfortunately, they will not all get to speak. I ask speakers to be brief to help facilitate all five members to speak. That would be appreciated. First, I call Senator Bradford and Deputy Mathews, in that order.

Senator Paul Bradford:

I will be brief. I have two quick questions for the witnesses. Virtually every speaker who has come before the committee to advocate for the legislation uses the following line: “This Bill is about saving women’s lives.” Could the witnesses comment briefly on that because some, myself included, who might have concerns about the legislation, feel quite angry at the insinuation that people with questions about the Bill are somehow not concerned about women’s lives?

Second, a philosophical question is often asked of politicians, which is difficult for us to answer because we are politicians, but it might be easier for the psychiatrists to answer. It is what one would say to a parent of a 14 year old child who is a victim of rape or other dreadful crime. Is there a humane approach?

Chairman:

I thank Senator Bradford for being brief. It would be great if Deputy Mathews could be equally brief.

Deputy Peter Mathews:

I thank the witnesses for attending. I have a feeling this afternoon of great compassion, understanding, wisdom and professionalism. I thank them for that. I wish the Taoiseach and the Tánaiste were present for the hearings because this is their Bill.

Chairman:

We are dealing with the heads of the Bill.

Deputy Peter Mathews:

I know. We are even on the Title of the Bill.

Chairman:

We are not discussing the Taoiseach’s diary.

Deputy Peter Mathews:

I wish the Minister for Health, the Taoiseach and the Tánaiste were here. They are in America celebrating 150 years of a Jesuit college but the focus for this country is the committee hearings.

Chairman:

Does Deputy Mathews have a question?

Deputy Peter Mathews:

One woman taking her life is too many. One baby’s life lost while we mess around with law is too many. I fear not just one baby’s life will be lost but hundreds if we introduce the legislation under discussion. That is wrong.

Chairman:

I would appreciate it if Senator Mullen could be equally brief.

Senator Rónán Mullen:

I appreciate the job you are doing, a Chathaoirligh. One thing is clear to me having been present at the hearings for two days. The obstetricians are in agreement about the obstetrics, they are in disagreement with the psychiatry, and the psychiatrists are completely split. That tells its own story.

If I understand the situation correctly, and the witnesses might clarify if I am wrong, the one in 500,000 refers to women who commit suicide in pregnancy, and that is associated with mental illness. If I understand it correctly, it would be impossible to find that one person in the 500,000 and abortion would not be a treatment anyway. Therefore, what we are talking about is finding the cohort of women who say they will commit suicide and whom the earlier group of psychiatrists said must be believed. We all understand why that is important, but it seems they are not in the realm of medicine anymore and that they are really in the realm of certification, which might explain why Dr. Peadar O'Grady said this should not necessarily involve doctors at all. Is that the problem here, that to catch the cohort we are talking about, it is not a medical decision the psychiatrists are being asked to make? Is that the essence of their concern, that it is a question of some kind of intelligent guesswork they cannot do because they do not have the ability to predict who might or who might not? Do I understand the situation correctly?

Deputy Michael Creed:

I thank the witnesses. Sometimes I see the situation with great clarity and other times I am in an indeterminable fog. Perhaps the witnesses could tell me what the case is at present. In their professional lives on a daily basis, the witnesses before us and their colleagues this morning adjudicate on the clinical risk of suicide and they make decisions on whether to admit, commit or treat as an outpatient. In head 4, as I understand it, what they are being asked to do is determine that there is a real and substantial risk of loss of a pregnant woman's life by way of self-destruction. The previous speaker alluded to the risk of one in 500,000 which exists, rare and all as it might seem. Psychiatrists are not subsequently being asked to prescribe a termination.

Psychiatrists are being asked if in their reasonable opinion this risk can only be averted by a termination. If that is the best analysis of the individual situation, they are not being asked to prescribe any other treatment, they are being asked to include or exclude one option. Is it not the case that if it is their professional opinion that is at issue, and I accept the College of Psychiatrists of Ireland is divided on this issue, most agree there is no evidence for sanctioning a termination on the grounds of risk? Are they not really being given a veto in the legislation as a profession?

Psychiatrists are being given the ultimate authority and power. We are mere lay people trying to grapple with very complex issues but psychiatrists deal with the risk of suicide and it is not politicians who make the assessment, it is professional medical people; they are being given the power. Are we making a mistake that should assume that authority as non-professional people or are we right to give it to the people who have the best legal and medical training?

The psychiatrists are only being asked to rule out. I accept there is no evidence basis for including termination as a treatment so I would expect the psychiatrists, be they pro-life or pro-choice, to ground their decisions on best medical practice.

Deputy Bernard J. Durkan:

On the procedures to be followed by psychiatrists in the event of certain cases presenting, is it understood and accepted that there is a requirement to comply with the Constitution as determined in the X case by the Supreme Court? Notwithstanding whether or not a wish to have a termination may be based on one or other reason, to what extent do psychiatrists in general accept the need to be in compliance with the Constitution in so far as it has already been determined by the courts?

Dr. Seán Ó Domhnaill:

Senator Bradford asked about the purpose of the legislation. Having gone through the minutiae of the legislation at great length-----

Chairman:

To clarify, we do not have legislation yet, we have the heads of a Bill.

Dr. Seán Ó Domhnaill:

Having gone through the heads of the Bill, it scared the living daylights out of me. That was my response and I communicated that to many people I know. I felt it was extremely loose and the terms used were poorly defined, with many of the them not defined at all. There were many omissions and I came to the conclusion that this is not the protection of human life in pregnancy Bill, it is the legalisation of the killing of one of the two patients in obstetrics Bill.

On morbidity and mortality, for women who have had terminations, the figures vary. In 16 years of psychiatry, and I am not someone who is not extremely busy, I have never come across a case of a woman who has killed herself because she was refused an abortion, either in my own practice or in the practice of anyone I have ever worked with, and I have worked in at least 20 different psychiatric units.

I have, however, dealt with the families of people who have ended their lives as a direct result of having a termination. In 1992, the year of the X case, I had the unpleasant experience of losing a colleague on the anniversary of her abortion. These are the forgotten people. In the psychiatry textbook I used, by Professor Basant Puri, the quotation that always struck me, because the word "only" was used, according to a chapter written by two female British psychiatrists, only 10% of women who undergo abortions suffer severe and/or protracted sequelae from abortion. That suggests nearly 20,000 women per year in Britain and at least 400 women per year in Ireland. Where are they going and who are they going to? I treat probably more post-abortion women than anyone else in the country by virtue of the fact that I am an easily identifiable pro-life person who understands the trauma associated with abortion. They avoid the doctors who sent them, and they certainly avoid the clinics that sent them, because they feel they have been let down and not informed and were never given any indication at any point they could end up severely depressed or suicidal as a result of having

an abortion. Anyone who really cares about the welfare of women in this country should consider that as he or she looks at this legislation.

Professor Kevin Malone:

There was a statement about there not being any treatment for suicidality. There is a substantial evidence base for the treatment of suicidality. There is a series of dialectal behaviour therapy studies by Marsha Linehan and there is a very strong cognitive behavioural therapy literature on the treatment of suicidality within and without of major depression and other psychiatric disorders. Marsha Linehan's work deals specifically with people who do not have access one psychiatric disorders, in other words people with personality difficulties who experience high levels of suicidality, who can be very effectively treated in terms of reducing the experience of suicidal ideation and attempted suicide. That is worth noting for the record.

Dr. Bernie McCabe:

I would like to think I try to save the lives of women who are suicidal every day, we all do, and so do most of my colleagues, despite the idea that is going around that there is dissent in the college.

Dr. Jacqueline Montwill:

There is a sentence that this Bill is about saving lives. It is not about saving lives because we want to work to save the life of anyone who is suicidal regardless of the costs. This Bill is about providing abortion procedures.

I remind the committee that the IMO defeated all those motions and during that time a motion was put to the IMO to change the words "abortion procedures" and to put instead "evidence-based, life saving treatment" and that was refused. All of the motions that wanted abortion procedures were defeated by the IMO and the ICGP.

Our survey was the equivalent of saying to colleagues that this is not right and asking what they think of what the Government is doing, regardless of any opinion of it being pro-choice or pro-life. We sent our letters to consultant specialists in the medical directory at their own addresses they had put in. It is my opinion that half of those letters did not get to the right address because the consultant had most likely left any home address. I think there are many more than 120 respondents who think we should not be involved in this because there is no basis in the medical literature available. That is the key; it is nothing to do with religion or being pro-choice, it is about the evidence base.

The actuarial equivalent number of babies is 35 to save one woman. The last question related to a humane response to a victim of rape and her family. Patients who have mental illness are heroic because society does not understand them, they carry a stigma and are fighting a losing battle and we must do our best to advocate for mental illness.

Moreover, sometimes the circumstances of a patient's family, home and social life are horrific. I would say to every patient: "I am terribly sorry this has happened to you and while we cannot stop what has happened, we can ensure you receive the best available treatment and support and we will take care of you." That is what should have happened in the case of the 14 year old girl. It may appear that we will lock up the girl, that is not the case. The

reality is that when the adjustment reaction settles, she may no longer be suicidal. What is not being understood in this debate is that suicidality reduces, sometimes only with psychological support. A problem shared is a problem halved. That is the cliché and the reason people offload. As our colleagues will say, if the patient consents, members of the family will be contacted and the boyfriend or husband who may not be supportive may become involved in the treatment, which is very important.

Are we legislating for one in 500,000 women? The deaths of one in 500,000 women from suicidality are due to mental illness. Any cases members will have heard of that have come into the public domain - I do not know anything personally about these cases but I have read about them in the newspaper - are cases of mental illness where there was a systems failure. If there was a difficulty, abortion would not have been appropriate for any of the women in question and would certainly not have saved their lives.

Deputy Bernard J. Durkan:

No one replied to the question on compliance with the constitutional determination of the Supreme Court.

Chairman:

To be fair, that issue is probably not relevant, although it will arise tomorrow when we discuss constitutional law.

Dr. Jacqueline Montwill:

On the view that psychiatry is divided, I will do everything I am meant to do by law. I will treat my patient, regardless of whether she is going for an abortion and if she has an abortion, I will treat her afterwards. I have come here to explain to members that what the Government is asking us to do does not make sense and is not based on good medicine. As doctors, we have to stand up and say this is not good practice. Best practice is full appropriate assessment.

Deputy Bernard J. Durkan:

What is the witness's view on the Supreme Court determination?

Chairman:

If I need help chairing the meeting, I will ask for it.

Dr. Jacqueline Montwill:

So many questions were asked. I do not accept the outcome of the Supreme Court case because the judges stated there was a real and substantial risk that could only be averted by abortion. That is never the case because all real and substantial risk can be averted by treatment and assessment. There were some problems with the decision.

Chairman:

I do not propose to rewrite it.

Senator John Crown:

I apologise for leaving the meeting for a while; I had to attend at the hospital. With great respect to my professional colleagues, I also live and work daily in the world of evidence-based medicine.

Chairman:

I ask the Senator to put questions rather than engage in commentary.

Senator John Crown:

If I have a patient in front of me - there are sometimes two patients in front of me in one person - I will never make a decision that it is not the right decision for the patient. No one is ever going to ask physicians to do that. However, we are constitutionally bound as a result of Professor Binchy's interventions 30 years. The ambiguous constitutional position in which we have found ourselves, despite five referendums and a Supreme Court judgment, means there is no legal way that we can exclude suicidality as a potential cause. If the evidence base in medicine dictates that abortion is never the right thing to do, all psychiatrists will be asked to do is tell the patient before them that abortion will not fix their suicidality and refuse to sign off on an abortion. Why can that not be the case?

Dr. Jacqueline Montwill:

I can answer that. Colleagues have already stated that they want to have a panel of doctors who will not obstruct the process. I presume, therefore, that there will be some kind of bias. The second issue is that, as we have stated from the beginning, there is no way we can say which patient will kill herself. To be honest, I am not sure how many women with a crisis pregnancy have committed suicide. However, we can never say that it could not happen. Under the proposed legislation, if a woman tells the panel she will kill herself, what psychiatrist can say she will not kill herself?

Deputy Michael Creed:

Did Dr. Montwill not indicate that psychiatrists assess that risk every day?

Dr. Jacqueline Montwill:

We assess that risk to aid our treatment. We decide, for example, that a patient needs to be in hospital or in a clinic.

Deputy Michael Creed:

The preliminary question is whether termination is an appropriate treatment for the patient's condition as she presents. If it is not appropriate, the psychiatrist will indicate that is the case and may well indicate in a footnote that she should be treated in a different fashion.

Dr. Jacqueline Montwill:

The point is that the panel will never be able to say that a woman will not kill herself and the request will, therefore, be passed. As one can never say a woman will not kill herself, the request will be passed.

Dr. Seán Ó Domhnaill:

To respond to Senator Crown, he knows my position on abortion. It has been made clear by some of the psychiatrists who have appeared today that anyone who holds my position on abortion should be excluded from the panels. If all doctors who believe that abortion is not a treatment for suicidality are excluded, we will be left with certain psychiatrists and their friends. We are relying on the Oireachtas to provide a safeguard. That is the simple truth of the matter.

Senator John Crown:

On a point of information, the evidence base in medicine is available for all doctors who can all see the same evidence. There is not different evidence for different doctors.

Chairman:

Members may not make points of information. I thank most sincerely Dr. Jacqueline Montwill, Dr. Bernie McCabe, Professor Kevin Malone and Dr. Seán Ó Domhnaill for taking time to come before the committee voluntarily to assist us.

Sitting suspended at 6.15 p.m. and resumed at 6.30 p.m.

Other Medical Specialties

Chairman:

We will now resume in public session. I remind witnesses, Members and those in the Public Gallery to switch off their mobile phones. This is our eighth session in our series of hearings on the heads of the protection of life during pregnancy Bill. I thank Mr. John Saunders, Dr. Janice Walsh, Ms Eileen Lawrence and, when he arrives, Dr. Kevin Walsh, who are here today to assist us in our analysis of the heads of the Bill. I hope Members will come in to the Chamber for this session because our witnesses have come to this meeting voluntarily. I thank the witnesses for their attendance and apologise for the late start.

Before we commence, I remind witnesses that they are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter but they continue to do so, they are entitled thereafter to only a qualified privilege in respect of their evidence. They are directed that only evidence connected to the subject matter of this meeting is to be given and are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the House or an official, either by name or in such a way as to make him or her identifiable.

Dr. Kevin Walsh has sent his apologies - he hopes to be here by 7 p.m. I now invite Mr. John Saunders to make his opening statement.

Mr. John Saunders:

I thank the Chairman for his invitation to this meeting.

As the Chairman and members of the committee will be aware, the Mental Health Commission is an independent statutory body established in April 2002 pursuant to section 32 of the Mental Health Act 2001. The commission was established to perform the functions conferred on it by that Act which was commenced in full in November 2006. The role of the commission is to promote, encourage and foster high standards and good practices in the delivery of mental health care services and to protect the interests of persons detained in approved centres. The commission's remit extends across the broad spectrum of mental health services. Mental health services are defined in section 2 of the Mental Health Act 2001 as "services that provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist".

The procedures referred to in the heads of the Bill do not fall within the definition of mental health services and by extension are not within the remit of the commission. All references to the Mental Health Commission in the heads solely relate to the registration of a centre at which the psychiatrists involved must be employed. There are two references to the Mental Health Act 2001, both of which indicate that this Act provided guidance to assist in the drafting of the relevant heads. The Mental Health Commission notes that the committee is seeking its views on how the proposed legislation will operate. The heads of the Bill clearly specify that operational matters will be the responsibility of the Health Service Executive, HSE, and agencies providing health and social care services on behalf of the HSE under section 38 of the Health Act 2004. It is suggested by the commission that the HSE and relevant Section 38 agencies are best placed to advise the committee on operational matters.

The regulatory body for an "appropriate location", as defined in head 1, is the Health Information and Quality Authority, HIQA, only and not the Mental Health Commission. The regulatory authority for the relevant medical practitioners is the Medical Council. Formal medical review procedures will be the responsibility of the HSE, which shall be required to establish a panel of relevant experts populated with nominees from the relevant colleges, including the Irish College of Psychiatry. Therefore, there is no role for the commission, under any of the heads, in assessment or oversight.

The Mental Health Commission, from its experience in implementing provisions of the Mental Health Act 2001, has a number of general comments on the heads of the Bill which, in the view of the commission, may assist the committee in formulating its report to Government.
On head 1, interpretation,"psychiatrist" means a medical practitioner who is registered in the specialist division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007, under psychiatry. The commission suggests that clarification is required to ensure inclusion of relevant specialties within psychiatry, for example, child and adolescent psychiatry. The term "self-destruction" is used in the heads of the Bill but the commission notes that there is no clear definition provided. There is no legal or medical dictionary definition of self-destruction.

Head 6, subhead (4) refers to the appointment and authorisation by the HSE of one or more of its employees with appropriate qualifications and experience for the purposes of establishing and convening a committee for the purposes of a review. It is unclear as to what constitutes "appropriate qualifications and experience". The Mental Health Act 2001 may provide guidance in this regard, specifically section 9(8), and the Mental Health Act 2001 (Authorised Officer) Regulations 2006 (S.I. Number 550 of 2006), whereby the grade of person who is authorised to perform the role of an "authorised Officer" is prescribed.

On head 4, clarification is provided in the explanatory note that the two psychiatrists involved must be employed at an approved centre and one of them must be attached to an institution where the procedure will be carried out. The Mental Health Commission advises the committee that the above criteria may exclude psychiatrists working within specialist community mental health services, as they are not always employed at an approved centre, that is, a centre that is registered by the Mental Health Commission. A requirement that one of the psychiatrists involved must be attached to an institution where the procedure is to be carried out is a further restrictive criterion, as there are only three such psychiatrists in the country and they provide services on a part-time basis in the Dublin region only. The explanatory note refers to self-destruction as "suicidal intent". However, this term is not specifically stated within head 4 or in the interpretation section, head 1.

On head 5, the Mental Health Commission is of the view that the reasonable opinion of the medical practitioners should be required in writing, following an examination of the woman concerned and the reason(s) for the opinion should be provided. The definition of "examination" in Part 2 of the Mental Health Act 2001 may be of assistance to the committee. With regard to certain procedures under the 2001 Act, an examination means "...a personal examination carried out by a registered medical practitioner or a consultant psychiatrist of the process and content of thought, the mood and the behaviour of the person concerned".

The heads of the Bill are silent on a mechanism for appealing a decision of a review committee. I will now deal specifically with the heads of the Bill *vis-à-vis* a person under the age of 18.

The heads of the Bill are silent on a requirement to hear, consider and document the views of a woman who has not yet reached the age of consent. Furthermore a child who has a mental disorder and is receiving care and treatment for that mental disorder in an approved centre is detained under section 25 of the Mental Health Act 2001. A decision, for example, on the administration of electroconvulsive therapy may only be provided by the District Court. The heads of the Bill are silent on children detained under the Mental Health Act 2001.

Dr. Janice Walshe:

I thank the Chairman and members of the committee for the invitation to express my opinion as a medical oncologist on the proposed heads of the Bill as presented for cancer in pregnancy. I am a consultant medical oncologist in both St. Vincent's University Hospital and the Adelaide and Meath Hospital, Tallaght.

Cancer is a disease of increasing age so while cancer during pregnancy is encountered, it is rare. International data suggest that it complicates approximately 0.1% of all pregnancies, therefore in the absence of published Irish data we estimate there are approximately 60 to 70

cases diagnosed in Ireland per year. However, with increasing age of childbearing, it is likely that this number will increase. In pregnancy, a variety of cancers occur, but breast cancer, haematological cancers such as lymphoma or leukaemia, gynaecological and skin cancers are the most frequently encountered. As there are many gynaecologists who can comment on surgical cancer treatment on the panel, my focus is the administration of drugs during pregnancy. Agents used in medical oncology include traditional cytotoxic chemotherapies, biological therapies and anti-hormonal agents which for convenience I will refer to as chemotherapy.

When considering the implications of this Bill for cancer in pregnancy, two main questions arise. Does the pregnancy confer a worse outcome to the pregnant mother with cancer and, if so, will a termination of pregnancy improve her outcome? The literature here is consistent in demonstrating a lack of evidence to suggest that termination will abrogate mortality risk in pregnant women with cancer.

Does the administration of chemotherapy in the pregnant woman put that woman's life at risk in a way that is not experienced in the non-pregnant woman? In clinical practice, we in the haematology and medical oncology field not infrequently navigate this challenging scenario. In the vast majority of cases, chemotherapy will be administered to the pregnant woman as curative or life-prolonging therapy without significant modification as per international guidelines. We work very closely with our obstetric colleagues to identify the optimum time for delivery of the baby, striving for foetal maturity rather than just foetal viability.

There are risks with chemotherapy administration in every trimester for mother and foetus. However, available evidence suggests that many of the agents used in the treatment of cancer have a safe profile, particularly if initiated after the first trimester thereby minimising risk to the unborn. As doctors, a challenge for us is balancing the risk of foetal abnormalities in the unborn as a result of the administration of chemotherapy during the first trimester or its deferral until a potentially safer time for the foetus but this has implications for the mother when immediate chemotherapeutic intervention is required. Organogenesis occurs during weeks five to ten of gestation. The administration of chemotherapy may have unintended complications, requiring intensive care unit management potentially threatening the life of the mother. May a termination be required to save the life of the mother in this circumstance? It is possible but these situations are exceedingly rare.

In answering these questions, I acknowledge a dearth of large prospective randomised trials investigating each question here but through retrospective cohort studies, case series and case reports the results achieved reach similar conclusions, regardless of the country where the study was performed. It is universally recognised that treatment recommendations in pregnant women with cancer will always rely on limited evidence.

My only comment in appraising the heads of the Bill is that should a situation arise where the life of the mother is at significant risk, it would be advisable that two medical practitioners on the specialist register with expertise in this area be involved in the certification process with the consultant obstetrician - for example two consultant medical oncologists or consultant haematologists, as they would have the medical expertise to advise and guide in this difficult area.

Chairman:

For members who were late, I wish to inform them that Dr. Kevin Walsh will be late arriving. We expect him at approximately 7 p.m. The committee has already agreed to allow him to speak when he arrives.

Deputy Mattie McGrath:

With respect to the guests and all of us, we are doing our best here. I believe that if we do not get a longer break than 15 minutes, we should arrange for some refreshments to be brought up - just something light. It is too far to go to the restaurant, which appears to be half-closed. I thank the staff who looked after us, but people are still trying to get some food.

Chairman:

During the meetings in January we made that request but because of health and safety it is not allowed.

Deputy Mattie McGrath:

In that case the Chairman should allow more time for breaks. It is not fair.

Chairman:

With respect for our witnesses, we were delayed-----

Deputy Mattie McGrath:

That is why I say it because we are late coming back.

Chairman:

I have not eaten since this morning at 8 a.m.

Deputy Mattie McGrath:

That shows the indecent haste of the whole thing. It is ridiculous.

Chairman:

I accept the point and we are doing the best we can.

Deputy Mattie McGrath:

What is the indecent rush? We are Members of the House and we are expected to eat. With respect to our guests, we should be here on time for them. I only had tea and a scone, and I was glad of it, but it is not fair.

Chairman:

I call Deputy Kelleher.

Deputy Billy Kelleher:

My first question is for Mr. Saunders.

Deputy Caoimhghín Ó Caoláin:

May I ask-----

Chairman:

I should have said that Ms Lawrence is not making an opening presentation.

Deputy Caoimhghín Ó Caoláin:

I understand. I beg your pardon.

Chairman:

Sorry, I got sidetracked.

Deputy Billy Kelleher:

My train of thought has been disrupted.

Deputy Caoimhghín Ó Caoláin:

I am sorry.

Deputy Billy Kelleher:

It is not the Deputy's fault - it is the hunger.

Chairman:

Some people go to Lough Derg and it is no problem there.

Deputy Billy Kelleher:

I ask about the Mental Health Commission's view on an examination-----

Chairman:

I apologise. I ask the Deputy to stop because Dr. Kevin Walsh has now arrived and we will let him speak.

Deputy Billy Kelleher:

Perfect.

Chairman:

I apologise. It will allow the Deputy to get his train of thought back and he can dream of chocolate or whatever. We will suspend for two minutes to allow Dr. Kevin Walsh to take his seat.

Sitting suspended at 6.47 p.m. and resumed at 6.50 p.m.

Chairman:

I welcome Dr. Kevin Walsh to our meeting and invite him to make his opening presentation.

Dr. Kevin Walsh:

My role is in congenital heart disease in pregnancy. I jointly run a clinic for maternal heart disease with Dr. Peter McKenna in the Rotunda Hospital.

Advances in treatments for congenital heart disease over the past 50 years have created a cohort of survivors with heart disease that has been either palliated or repaired, but with significant residual problems requiring ongoing medical supervision and repeat catheter and surgical interventions. In the Republic of Ireland there are approximately 1,700 adults alive with complex congenital heart disease and 14,000 adults with simple congenital heart disease.

Many women with repaired congenital heart disease wish to have children. There are now more pregnant women with congenital heart disease than acquired heart disease in the developed world. Pregnancy causes significant changes to cardiovascular physiology, with marked increases in blood volume, cardiac output, namely, increased stroke volume and heart rate, and a reduction in systemic vascular resistance, namely, reduced blood pressure. These changes may be tolerated poorly by women with pulmonary vascular obstructive disease of any cause - for my patients, usually Eisenmenger syndrome, very poorly functioning systemic ventricles or severe left-sided obstructive lesions.

Pregnancy also causes changes in the vascular wall, with a risk of aortic dissection in patients with coarctation of the aorta, Marfan syndrome and Ehlers Danlos syndrome. A pro-thrombotic state exists during pregnancy and women with artificial valves have an increased risk of life-threatening valve thrombosis. The oral anticoagulant Warfarin crosses the placenta and can cause abnormalities in the foetus, known as embryopathy, in the first trimester, haemorrhage and foetal loss throughout pregnancy. Heparin injections are often substituted as it does not cross the placenta but is a less effective anticoagulant. Even if meticulously monitored, the mother is at risk of potentially fatal valve thrombosis.

Preconception counselling is the most important part of the care of these women and should start once puberty is under way. Risk assessment and planning of management during pregnancy for these women is conducted through a joint Mater-Rotunda maternal heart disease multidisciplinary team meeting involving obstetrics, cardiology, anaesthesia and haematology. This results in three to four high risk women per year being delivered in the Mater Hospital rather than in the Rotunda so that they can be monitored more closely and go to intensive care for postpartum monitoring. With this Mater-Rotunda team approach there have fortunately been no maternal deaths in our group of patients with congenital heart disease over the last ten years.

In terms of experience elsewhere a paper published by Drenthen reports a 5% elective termination for congenital heart disease. Colleagues from the UK with large adult congenital heart disease practices report very small numbers of terminations for medical reasons - one or two a year out of a practice of 3,000 women with adult congenital heart disease. This lower than reported termination rate is probably because of good preconception counselling and means that most high risk women either do not get pregnant or know before becoming pregnant that the pregnancy will be very high risk. The terminations were either early following accidental pregnancy or late to save the mother's life. There have been approximately two in the past 13 years.

When termination is required to save the life of a woman with critical illness then it would have to be performed in the adult major teaching hospital with access to intensive care and the relevant specialists. This clearly would not be the case in any of the Dublin public obstetric hospitals. The termination would likely be on an urgent planned basis rather than immediate emergency basis.

Deputy Billy Kelleher:

My first question is for Mr. Saunders of the Mental Health Commission. Mr. Saunders stated in his presentation that the commission is of the view that the reasonable opinion of the medical practitioner should (a) be required in writing, (b) follow an examination of the woman concerned and that (c) the reasons for the opinion should be provided. He then went on to define an examination. Head 5 of the Bill provides that the medical opinion should be in a form and manner prescribed by the Minister. Is Mr. Saunders suggesting that the Mental Health Commission's view of an examination and the reasonable opinion of the medical expert should be provided for in the legislation?

My next question is to Dr. Janice Walshe and Dr. Kevin Walsh. Has either doctor, in discussions with their peers or personally, ever come across a case whereby a woman because of her physical condition, and based on medical advice that her life was under threat if she received a particular treatment, opted to terminate the pregnancy? In other words, have they come across a case whereby following explanation to a pregnant woman that a particular treatment could have a profound impact on her life or the quality of life of the foetus, that woman decided to terminate the pregnancy as a life-saving measure?

My final question is on head 12 and relates to conscientious objection. Are the organisations happy with the heads of the Bill as prescribed with regard to conscientious objection?

Deputy Caoimhghín Ó Caoláin:

I join in welcoming each of our witnesses. I thank Mr. Saunders, chairman of the Mental Health Commission, for the points offered by the commission in relation to definition. Each of the other points offered were highlighted on Friday and earlier today. As such, they are confirmatory in terms of points already shared across each of the different disciplines.

My first question is to Dr. Janice Walshe. Dr. Walshe made reference to international research regarding the impact of chemotherapy treatments on pregnant women. How extensive is that research and across what cohort of international experience was it compiled? Is there a body of evidence already accrued based on the situation in Ireland and factored into this international research?

I thank Dr. Kevin Walsh for his presentation. I know a number of people who attend the Warfarin clinic at my local hospital. Is it the case that there is a lowering age group who may be exposed to the use of Warfarin, with the result that there might thereby be an increased risk to women in years when conception is realistic? Because women are now getting pregnant when they are older the use of coagulants is becoming more prevalent and the age profile is lowering. Therefore, there is an increased risk in relation to Warfarin intake because as Dr. Walsh indicated it crosses the placenta and can cause foetal loss throughout pregnancy. I would be grateful if he could elaborate on that point.

Dr. Walsh cited statistics obtained from colleagues across the water regarding adult congenital heart disease and the termination of pregnancy. Is the statistic of one or two women in every 3,000 particular to some practices or are they indicative? Can Dr. Walsh extrapolate from that in relation to the likely situation that applies across the neighbouring island?

Deputy Mattie McGrath:

I welcome the witnesses and thank them for attending at this time in the evening. My first question is directed to Mr. Saunders. Mr. Saunders mentioned in his opening statement that the procedures referred to in the heads of the Bill do not fall within the definition of the mental health services or come within the remit of the Mental Health Commission. All references in the heads of the Bill to the Mental Health Commission relate solely to the registration of a centre. Perhaps Mr. Saunders would clarify the situation in that regard.

Mr. Saunders also stated that the heads of Bill are silent on the requirement to hear, consider and document the views of a woman who has not reached the age of consent. I recently had the privilege of meeting Miss C. We all know what happened in that case, which was not very pleasant. Perhaps Mr. Saunders would, if he can, comment on that matter.

It is necessary in the context of our discussion to look to other jurisdictions. Following the *Roe v. Wade* case in California in 1973 the Supreme Court decided that abortion could be allowed for a variety of reasons, including the mental health of pregnant women.

They accepted that the mental hospitals would be full if all the people permitted abortions on mental health or suicide grounds had been admitted. They had to change the law and it was beyond all proportion. Perhaps the witnesses can comment on that.

Mr. John Saunders:

The experience of the commission in interpreting and implementing the Mental Health Act 2001 is such that we feel it is best practice, provides clarity and ensures safety to include as much detail as possible on procedures in the body of the legislation. If that is not possible, then perhaps clear statutory instruments supporting the Act could spell out these details, as opposed to leaving them to the Minister of the day. We could deal further with the issues that arise subsequent to the Bill's enactment if a mechanism is built in to allow a review of these procedures in light of experience, perhaps after one, two or three years. We do not know what is ahead of us in terms of this legislation.

In regard to the issue of children, nothing in the heads of the Bill addresses the different circumstances of children or women who are below the age of consent, which is 16 years or

18 years depending on the perspective one is taking. Specific mention should be made of children who find themselves pregnant, as opposed to adult women.

I cannot quote Roe *v.* Wade because it is history, but to my knowledge the main issue arising was the mental distress and well-being of the woman as opposed to her suicidality, which is a separate issue.

Dr. Janice Walshe:

Deputy Kelleher asked if I had dealt with a case personally. I have not personally referred anyone for a termination.

Deputy Billy Kelleher:

I did not use the word "refer".

Dr. Janice Walshe:

I have not come across such cases. In terms of psychological distress, we encounter a lot of that among non-pregnant women and, of course, it is even greater among pregnant women. In terms of how one deals with the issue, when I meet a pregnant woman who has cancer, her main concerns relate to the risk to her own welfare and the risk to the foetus. Once it is explained that a termination is not likely to add anything in terms of outcome, that we will navigate the situation in clinical practice on a regular basis and that treatment can be administered safely for the most part, they tend to become less distressed and proceed with treatment.

In regard to Deputy Ó Caoláin's question, such is the rarity of cancer in pregnancy that it is difficult to have a perspective on randomised trials, but we have a considerable amount of data from retrospective studies, cohort studies and case series. These can be in the hundreds in some cases. We can extrapolate from these data to discuss them with our pregnant patients.

Dr. Kevin Walsh:

I thank Deputy Kelleher for his question. On the need for termination, I think it would be unusual. Perhaps once every few years one would need to deal with a case because of something like Ehlers-Danlos syndrome or Eisenmenger's syndrome. The numbers are relatively small, but they are real and they are difficult problems when they occur.

We use warfarin increasingly but we walk a tightrope in this regard because while warfarin is good for the heart valve, it is not good for the foetus. The mother obviously wants the best outcome for the foetus and we want the best outcome for both, but primarily for the mother. We have to strike a balance between Heparin and Warfarin and occasionally this will lead us into trouble with a valve clotting. That is a situation in which one could end up with a termination, but foetal loss is usually part of that.

With regard to the experience in the UK and other centres, I spoke with more than one centre and they had encountered only a handful of cases over many years. There are one or two occasions per year in big practices when a woman's life may have to be saved by terminating a pregnancy.

Ms Eileen Lawrence:

The Irish Nurses and Midwives Organisation is requesting that the conscientious objection clause be maintained in the heads of the Bill. We also ask that the legislation be clear in respect of nurses and midwives.

Deputy Ciara Conway:

I thank the witnesses for giving us their time. Dr. Janice Walshe suggested that two consultant oncologists and one obstetrician would be her preferred option. Given that the Bill suggests one oncologist, I ask her to explain the basis of her opinion. When a woman presents to her primary care provider with concerns that her pregnancy is threatening her life, what is the preferred referral pathway? Perhaps Dr. Kevin Walsh can also respond on that issue. What if the woman was previously advised against becoming pregnant because of her condition?

How long should a referral take, and do the heads of the Bill include adequate safeguards so that a woman whose life is at risk can see a specialist and receive a decision quickly? Is time of the essence? In our earlier sessions we discussed the role of GPs in this process. Could the requirement to consult a GP act as an obstacle to women who require speedy interventions?

There was considerable discussion today about multidisciplinary approaches to women in crisis. I ask Ms Lawrence to outline the role played by midwives when assessing, alongside obstetricians, pregnant women in their care and deciding on appropriate referral pathways.

Senator Jillian van Turnhout:

I thank the witnesses for attending the committee. My first question is for Dr. Kevin Walsh and Dr. Janice Walshe. I am trying to tease out the pathway for a woman making a decision. I imagine that she would have seen a specialist prior to finding out that she had become pregnant and must make a decision. The witnesses stressed that such cases are rare, but does Dr. Kevin Walsh agree with Dr. Janice Walshe that two specialists should be involved? Does the legislation before us confirm what the witnesses are doing in practice, or will it place obstacles in their way? I am trying to understand the role the legislation will play in medical practice.

Head 4 provides that the psychiatrist must be employed by an approved centre. Mr. Saunders indicated that not everybody works at an approved centre. Can he suggest a form of language that would ensure we do not get into a situation in which lists must be drawn up of those who will or will not do something? How can we develop a system that is balanced and fair? I note his comments on the silence of the legislation with regard to children. As several witnesses have raised this issue, it is something we will have to address.

Deputy Regina Doherty:

I will ask Dr. Kevin Walsh and Dr. Janice Walshe the same three questions. As I did not hear the beginning of Deputy Kelleher's intervention, I am not sure if I will be repeating his questions. Were any medical terminations carried out in either of the witnesses' specialties in Ireland in the past several years? Were any of their patients delayed treatment, voluntarily or

otherwise, or refused treatment because of their pregnancy? Do they know of any patients who were pregnant and travelled outside of our jurisdiction?

If this legislation is passed, I ask Ms Lawrence whether it will change how nurses and midwives react to pregnant women presenting with a medical emergency such as ectopic pregnancy or pre-eclampsia, aside from mental health issues or the two specialties represented by Dr. Kevin Walsh and Dr. Janice Walshe.

Will the legislation, if passed, change the way in which our guests would receive and treat that woman from the way in which they do so now?

Mr. John Saunders:

For the record, it is Mr. Saunders not Dr. Saunders. The answer is already found in the interpretation of the heads of the Bill where it is stated that ""psychiatrist" means a medical practitioner who is registered in the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007" - simply to leave out the fact that the person needs to be employed in an approved centre.

Dr. Janice Walshe:

I thank Deputy Conway for her questions. Having two medical practitioners in medical oncology might be wise because cancer in pregnancy is exceedingly rare. As I stated, we are seeing only 60 to 70 cases in Ireland per year. It is conceivable that there could be a medical oncologist or a haematologist who has never encountered this kind of situation. I would feel personally that, from a safety perspective and in order to ensure we make appropriate decisions, a second medical practitioner in that area should be consulted. In terms of the pathway, once that process had occurred, certification would occur in combination with the obstetrician. I would not envisage this happening often, as indicated through my data. It would be exceedingly rare that this situation would arise. In the context of timelines, we tend not to have extreme medical emergent situations so seven days would be adequate. The Deputy inquired as to whether GPs could be an obstacle. In terms of specialist care such as this, GPs tend to rely very much on the information they receive from us. I would not, therefore, see them as being an obstacle.

Some of Senator van Turnhout's questions overlapped in the context of the pathway and she asked if the legislation would help this situation. It arises so rarely that I am of the view it will be helpful. However, I hardly ever see it arising.

Deputy Regina Doherty asked if we know of patients who have travelled for terminations. I have heard of patients who have travelled in order to have terminations completed. That is more on the basis of foetal abnormalities in the first trimester if they receive treatment. Again, I have no personal knowledge of the ins and outs of that but I have spoken to colleagues about the matter. It would also be exceedingly rare.

Dr. Kevin Walsh:

On Deputy Conway's questions, we usually would provide preconceptual advice in respect of pre-existing conditions. When they are known to the system, they have rapid access to us via nurse specialists and their general practitioners. There is no real problem with that. In terms

of a critically ill woman where time would be of the essence, they would usually be very unstable, have blood pressure problems and be in hospital. That would be a pretty unusual event.

I must inform Senator van Turnhout on the prior advice, preconceptual warning, we may advise against it but we would fully support them if they went ahead with the pregnancy. We always make them understand that. We say that we do not think it is a good idea and we try to get their partners involved. However, if they go ahead, they will get full support all the way with it because that is ultimately their choice.

On the two specialists, the problem is that I am the only specialist in adult congenital heart disease. We have been waiting five years for the HSE to appoint another one. At the moment we would probably try to keep it simple and have one specialist. We are always going to be consulting obstetricians - as part of a multidisciplinary team involving all the specialists - in order to make that sort of decision. For us, it would not be a bleeding emergency or something of that nature, we would have a day or two to organise things. The legislation clearly would be very important because it would place matters on a firm footing and would make it happen for women.

Deputy Regina Doherty inquired about women being obliged to travel. I have had two patients in the past number of years who were obliged to travel for terminations. Patients will sometimes delay heart treatment to try to get a pregnancy over but usually they have a reasonable set up in order that they can survive and manage it.

Ms Eileen Lawrence:

I thank Deputy Conway for her question which, I think, has actually been covered by two of my colleagues. From a nursing point of view, it would be down to the consultants and they have covered it very well in the context of the pathways.

Deputy Regina Doherty referred to medical emergency as regards change in the treatment. I do not believe that this would lead to anything different from the treatment that is already being offered.

Deputy Peter Fitzpatrick:

I welcome our guests and thank them for attending. I wish to pose three questions. Will doctors and nurses who, under head 4 of the Bill, wish to have no part in abortions - either directly or indirectly - be significantly protected in the context of their professions and livelihoods? Will doctors and nurses who, under head 4, wish to have no part in abortions - either directly or indirectly - be likely to be subjected to discrimination in their careers? In the interests of equality, should the proposed legislation make provision for consultations with the fathers of unborn children?

Deputy Denis Naughten:

Mr. Saunders made the point that the commission has no role under the heads of the Bill. Is he of the view that it should have a role? He also commented on the fact that there are only three perinatal psychiatrists based in the Dublin hospitals. Is it his impression that decisions under head 4 would be made by perinatal psychiatrists? That is the impression some of us

would have obtained but the psychiatrists provided different evidence earlier today. Will Mr. Saunders elaborate on that matter?

Under head 3, consultants will sign off on medical emergencies. Will senior midwives have a role to play in respect of this matter? For example, could they offer second opinions with regard to medical emergencies? Does the INMO have any concerns about the structure of the heads of the Bill, as they currently stand, and the impact they might have on some of the smaller units throughout the country, which are very much midwife-oriented?

Dr. Janice Walshe indicated that there is a dearth of large perspective randomised trials. That is understandable because one would not carry out randomised trials in respect of someone who has cancer. Is Dr. Janice Walshe satisfied with the quality rather than the quantity of the research available? While that research is limited, is she satisfied that she has available to her the medical evidence necessary to best advise a woman in those circumstances? Does she have access to colleagues who can assist her in making a determination?

Senator John Crown:

I welcome my colleagues and thank them for their particularly learned, focused and well-informed presentations.

My first question is for Dr. Kevin Walsh. One of the issues which has exercised the committee in recent days relates to the quantification of risk, namely, the percentage chance an individual has of dying. It is clear that this becomes very nebulous and contentious in the area of the highly hypothetical and probably-never-going-to-happen psychiatric indication. In various medical conditions, however, it is a very real concern. I refer to blood pressure complications, congenital heart problems etc. I am guessing that the answer to my question is "Yes" but perhaps Dr. Kevin Walsh could provide some reassurance. If someone comes to him with a particular congenital heart lesion which has caused a certain level of left ventricular dysfunction, valvular regurgitation or whatever, does he have available to him reasonably good guidelines which indicate what is the incremental risk of death to the woman in question if she carries her pregnancy to full term as opposed to her not doing so? At what level would he consider that the threshold is such that he would strongly urge that the risk to her life is so great that she really should have a termination?

My second question is for my colleague and very dear friend, Dr. Janice Walshe. Obviously, she and I work very closely in respect of cases of this nature and she has given the committee a really good insight into the various dilemmas relating to the life of the mother, the risk of foetal malformation etc. She is correct, we have worked out ways of trying to get the balance right.

While we may not have cases where we send people for termination of their pregnancy, would the delegation hold that it is fair to say that sometimes we end up making compromises in what would be the absolute standard care for an individual person if she was not pregnant to accommodate the special needs of the developing foetus?

Mr. John Saunders:

In respect of the question about the involvement of the Mental Health Commission, it is clear from the heads of the Bill that the services proposed arising out of the Bill will be delivered

by the HSE and by the voluntary bodies under section 38 of the Health Act. It is also clear that the responsibility for regulation would be with the Health Information and Quality Authority, HIQA, and that the regulatory authority will be with the Medical Council. Therefore, it is more than adequately provided for that the Mental Health Commission will not have a central role in whatever legislation arises out of the heads of the Bill.

The second question was about perinatal psychiatrists. Our submission on the heads of the Bill includes an assumption that in the three large voluntary hospitals the perinatal psychiatrist is the person who would be involved in the procedures outlined. There is an assumption that the second one would be as well, but that is not entirely clear. However, we know there are 60 other centres throughout the country and, as far as we understand, those centres that are served by psychiatry could well be served by liaison psychiatrists from general hospitals or indeed by general adult psychiatrists. They would not necessarily be perinatal psychiatrists.

Dr. Janice Walshe:

There was a question on randomised trials. As a background point, randomised trials are the cornerstone of cancer therapies. We perform prospective randomised trials in all areas of cancer management. The only thing that holds us back in terms of cancer in pregnancy is the dearth or the small number of cancer cases. It is very difficult to perform large randomised trials. I am comfortable with the data that is there. There are many retrospective cohort studies, case series and case reports that are all consistent no matter what country they have been performed in. In that regard I believe that the data can be extrapolated to the Irish situation and in that I am completely comfortable.

With regard to the question of Senator Crown on the challenges that we face for appropriate therapy of pregnant women with cancer, there is no question that we have to make small compromises, but they are recognised to be internationally acceptable. Where the real difficulty lies, however, is in the treatment of women where we do not have time to wait and in the first trimester. As a result of that we are certainly compromising in terms of the agents that we can offer.

Dr. Kevin Walsh:

Senator Crown asked a question about the quantification of risk. We have some scores for major adverse cardiac events but they usually include death along with other complications. Generally, we consider a condition where the risk of death is 5% to 10% as being very significant. Mothers will take any chance to have a baby but a 5% to 10% risk is really significant. In the Eisenmenger patient the risk is up at 30% to 50%. That would be a case where if there was earlier identification we would certainly want to recommend an early termination. It is different. We have had Eisenmenger patients come to term or close to term. Equally, Eisenmenger patients have died in this city during pregnancy. That is the sort of level of risk.

Ms Eileen Lawrence:

To answer Senator Crown's question, the senior staff nurse, of course, should have an input as part of a multidisciplinary team and as an expert in her field.

Deputy Denis Naughten:

What about for smaller units? Does the Irish Nurses and Midwives Organisation, INMO, have any concerns about the heads of the Bill as they are currently drafted in respect of the smaller maternity units throughout the country?

Ms Eileen Lawrence:

I cannot comment on that right now.

Senator Colm Burke:

I thank the delegations for their contributions today. My first question is for Mr. Saunders in respect of head 4 of the Bill. I have raised this with several people already. The Medical Council and the Royal College of Psychiatrists of Ireland are suggesting that the heads of the Bill provide that three people would sign off on the issue in respect of where there is suicidal intent, whereas they are suggesting that two psychiatrists would sign off and then consult with the obstetrician. Will Mr. Saunders offer his views on that?

Mr. Saunders commented that the heads of the Bill are silent on the issue of people under 18 years of age. I wonder what structure-----

Chairman:

Could we have one meeting with respect for the speaker, please?

Senator Colm Burke:

In respect of people under 18 years, what structure would Mr. Saunders like to have put in place to deal with that issue in the proposed legislation? Mr. Saunders is right. The heads of the Bill are silent on that issue and it is an important point that he has raised.

The third question is for Dr. Janice Walshe. She suggested that two people should sign off in respect of the area that she deals with. I presume she would be happy that in an emergency one person would sign off, together with the obstetrician. Perhaps she will clarify the position.

Senator Jim Walsh:

As someone who responds to different pronunciations of the surname Walsh, I believe I am correct to say that I am directing my questions to Dr. Janice Walshe and Dr. Kevin Walsh. I believe we have good maternal health outcomes in this country which compare favourably with any international comparator. Would the delegations agree with that?

My second question deals specifically with the physical medical emergencies and non-emergencies that arise. Given the provisions in the Bill, do the delegations believe that they will broaden the availability of abortion, or will they merely reflect current medical practice? Mr. Saunders made a sensible suggestion under head 5, which my colleague, Deputy Kelleher, referred to. It is a good recommendation to the effect that the reasonable opinion of the medical practitioner should be required in writing and that examination of the woman

concerned would be documented, including the reason and the opinion. There are two points. Does Mr. Saunders believe that the word "reasonable" should be attached to the word "opinion"? Some have been canvassing that the word "reasonable" should be removed and this concerns me. Does Mr. Saunders believe that as part of the recording of information - which I believe is essential in future for making decisions - the consultation with the general practitioner should also be fully recorded by the consultant involved in dealing with it?

Reference was made earlier to Miss C. As the delegations may remember, in 1997 she was brought to Britain by State officials to have her baby taken out, as she has described herself. She understood that would not lead to the death of the baby and it was against her parents' wishes. She subsequently has attempted suicide on a number of occasions. What should be included in the legislation in the opinion of the delegations to protect against this happening in future?

Mr. John Saunders:

The first issue was around the difference between head 2 and head 4 in terms of the number of practitioners involved. When the commission was discussing the issues it noted the difference and that in the case of physical severe illness there was a requirement for a consultant obstetrician plus medical specialists up from the disease entity - that was the issue - whereas head 4 refers to two psychiatrists. This is explained in the heads by the statement that the provision for two psychiatrists in addition to an obstetrician arises from the recognised clinical challenges in accurately assessing suicidal intent and the absence of objective clinical markers. In these cases the Bill provides that the opinion will be jointly certified by an obstetrician gynaecologist and two psychiatrists. I suppose that is the answer. There is a recognition in general that the ability to predict the seriousness and consequence of suicidal ideation is a difficult one. There is a distinct difference between head 2 and head 4. One could argue conversely that perhaps it should be the same and that there should be an obstetrician and one psychiatrist in the same way that there is one obstetrician and one physical specialist in the case of head 2, but I believe it is a matter of debate and opinion rather than a matter supported by scientific fact.

The question of children was raised. We have noted the absence of any specific legislative proposals around children.

Again, in most social legislation dealing with children and adults, a specific part of the Act details the provisions for children. This legislation should recognise that children who find themselves in a situation where there is a pregnancy are a particularly vulnerable set of people in the general population of women. Second, there is the issue of their capacity around their status as a child versus the wishes of their parents, for example, and there are also issues around decision making and competency around decision making. Members may be aware that there is also assisted decision making legislation on the schedule of the Oireachtas and both pieces of legislation will have to reflect the provisions of the other piece of legislation. To answer member's question about decision marking, there is the capacity and vulnerability of the person who is below the age of 18 as opposed to an adult. An additional group of people are children who are in care, usually of the HSE, and there is the matter of where the responsibility lies in terms of decision making on behalf of those children should one of them find themselves pregnant and in the situation that has been outlined.

Dr. Janice Walshe:

In response to Senator Colm Burke's question, my idea for the two medical practitioners, as I said before, is related to the fact that this is a rare entity and we are dealing with a very small number of cases. In that regard, in a scenario where someone had not encountered this before, I felt it would be more practical that the person would be able to have the ability to seek advice from another medical practitioner in the same area. In terms of an emergency situation, I envisage that arising extremely rarely but I accept that would have to happen.

I thank Senator Walsh for calling me "Welsh". I only hear that when I go home to the west and I thank him for making me feel at home. In terms of the head of the Bill, as it stands, I think it will reflect current practice and I do not envisage that it should be broadened.

Dr. Kevin Walsh:

To answer Senator Walsh's questions, maternal outcomes are excellent but there is a problem with isolated maternity hospitals in Dublin. This is why, in terms of the location element of the heads of the Bill, termination procedures would have to be also in large adult teaching hospitals as well if we were really to address the lives of women. There is where critically ill women have to go. Equally, the fact that we still do not have a plan to have maternity hospitals and adult hospitals located right beside each other on the same campus continues to be a big concern. It was part of the problem regarding the children's hospital. With regard to whether allowing terminations would broaden the use of terminations, in terms of women with severe heart disease who have travelled to the UK to have a termination, they may be able to have it done in Ireland rather than England, and that is important because these women go abroad with major difficulties - financial, psychological and all those problems - so dealing with the problem ourselves has to be better.

Chairman:

Does Ms Lawrence wish to comment?

Ms Eileen Lawrence:

No.

Chairman:

That ends the members' time. We now have a half an hour of time for non-members. Four Members have indicated and I will take the four together starting with Senator Fidelma Healy Eames.

Senator Fidelma Healy Eames:

Good evening panel and I thank them for being here. I will direct my first question to Dr. Janice Walshe. It is particularly interesting that C in the ABC case - we are here because of the European Court of Human Rights judgment in that case - was a woman who had cancer. Could Dr. Walshe clarify for the record what is available currently in Ireland for a woman in the position of C? We know she Google-searched what she did not know was available here, and this has given rise to the European Court of Human Rights judgment. Does Dr. Walshe think the public would benefit from an information campaign on what is currently available

regarding terminations to save women's lives in this position? How will this Bill change her practice for the better?

My question to Mr. Saunders is around the issue of mental capacity. To make a will, one has to be of sound mind, yet with this Bill essentially we will be certifying a woman who is suicidal, and in that respect she could be considered not to be of sound of mind, to make a final decision about her unborn baby. Does this make sense to him? Does a suicidal woman in his view have the mental capacity to consent to something that is so final and irrevocable as the taking of the life of her unborn child?

What role does Ms Lawrence currently play in psychiatric teams around the care and observation of women who are suicidal in pregnancy?

Deputy Terence Flanagan:

I have brief questions and it would be great if the witnesses could answer them. Does the INMO have concerns about the extremely limited rights of conscientious objection in relation to abortions carried out under head 4? Has the organisation had an any consultation with its members regarding any changes as a consequence of this Bill? Can Dr. Walshe indicate in what percentage of cases where cancer is diagnosed before viability is it possible to manage treatment in such a way as to facilitate the safe delivery of the baby?

I have a question for Mr. Saunders regarding the Health Act 2007. We know that the Minister for Health has expressed a view that the 2007 Act offers scope for oversight of termination of pregnancy permitted under the Bill and consistent under Article 40.3.3o of the Constitution. From the explanatory note under head 1 it is not obvious which provisions of the Health Act of 2007 would authorise the Minister to investigate, discipline and-or refer for prosecution a physician or a psychiatrist who would certify, without justification, that an abortion was necessary to prevent the woman from killing herself, or to remove a physician, including a psychiatrist. from the panel's consideration of an application for abortion or reviewing denials of such applications. Will Mr. Saunders indicate what authority exists in that respect under the 2007 Act?

Deputy Michael Creed:

I welcome the delegation and thank the witnesses for their presentations. Mr. Saunders made a point in respect of a review mechanism in the legislation and its effect. There is a provision in head 10 or head 11 for a reporting mechanism back to the line Minister on the number of cases, the applications for review, etc., but there is not any role envisaged in that reporting mechanism for the Houses of the Oireachtas to be informed or consulted on its continuing operation based on the experience of the legislation to date. Can Mr. Saunders flesh out in greater detail his idea of a review mechanism in the legislation? I refer in particular to head 4 and how that might be expanded to include the Houses of the Oireachtas, or is that something to which he have given any consideration?

Mr. John Saunders:

On the question on mental capacity, my understanding from the heads of the Bill is that the consultant obstetrician in conjunction with two consultant psychiatrists will be asked to assess the validity or otherwise of the suicidality that the woman is stating and, as such, it is

not an assessment of her capacity, it is an assessment of the risk of suicide, as expressed, and they then have to make a recommendation based on that. That is a very different thing, as I and the commission understand it, from capacity. As a note of interest, the capacity legislation that is promised in the Dáil takes a view that capacity is neither 0% or 100%. One can have capacity in one area of life and not have capacity in other areas of life. The concept of partial capacity is the principle that people are applying.

In respect of the Health Act 2007, I presume Deputy Terence Flanagan means the Medical Practitioners Act 2007 in regard to the regulation of medical practitioners.

If that is what Deputy Flanagan means, as I understand it every consultant psychiatrist and obstetrician has to be registered under that Act in terms of his or her speciality.

On the review of legislation, I can point Deputy Flanagan to a number of pieces of legislation where, within the Act, a Minister is given power to review either the Act in full or in part at a given period of time. For example, in the Mental Health Act 2006 the current Minister is given the power to review the full Act five years after commencement and therefore make changes in the light of experience. I know also that certain Acts will allow Ministers to act according to advice received on particular issues in the form of ministerial orders or miscellaneous provisions in legislation. Those are the types of legislative reviews that need to build into the parent Act.

Dr. Janice Walshe:

With regard to the first question pertaining to the C case, this was a lady who got pregnant on remission from cancer and got information via the Internet. Currently, somebody in the position of C will present to her medical oncologist where a detailed discussion will be held based on prognosis of that woman and the best way to proceed in terms of her treatment. We will discuss the risks to the mother as well as risks to the foetus. She will also have an interaction with the oncology liaison nurse, and we may involve a psycho-oncologist if we felt that was appropriate.

In terms of resources available, they are available in all of the units and therefore it would be a fairly uniform approach in most units one would encounter in Ireland.

In terms of the information packs, to my knowledge there is no specific information out in this regard but it would be important going forward because this scenario is so rare and variable according to the cancer that arises. It would be an important matter. In terms of my envisioning this Bill changing practice, currently I do not see that it would change practice.

With regard to the percentage diagnosed in the first trimester, we do not even have numbers of cancers diagnosed in pregnancy in Ireland. We are extrapolating from international data and, therefore, I do not have those type of numbers but I can tell the member that if someone presents to us with cancer in pregnancy, in the vast majority of cases we navigate that very successfully. We will treat them with chemotherapy from their second trimester onwards with agents we know are safe in that regard, with very good success for both the mother and the foetus. We will strive for foetal maturity rather than foetal viability so we will bring them up to about 35 weeks gestation and then discuss the best way to proceed with delivery, depending on the cancer involved.

Dr. Kevin Walsh:

I do not think I have any answers to that.

Chairman:

Deputy Flanagan asked a question about consultation.

Ms Eileen Lawrence:

Yes, and there was a question concerning-----

Deputy Terence Flanagan:

I asked two questions on consultation and conscientious objection.

Ms Eileen Lawrence:

To my knowledge we are welcoming of that being in the Bill, and also to be clear on the legislation for nurses and midwives.

Deputy Terence Flanagan:

Was there consultation with Ms Lawrence's membership?

Ms Eileen Lawrence:

Serious consultation regarding that will take place so that people will have choices as in the conscientious objection clause.

Deputy Terence Flanagan:

My question is whether there has been a debate yet. Has there been a debate?

Chairman:

Thank you. I call Senator Mullen.

Senator Rónán Mullen:

I thank all our guest experts and specialists for their contributions this evening. It is reassuring to hear the last point about foetal maturity, with the ethos of care coming out strongly in terms of bringing both cherished patients to a safe place. I thank Dr. Walshe for the good work she does.

I have a question for Mr. Saunders. We heard earlier from Dr. Yolande Ferguson, one of the psychiatrists who appeared before the committee, who spoke about the way psychiatrists routinely defend their decisions in mental health tribunals. It struck me that given the far-reaching and fatal consequences for the unborn child of the decision to certify that a person is suicidal and that there is a real and substantial risk which can only be averted by a

termination of pregnancy, would it not be appropriate that there should be a forum where such decisions would also be defended? That is arguably a more far-reaching consequence than something like detention, for example. That thought has struck me.

Turning it around, perhaps I have overlooked it but I do not see in Mr. Saunders' submission any comment on the fact that whereas a review is possible of the decision to refuse to certify that abortion would be lawful on the head 4 ground, there is no provision that any person or official would have the right to seek a review of the decision to permit a termination to go ahead. Again, given the far-reaching consequences for one constitutionally protected actor, does Mr. Saunders believe there should be, to use a phrase that became popular some years ago, parity of esteem and that there should be the possibility of a review in those situations?

I do not think Mr. Saunders made any comment on head 11, but head 11 essentially provides that records would be submitted to the Minister where a decision is made under head 4, or under any of the heads, permitting lawful termination of pregnancy. Again, with particular regard to head 4, it mentions that no notification shall give the name or address of the woman in respect of whom the termination was carried out. Everybody would agree that is right and proper, whatever people feel about the appropriateness of making any such certification under head 4. However, it goes on to state that the Freedom of Information Act shall not apply to any record under this head. Given that there would be no question of giving personal or identifying details, is that appropriate? Can Mr. Saunders think of any reason the Freedom of Information Act should not apply because if people are concerned about procedural abuses here, surely one important mechanism to allow us to know whether there is a procedural abuse is that the Freedom of Information Act should not apply. I would be grateful for any thoughts and insights Mr. Saunders has on that.

Chairman:

The Senator's time has concluded.

Senator Rónán Mullen:

Finally, would Mr. Saunders agree that the law in this area should reflect section 21.1 of the Medical Council guidelines, which requires due regard to be had to clinical research in the area of psychiatry in regard to any certification being made under head 4?

Deputy Peter Mathews:

To recap on this morning's and this afternoon's-----

Chairman:

We will not recap. I ask the Deputy to go forward.

Deputy Peter Mathews:

It is to ask a question.

Chairman:

That would be most helpful.

Deputy Peter Mathews:

We know what the Constitution states; it is written in plain English.

Chairman:

On the Bill, please.

Deputy Peter Mathews:

We know the Supreme Court said that where there is a real and substantial threat to the life of a mother, it is legal for medical personnel from all disciplines - fire brigade officers, their executives, doctors, nurses and midwives, to do what needs to be done. We have heard also that where there is a threat or an intent of a distressed mother to be to take her own life, the answer is not a termination. What sort of word games are going on here? The last session answered that question and said that no matter what the Supreme Court said regarding the X case, which was a unique case in history, it will never be replicated. Every event in history is a unique event and therefore to legislate for a unique event that will not recur is logically absurd. What we are doing now is looking at real life situations within the constitutional framework of the value and sacredness of life from start to end to ensure we avoid issues such as euthanasia at the other end and abortion-----

Chairman:

I ask the Deputy to speak to the Bill.

Deputy Peter Mathews:

Why are we following all these long, drawn-out avenues into wordy discussions when we know what we are about? Also, what was said about unsound mind is very true. Lawyers can play with words and say unsound mind only applies to writing wills. That is nonsense. Unsound mind is where there is stress, duress, sociological, personal and guilt coercion. Conscience is about clear knowledge and full consent, regardless of what one is doing.

Senator Paul Bradford:

I welcome the visitors. I apologise I was unable to be present for the commencement of their addresses but I have read through the scripts.

I was interested in Dr. Walshe's very precise response to Senator Healy Eames who asked whether the proposed legislation would make any difference to her practice of medicine - I have paraphrased the question - and the reply was that it would not and that life, if one excuses the pun, will continue as heretofore.

In the previous session I asked for a response from the four witnesses on whether they agreed with the phrase which is becoming a mantra, that this legislation is about saving women's lives. Each one said they did not. If the legislation will make no difference to practice, and if it is supposed to be simultaneously about saving women's lives, are we in a position where

women's lives are not being saved? I am as confused as everybody else. We are putting a new meaning on words. If this legislation will make no difference is the country a hugely dangerous place for Irish women at present from a medical perspective?

Chairman:

We are discussing the heads of the Bill.

Senator Paul Bradford:

The question is whether it would make a difference to medical practice and apparently the answer is "No".

Senators:

She did not say that.

Chairman:

Thank you. I am chairing the meeting.

Senator Paul Bradford:

The answer to the question asked by Senator Healy Eames was that there would be no difference in practice. What does this mean? What we fear is the current inadequacy of the law with regard to women's lives. We cannot have it both ways. We cannot state we can change the law but nothing will change or that there will be no difference. I would like clarification if possible. I appreciate it is complicated.

Mr. John Saunders:

A form of tribunal was suggested as a possibility. The committee may know the mental health legislation in place operates tribunals for third-party reviews of decisions made to detain people against their will in approved centres. It is a cumbersome and costly process but it is effective enough. I am not sure how it might translate to the situation included in the heads of the Bill.

With regard to third-party review, the issue I raised is that at some point in most appeals mechanisms one can make an application to court, usually the Circuit Court, to review a decision. The point I made is that under the heads of the Bill as read now, there is no provision beyond the initial review for any appeal to a court of any description, regardless of the decision made.

With regard to notifications under head 11, the commission examined this head and it appears to be quite sensible in the sense that ultimately the Minister and the Department are responsible for all health care service delivery and should have routine information provided to them to help them understand how the services operate. It is self-evident that details about personal names and addresses should not be included in this data. With regard to the Freedom of Information Act, I understand the Act already has provisions whereby information is

withheld because of its sensitive or personal nature, so a decision will need to be made with regard to the information we are discussing under the heads of the Bill.

With regard to the questions on psychiatry, psychiatrists will be asked to make decisions on the evidence presented by a woman and it is a matter for psychiatrists to reach a conclusion. I am not a doctor and I cannot give a response.

Senator Rónán Mullen:

A question was not answered.

Chairman:

I will come back to the Senator. I will chair the meeting.

Senator Rónán Mullen:

No-----

Chairman:

If I need help I have a very good Vice Chairman.

Senator Rónán Mullen:

I am very happy with how the meeting is being chaired, but there is a little ambiguity.

Chairman:

I will bring the Senator back. He is very good at that himself.

Senator Rónán Mullen:

Go raibh maith agat.

Dr. Janice Walshe:

I wish to clarify the final point. I feel legislation is required in the unlikely event the mother's life is at risk as a result of the pregnancy, and to clarify my point, the likelihood of this legislation being enacted in my area is exceedingly rare.

Dr. Kevin Walsh:

There is the potential to save women's lives. Patients with Eisenmenger's syndrome have died. Travelling abroad to have a termination in the UK with critical heart disease is not a good idea. We must deal with our own problems.

Chairman:

Senator Mullen indicated but he cannot give a three-minute dissertation.

Senator Rónán Mullen:

I understand this. Gabh mo leithscéal if there is a míthuiscint about what point one seeks to get a precise answer to a precise question.

Chairman:

Tá a lán míthuisceana ann.

Senator Rónán Mullen:

I am certainly happy to wait until other questions have been answered. With regard to the Freedom of Information Act, given that personal information is already excluded I asked whether there was any good reason the Act could not be used given the information being submitted to the Minister is not of a personally identifying nature anyway. With regard to the issue of review I asked for comments, not so much on the fact there is no further review beyond the existing one, but on the discrepancy between the fact there is a review possible of the decision to refuse but not of the decision to permit an abortion.

Mr. John Saunders:

I cannot answer the last question because I am giving views on procedural arrangements. We noted there was no appeal to a court, regardless of the decision made by the review group and we stand over this. The Freedom of Information Act is about transferring information to the public domain and it has provisions on withholding personal information. It is a matter for the Houses of the Oireachtas to decide whether the Act applies in total or not under this legislation.

Senator Jim Walsh:

I wish to ask one small point of clarification. Dr. Kevin Walsh stated current practice will not be changed by the legislation and then stated women go to England because they have heart conditions which cannot be treated here. Will Dr. Walsh clarify this? It cannot be both. Does Dr. Walsh have evidence as to why people go to England? Last time we heard evidence of people going for a sixth abortion.

Dr. Kevin Walsh:

We have too many Walshs. Dr. Janice Walshe said things will not change directly. There will be small changes. People have had to go abroad to get things which have not always worked out.

Senator Fidelma Healy Eames:

Such as what?

Chairman:

Sorry-----

Senator Fidelma Healy Eames:

Chairman this is a very important point

Chairman:

We are not in Ballymagash so please respect the witnesses, other committee members and this Chamber.

Dr. Walsh answered the question and I thank him. This brings us to the end of a session. I thank most sincerely Mr. John Saunders, Dr. Janice Walshe, Dr. Kevin Walsh and Ms Eileen Lawrence for coming before the committee. I thank the secretariat, the ushers, the stenographers, the sound personnel and the Houses of the Oireachtas staff for their work. I thank the expert witnesses who have attended all of the sessions. As I keep telling members they come voluntarily and change their schedules to assist us.

The joint committee adjourned at 8 p.m. until 9.30 a.m. on Tuesday, 21 May 2013.

Heads of Protection of Life during Pregnancy Bill 2013: Public Hearings

Tuesday, 21 May 2013

The Joint Committee met at 09:30
MEMBERS PRESENT:

Deputy Catherine Byrne,	Senator Ivana Bacik,*
Deputy Ciara Conway,	Senator Colm Burke,
Deputy Regina Doherty,	Senator John Crown,
Deputy Robert Dowds,	Senator Aideen Hayden,+
Deputy Peter Fitzpatrick,	Senator Imelda Henry,
Deputy Seamus Healy,	Senator Jillian van Turnhout,
Deputy Billy Kelleher,	Senator Jim Walsh.*
Deputy Mattie McGrath,	
Deputy Sandra McLellan,	
Deputy Eamonn Maloney,	
Deputy Denis Naughten,	
Deputy Caoimhghín Ó Caoláin,	
Deputy Mary Mitchell O'Connor,	
Deputy Robert Troy,	

* In the absence of Senators John Gilroy and Marc MacSharry, respectively.

+ In the absence of Senator Ivana Bacik, for part of meeting.

In attendance: Deputies Paudie Coffey, Michael Creed, Jim Daly, Bernard J. Durkan, Alan Farrell, Terence Flanagan, Tom Hayes, Kevin Humphreys, Derek Keating, Tony McLoughlin, Peter Mathews, Olivia Mitchell, Michelle Mulherin, Seán Ó Fearghaíl, Aodhán Ó Ríordáin, John O'Mahony, John Paul Phelan, Brendan Ryan, Arthur Spring, David Stanton, Billy Timmins, Peadar Tóibín and Liam Twomey, and Senators Paul Bradford, Terry Brennan, Martin Conway, Michael D'Arcy, Fidelma Healy Eames, Terry Leyden, Rónán Mullen, Michael Mullins, Catherine Noone, Labhras Ó Murchú and Susan O'Keeffe.

DEPUTY JERRY BUTTIMER IN THE CHAIR.

Heads of Protection of Life during Pregnancy Bill 2013: Public Hearings (Resumed)

Medical Law

Chairman:

I believe in starting committee meetings punctually every Thursday morning, although this is our third day. I thank members. We have a quorum of six members, at least one being from each House. Is it agreed that we begin in public session? Agreed.

I remind committee members, Members in the Gallery, witnesses and members of the media to switch off their mobile telephones instead of leaving them on silent, as they interfere with broadcasting.

I welcome everyone to our ninth session in the series of hearings that the Joint Committee on Health and Children has been asked to conduct to discuss and analyse the heads of the protection of life during pregnancy Bill. I ask committee members and non-members to be brief in their questions and relevant to the heads of the Bill. I will be strict with time today. I also want to be fair to people. I apologise to those who did not have an opportunity to contribute yesterday, in particular Deputy Maloney. I hope that he will have an opportunity today.

Deputy Eamonn Maloney:

I did not sleep all night.

Chairman:

I remind members to make balanced and fair remarks and to use temperate language. We should hold our debate in a balanced, fair and calm manner that befits the Houses of the Oireachtas. I thank them for their co-operation during the past three days. I ask members to focus their remarks on the Bill on a head-by-head basis.

I welcome Ms Caroline Simons, Mr. Tony O'Connor, Mr. Paul Brady and Dr. Simon Mills, who have given freely of their time to assist us. Every expert who has appeared before us - they are witnesses, not experts - has given of his or her time freely to assist us.

I remind members and witnesses of privilege, in that witnesses are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to do so, they are entitled thereafter to only a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of the proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise nor make charges against any person or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice or ruling of the Chair to the effect that, where possible, they should not comment on, criticise or make charges against either a person outside the Houses or an official either by name or in such a way as to make him or her identifiable.

We have 50 minutes for opening statements, with four speakers. I invite Dr. Mills to begin.

Dr. Simon Mills:

I thank the committee. I compliment it on the extensive amount of work involved in the hearings of recent days as well as in the preceding hearings and the output of same, namely, the committee's report and the heads of the Bill that we are discussing today. The Bill

encapsulates the terms of the X case. My broad overview of matters is that it does so adequately. As the Government was entitled to do, the Bill leaves to one side broader considerations of Article 40.3.3° for another day.

The committee has my brief written submission. Due to tight timelines and as with everyone who has contributed to the hearings, not everything that I originally thought about the Bill was contained in that submission. As I have considered the Bill, a number of other matters have also come to mind. I propose to use my opening submission to address a number of matters, aside from those set out in my written submission, that would be of relevance for the committee and, in due course, the Oireachtas to consider. I will do so in the order of the heads of the Bill, precisely as one would do if making a written submission.

The definitions of unborn and implantation as set out in the definitions section could be merged into one. Implantation is defined as "implantation in the womb", but the word only appears once in the legislation, that being in the definition of unborn. It seems logical that, if unborn is to be defined in the Bill, one could simply refer to implantation in the womb.

The requirement to form a reasonable opinion is set out in heads 2 and 4 and defined in head 1. As currently drafted, the reasonable opinion provision requires the doctors to have regard, in so far as is practicable, to the right to life of the unborn. If this definition is to articulate fully and properly the tests laid down in the X case, the expression it gave to Article 40.3.3° and the language of that Article, the reasonable opinion should also include, by way of balance, the obligation to have regard to the right to life of the mother.

I will address heads 2 and 4 together. Head 2 deals with a threat to the life of the mother arising other than by the threat of self-destruction. Head 4 deals specifically with the question of suicide and suicidality. Clearly, a decision has been taken to treat suicidality in a different and contingent fashion when compared with the threat of physical injury. We must all be pragmatic about this - the reasons are, to some extent, political. However, a number of issues should be considered in respect of heads 2 and 4 if head 4 is to survive and become part of the legislation. I will refer to that matter in a moment.

Heads 2 and 4 do not give sufficient detail to the test that is to be applied by doctors in assessing the threat to life. An aspect of the X case judgment and the articulation it provided of Article 40.3.3° is a requirement that the threat to life must be present as a matter of probability. In so far as this formed part of the X case judgment, the requirement that the standard to be met on the part of doctors assessing the threat to the life of the mother should be expressly stated to be a matter of probability.

Under heads 2 and 4, which require that there be an examination of the mother, it occurs to me that "examination" is the wrong word. I touched on this issue in my written submission. It may well be that there are assessments of the pregnant woman that do not require an examination of the woman herself, but an assessment of radiological images or blood tests. It may be that a particular condition is so rare that a consultation must be held at a distance, meaning that a physical examination is not possible. Where the word "examination" is used in heads 2 and 4, it might be made the subject of a definition under head 1 or be dealt with more extensively in heads 2 and 4 to address, among other issues, the express requirement for a consultation with the woman and the possibility that an examination might be other than a physical examination or might require something more than a mere physical examination.

I anticipate that the issue of whether heads 2 and 4 should be separate will arise in questioning and I do not propose to deal with it in this submission. I propose to speak to it later.

Heads 6 to 9, inclusive, address the issue of reviews and appeals of decisions that are or may be made under this legislation. I will deal with them collectively instead of breaking them down. Having given the Bill consideration subsequent to the preparation of my written submission, a number of issues occurred to me that may be matters that the committee and, in due course, the Oireachtas wish to consider. First, the requirement or otherwise for the provision of a scheme of legal representation for those who may require it in the setting of any review.

It strikes me that this requirement may arise in two possible settings. One relates to the simple fact that a person may not be best placed to put her own case and may require it to be put for her. Whether some form of assistance will be required is, of course, a matter for the Oireachtas. However, there is also another area that arises, relating to the question of capacity to argue one's case. Issues were touched upon yesterday by a number of the witnesses in regard to capacity in terms of age and mental capacity. It may well be that the committee and, in due course, the Oireachtas, may wish to give consideration to those.

I mentioned the issue of a matter of probability, namely, the requirement that the risk be present as a matter of probability in respect of heads 2 and 4. This issue also arises in any assessment that is to be made by a review panel under heads 6, 7, 8 and 9. The question may be asked whether ultimately there is, or should be, a role for the court in determining aspects of disputes that may arise - such as whether the High Court has a role to play as the ultimate arbiter of disputes that may arise in respect of the operation of the Act. It may be that nothing like that needs to be expressed because the court has its jurisdiction.

I refer to head 12 which deals with conscientious objection. I dealt with a number of matters in my written submissions. One issue that arises is how extensive is the right of conscientious objection, in particular to what extent, for example, conscientious objection arises where an opinion is sought; to what extent there is an obligation on an individual to notify either the existence of a conscientious objection or of previously publicly expressed views of which a patient may not be aware. It may be there is no such requirement but there is a necessity at least to consider the balancing of rights involved in freedom of conscience on the one hand and access to a constitutionally available right on the other.

The last matter I wish to deal with, briefly, is head 19, which provides for the criminalisation of certain acts. In my written submissions I set out a number of specific criticisms but it strikes me there is one more general observation to be made which, now that I think of it, was so obvious it did not occur to me at the time, as is often the way. This is the fact that head 19 is simply over broad in the offence it creates. The idea that any act done with intent to destroy human life would be a criminal offence is, on its face, a significant over-statement of the position contained within the 1861 Act. If what is intended by head 19 is a simple restatement of the criminal prohibition in the 1861 Act I would think head 19 misses that mark. It may also be wished to give some thought to the question of the criminalisation of the vulnerable and desperate pregnant woman, which the Act also contemplates. It may well be that this is dealt with by the need to bring prosecution only through the Director of Public Prosecutions but it is certainly a matter to which I ask the committee and, in due course, the Oireachtas, to give consideration.

Chairman:

I call Mr. Paul Brady.

Mr. Paul Brady:

I thank the Chairman and the committee for inviting me to attend. I echo the sentiments of my colleague, Dr. Mills, in commending the Chairman and the committee for the manner in which these hearings have been organised and conducted, both this month and earlier in the year.

I provided short written submissions that deal with two specific issues. As was noted, it was hard to be comprehensive in the time provided for preparation so I thought it best to focus on two issues. Before I speak on those, I wish to introduce myself briefly because I have not been before the committee up to now. I am a practising barrister and a co-author of the second edition of a book, *Psychiatry and the Law*. In addition to my primary degree in philosophy, I have postgraduate degrees in legal theory, or law, from University College London, Harvard Law School and the King's Inns, and am currently completing a doctorate in the philosophy of law at Oxford. My areas of interest are constitutional law, mental health law and medical legal ethics. My publications include a piece on Irish constitutional law and statutory interpretation in the light of the European Convention on Human Rights. My current area of research is the role of moral argument in judicial reasoning. It does not take much imagination, therefore, to see how abortion law might feature is such research. I am not here to argue for any particular moral or policy position on the question of abortion, however, nor, of course, am I here to give expert medical opinion. Rather, I believe the role of the lawyer in the legislative process is at least a twofold one although my colleagues may have other insights in this regard.

First, I believe professional legal opinion can assist legislators in better understanding the legal meaning and legal effects of different draft proposals. Supporters of a proposal may have a particular goal in mind but the draft may not accurately give effect to that goal. Perhaps the examination requirement is a good example of that. Second, professional legal opinion can assist legislators in better understanding the legal constraints within which they must operate. The most obvious and perhaps the overarching legal constraint is the requirement under Article 15 not to enact any law that is repugnant to the Constitution, including the Constitution as it is interpreted by the courts pursuant to Article 34. The converse of this is that legal advice should help critically to scrutinise claims that political decision making and legislative freedom are in some way restricted by certain legal requirements. To my mind, a very noticeable feature of the political debate on the draft heads of the Bill, especially on head 4, has been the extent to which its political proponents fall back on arguments of legal necessity, which emphasise the Government's lack of freedom of choice, rather than offering stand-alone or policy-based arguments to justify the drafting choices that have been made.

In sum, I believe the two functions of the legal input today are to help to clarify two issues, first, what is the legal effect of what is actually being proposed and, second, why it is being proposed. My submission speaks of these two points as they relate to head 4 of the Bill. I do not intend to summarise here those observations in detail but will be happy to take any questions members may have. I will make a few brief points, however. Many have called this Bill restrictive but that only begs the question - restrictive compared to what? Obviously, any

regulated abortion law will be restrictive compared to a wholly deregulated approach. The absence of any estimates as to the level of need which head 4 is designed to address - an absence that is based in some cases on a lack of information, studies and so on - is problematic. What will be the benchmark against which the operation of this Bill will be measured in order to confirm whether it is, in fact, as restrictive as its sponsors intend?

Rather than talk of restrictive or non-restrictive, I prefer to examine what is permissible and possible under head 4 - I stress the words permissible and possible. This does not mean "probably". Probability is not the only consideration. One of the functions of legal advice with respect to the drafting of any legal instrument, be it a will, a business agreement or a Bill, is to help to anticipate and avoid possible unforeseen or undesired consequences of a particular wording. I stress that this is a professional responsibility of lawyers and legislators alike. It is not about casting aspersions on anybody, no more than, for example, various default clauses in a contract imply ill will or distrust of the person with whom one is dealing. For lawyers and legislators not to ask difficult questions about the possibly unintended legal effects of a proposed wording would be irresponsible.

With respect to head 4, and in that light, I note in my submissions a number of legal effects which I believe, on its face, the Bill contains. First, it is clear that head 4 marks a change in the law. It is not accurate to say otherwise. It creates, for the first time, a statutory basis in Irish law for what may be a direct and intentional termination of an unborn child's life. In the January hearings Dr. Rhona Mahony articulated extremely well what she stated was the current practice in this area.

She stated:

> In my hospital last year we had three cases in which we had to intervene prior to foetal viability because of our concern that a woman would die. We never kill a foetus. That is not our aim. Occasionally it is required that we deliver a pregnancy before the baby is viable or capable of surviving in our neonatal intensive care unit. When there is any possibility at all that we can preserve the life of the baby we will do so.

She continues:

> In other cases we are required to terminate a pregnancy as part of a treatment of a medical condition because we feel a woman will die. That is not killing the baby. That is simply delivering the baby before it is viable. There is a difference. It is always our wish to preserve life.

That is a statement of how the practice proceeds currently.

Under head 4 it will be provided for statutorily that the aim of the procedure can be to bring about the death of the unborn child and that will be desired aim of the procedure and not some other form of treatment, relocation or therapy to the mother which has that consequence. Having that as the goal of the procedure is new, and it is a question of being honest about that. It is clear that head 4 permits such procedures at any stage in pregnancy. It has been stated by many that it will never be legal for an intentional termination to take place after viability but that does not reflect what is in the draft Bill. I can say more about that point if people so wish. I also note that head 4 does not require that the procedure be offered as a treatment for a recognised medical condition in the way in which Dr. Mahony stated those current treatments take place. I believe the committee heard from psychiatrists yesterday that

they do not perceive it as a treatment in that sense either.

Head 4 does not require that the abortion be an option of last or ultimate resort, and I believe the committee has also heard this from psychiatric evidence. It may be the case that a psychiatrist's job is simply to certify that it is permissible but not a question of ensuring that it is the last or ultimate option. Following from the definition of "unborn" referred to by Dr. Mills, it is important to point out that the Bill seems to provide for the possibility of a termination occurring at any stage until the baby has been completely delivered. That may be unintentional. The definition of "unborn" includes an unborn child or a child in the process of delivery. Although it may not be likely in practice, we should be careful about how we word the issue, as that may allow for a procedure to take place even upon a partially delivered child.

The requirements for certification by three doctors may seem very restrictive on the face of it but in practice there are reasons to believe the process may operate otherwise. I would be happy to take questions in that regard.

Mr. Tony O'Connor:

I am a practising barrister with no particular expertise in the abortion area, and the use of the word "abortion" may heighten people's feelings on the subject. Before proceeding, I echo the comments of my colleague barristers on the conduct of the meetings and I congratulate the Chairman on the way they have been conducted. It is a good exercise in democracy.

I am here to try to assist the committee and others who may wish to ask questions about practicalities in the practice of medicine and law. I find myself, in practice, most of the time trying to keep people out of court as opposed to fighting in court. With particularly sensitive areas like this, courts are the not the appropriate venue to fight in an adversarial way about who is right or wrong. There is some merit in the Mental Health Commission structure regarding inquisitive processes as opposed to the adversarial process.

I thank the committee for asking me to attend the committee meetings and I focused on two particular issues, which have already been covered. I took the opportunity of reading the transcript from last Friday and have had the benefit of reading in particular the views of Professor Kieran Murphy from the Medical Council. When I prepared my written submission I had not been aware that he would cover this area and I should say for the sake of full disclosure that I attend meetings in my professional capacity before the Medical Council. I have had no communications with the Medical Council with regard to its submission. Nevertheless, Professor Murphy summarised very concisely the facts on the capacity issue and I echo and endorse the view of the Medical Council regarding the public interest in ensuring clarity for doctors in making clinical decisions.

In the somewhat rushed draft I submitted early Friday morning in advance of any of these hearings I made a submission setting out present law regarding capacity and the scenario regularly faced by doctors. Such doctors come to lawyers for advice on what to do. It may be somewhat unsatisfactory in dealing with a woman's capacity to consent or refuse a procedure when there is impairment. I note the Oireachtas Joint Committee on Justice, Defence and Equality last year led to useful work by the Centre for Disability Law and Policy and I sincerely hope the assisted decision-making (capacity) Bill, which is due to be published shortly, will be enacted this year, as it will help in many areas for doctors and clinical

practice. It is not seemly or right that many of the areas concerning capacity end up in the High Court. Although it is not a frequent occurrence, one or two cases have been outlined in the written submissions of people going to the High Court in that respect.

I have suggested in the introduction an amended wording for head 2(5). It covers two or three issues that should be taken in by the legislation and although it is not perfect, it is suitable for discussion purposes. It reads:

> Following certification in writing by the two registered medical practitioners in accordance with head 2(1)(*b*), including certification has been had with regard to the right to life of the unborn, a decision by or on behalf of the patient must be made and communicated in accordance with law before the medical procedure is undertaken by a registered medical practitioner.

I am trying to cover two elements. Head 2(1)(*b*) as currently drafted indicates that the patient has the ultimate decision but I am anticipating instances where the patient would not have the capacity to consent or refuse permission, and I am trying to anticipate the introduction of the assisted decision-making (capacity) Bill, which will assist rather than substitute decisions. I will go into that in more detail if this committee so wishes, although I note the justice committee has already dealt with it.

Even if that Bill is not enacted, I suggest to the committee that the wording I propose would cover the area where a substituted decision must be made. It also helps to fulfil the duty of the State as required by Article 40.3.3° of the Constitution to ensure that regard has been had to both mother and baby.

It is important. Under the present draft I believe it maybe covered but there is no harm in copperfastening the certification by the doctors regarding the defence and vindication of the rights of both parties. I note the repeated request by contributors last Friday for the merging of heads 2 and 4 and that is a decision to be made by the committee, and subsequently when it is presented to the Dáil. It is principally a matter for the Parliamentary Counsel, however I see merit in attempting to rule out possible different applications under the different headings.

I endorse the opinion of the Medical Council that the monitoring system to be provided under heads 11 and 14 should incorporate appropriate requirements to preserve confidentiality of the patient and the certifying practitioners. The provisions already in the draft heads are of the type that would allow the Minister to bring in regulations, and this would be helpful. This is a very sensitive area and I suggested the Minister would be given a focus as to what those regulations are about. The regulations should provide that this is for monitoring as opposed to enforcing any particular regime.

I have heard the comments by my colleagues, in particular Dr. Mills, about criminalisation and I echo those views. These provisions are too widely drafted. Criminal provisions should be focused on what is to be criminalised as opposed to leaving it uncertain as to what can be prosecuted in time. Again, I can address that if the members of the committee wish.

Dr. Mills in particular referred to the definitions section and, again, I believe the Office of the Chief Parliamentary Counsel will pick up on many of the topic discussed at this hearing and when this Bill goes through the Oireachtas. However it is very important to scrutinise each of the terms used in the definitions section because it will have an impact on its application. For

example, the word "patient" needs a definition in light of what may happen in the future. Perhaps it is tangential to all this, but the patient in this case is clearly intended to be the woman who is carrying the foetus, as opposed to any other person who has an interest in that foetus and therefore perhaps some focus is needed in that regard.

I repeat my view that the High Court and the Supreme Court are not the places to fight out the issues that can be anticipated here. I am prepared to answer any questions and if I can provide any assistance, now or in the future, I am more than willing.

Ms Caroline Simons:

Good morning Chairman, members of the committee, Senators, Deputies, members of the press and the public. Once again I thank you for the invitation to attend today now that we have the heads of the Bill. I have tried to listen, not to everybody's contribution over the last two days, but to some of them. We have all been impressed by the professionalism and dedication shown by the medical experts. I use that term to cover the experts from all the areas of medicine who we have been listening to. In this phase of the committee's deliberations it has been particularly nice to hear testimony from some of the doctors who work in related areas.

Yesterday we heard from Dr. Janice Walshe, the consultant medical oncologist from St. Vincent's University Hospital. I was particularly struck by her when she said that oncologists who are dealing pregnant women who are suffering from cancer strive for foetal maturity rather than viability while providing all the care and cancer treatment the patient needs. We also heard from Dr. Kevin Walsh, consultant cardiologist at Crumlin and the Mater hospitals, who spoke of the outstanding success of the Mater and Rotunda team approach to dealing with congenital heart disease in women. I was delighted to hear about that because women listening to these proceedings need to know the medical teams in the hospitals are doing their best for patients with whatever complication of pregnancy they have and, happily, with great success.

If the opportunity and time allows I might suggest the committee might also seek the advice and testimony of doctors from another branch of medicine which touches on this. I refer, of course, to consultant neonatal intensive care doctors, who might have something valuable to tell us too, given the kind of conversations we have been having over the last few days about delivery of very premature babies.

Our function today as lawyers is to assist the members in their analysis of the Bill. As lawyers we can look to the formulation of the words in the heads of the Bill and advise the members as to its meaning and, more importantly, to the possibilities to which it might give rise based on our knowledge and understanding of the law. We are not obstetricians or psychiatrist and so we rely on those experts for their expert testimony within their area of expertise. I was interested and particularly impressed in the last couple of days with the understanding the psychiatrists have shown of the law and what this Bill will mean regarding the practice, although it is not their area of expertise. When I hear Dr. Mills and others talk about merging heads 2 and 4, I think there will be some difficulty with that given the difficulty there has been around the suicide issue, which is the subject, as members know, of head 4.

It is interesting that we have come to a point yesterday, which is a considerable development,

when we heard the chief medical officer of the HSE talking about this Bill conferring procedural rights on a woman who believes she has a life-threatening condition. We heard another psychiatrist talk about this Bill providing a service which should be accessible and efficient, which is a slightly different requirement than was made of us by the decision in A, B and C *v.* Ireland. We need to examine what exactly this Bill is doing. Is it about a service provision? Does it have the backing of medical evidence? It seems that it does not. Even though medicine does not prescribe this procedure, it seems the law will demand it. I agree with Mr. Brady beside me that, potentially, the law will allow it throughout the nine months of pregnancy, on a fair reading of the X case from paragraph 35 on and a subsequent case I dealt with in my submission.

In my written submission to the committee I made a number of points. The decision in the X case and these heads of Bill permit the termination of the life of an unborn child, not just the termination of pregnancy, and without any time limit, notwithstanding any of the statements of comfort which appear in the explanatory notes. No evidence has been given to the committee that abortion is efficacious in the clinical care of suicidal women in pregnancy, while there is evidence of increased risk of suicidality following abortion. The decision in the case of A, B and C *v.* Ireland does not require Ireland to legislate for the X case. There are alternatives which this committee ought to consider, even at this point.

The Bill proposes a procedure as a treatment which is untested, without any scientific basis and which must, therefore, be considered experimental treatment. The usual criteria for the use of an experimental treatment cannot be satisfied by this formula. There is an inconsistency throughout the Bill regarding what procedure the Bill permits. I referred to this in my submission. In head 1 it refers to the medical "procedure that will end unborn human life". In heads 2, 3 and 4 the wording is "medical procedure in the course of which or as a result of which unborn human life is ended" and in head 12 the wording is "termination of pregnancy". There are differences between these three wordings that have very different outcomes and this has ramifications throughout the rest of the Bill particularly regarding the conscientious objection clauses.

Members will see that in my written submission I have dealt with the requirements of the European Court of Human Rights decision in the case of A, B and C *v.* Ireland and the requirements of the X case, and then I have looked at the law regarding experimental treatments. Finally, because it is so important, I have looked extensively at the law on conscientious objection internationally. Having said that, the law on conscientious objection should have no relevance whatever where we are talking about doctors wanting to practice good medicine and wanting to avoid something which has not been proven to be in any way useful to the management of a patient in circumstances where suicide is an issue. I shall leave it at that and welcome questions the committee raises.

Chairman:

Members of the committee will be allocated 70 minutes and 11 members have indicated. Not everyone will get in but I will try to be fair to everybody. I ask members to be brief in their questions.

Deputy Billy Kelleher:

I welcome the witnesses. I shall address my questions to Dr. Simon Mills first. Can Dr. Mills elaborate what he meant in the context of capacity and representation under heads 6 and 9? Is he saying, for example, that a woman who has been refused through the panel and who lodges an appeal with the review panel would be entitled to legal representation or that somebody else could represent her if she felt she was not in a position to attend for whatever reason, medical or otherwise? I seek clarity on the matter.

Dr. Mills also mentioned a conflict of interest in the panel. Is that a conflict in the context of conscientious objection or is it a conflict for some other reason? He referred to being obliged to declare a conflict of interest. I seek clarity on the matter.

When Dr. Mills referred to criminalisation in the context of head 19, was he referring to the criminalisation of a person who would carry out the termination or also the criminalisation of the woman? He referred in that context to it being quite problematic, so I want to get clarity on that as well.

On the broader issues, Mr. Brady referred to the fact that a termination could take place up until birth. He implied that it would be the intentional destruction of the baby. Where is that stated in the legislation? Where could that possibly happen? Is he saying that the legislation overrides the right of the unborn contained in Article 40.3.3° and explicitly stated in the Constitution?

Head 4 has been quite contentious in discussions and we have had varying views. The Government has made the decision to legislate, although the Oireachtas will decide at the end of the day. Is there not a constitutional obligation on the Oireachtas when legislating to include the threat to the life of the woman because of suicide? I seek clarity on the matter because I have heard varying views. The Attorney General has a view but the senior counsel and BLs may also have a view.

Deputy Caoimhghín Ó Caoláin:

Go raibh maith agat. I thank each of our guests for attending this morning.

I have a question for Dr. Mills on his proposed rewording of head 2 regarding GP involvement, where the current wording includes "shall consult" and "where practicable" and he suggests "where clinically appropriate" as an alternative wording in that regard. This view argues for a less direct involvement by the GP, although the Bill as drafted does not require GP involvement as an absolute, only where practicable. This contrasts with the views expressed by psychiatrists yesterday who argued that the GP should be fully involved, even to the point of suggesting that the GP should be the first to determine the need, or possible need, for a termination in the context of head 4. Did Dr. Mills note their views? I know it is very difficult to follow each of the day's submissions. Would Dr. Mills like to offer any elaboration on his view in this regard and his view of their arguments, if he has had such an opportunity?

On Mr. Brady's submission, specifically his written submission, which I have gone through, he is at pains to point out his position on the X case decision. He says that a point not argued is a point not decided and references the two specific concessions, as he describes them. Counsel for the Attorney General formally conceded two points. The first was that abortion is lawful under Article 40.3.3° in certain circumstances, and the second concession was that in

certain circumstances, an abortion could be the only way to avert the death of a woman from suicide.

In his conclusions, Mr. Brady makes the point that the fact that these concessions, as he describes them, have determined the fate of such an important court case is perhaps regrettable. He concludes that 21 years later, this is determining the fate of our legislators' deliberations. As a legislator, I would like clarification of his view of this process. Is it the failure of the Legislature to address the issue over the past 21 years that is inexcusable, which is his very last word in his written presentation, or is it that a decision, albeit a flawed decision in his view, of the Supreme Court, with its pre-eminence in law, is dictating the parameters for addressing these matters that is inexcusable? I would appreciate it if he could clarify his position regarding these remarks.

I record my thanks to Mr. Tony O'Connor for suggesting that we redraft head 2(1) and for the points he made specifically on head 2(5). That is what this committee is about. It is trying to find a way to improve the legislation and make it fit for purpose. That is something we must evaluate.

Ms Simons makes the point in the opening page of her written submission that the evidence given by every obstetrician and psychiatrist to the committee in January 2013 is totally contradicted by what is now being presented. This has been strongly refuted during the course of these hearings by the most senior perinatal obstetricians in the land. Ms Simons must understand that we are trying to go through all of this information and it seems that there is a strong difference of opinion in that respect.

Deputy Seamus Healy:

I welcome the experts and thank them for their presentations. We have received quite a number of presentations and heard a lot of information. In the process we may have forgotten the basics. Am I right that the proposed legislation will be operated on the basis of Article 40.3.3° of the Constitution, which contains a constitutional commitment to the life of the woman and the unborn, on the basis that there is a real and substantial risk to the life, rather than the health, of the woman, that it will be permissible only where the risk can be averted by a termination, and that the woman make the final decision?

Senator Jillian van Turnhout:

I thank the panel for their expertise. I would like to raise head 12 on conscientious objection, because it has come up several times and all of the experts have testified to their appreciation of the right to a conscientious objection. However, it seems it has always been seen from the perspective of the doctor or the consultant. Does a patient have a right to know if their medical practitioner has a conscientious objection? We have seen it from one perspective.

With regard to heads 2 and 4, the majority of governing and regulatory bodies have proposed that the two heads be merged. Yesterday, for example, we heard that while in psychiatry there may be no biological markers, there are clinical signs and symptoms, and there was clear testimony to that fact. I would welcome the panel's views on why they would agree or not agree with the proposal that the two heads would be merged.

I note on head 19, which deals with the scope of the offence, that Dr. Mills' comments are in line with comments that have been made by me and others over recent days. It is an issue we must look at.

Several experts have raised with us the silence of the Bill when it comes to children, to girls, in particular Dr. Maeve Doyle's testimony on children who are in care because of an abusive situation. It greatly troubles me that we will have a Bill that will totally ignore this small cohort of children who are voiceless and, yet again, may be left voiceless. Is this an issue that we could or should address within the parameters we have?

Senator Colm Burke:

I thank each of the panel this morning for their constructive contributions.

First, I want to ask Dr. Mills and Mr. O'Connor about the issue of where the expectant mother is under 18 years of age. The question at present is that the heads of the Bill are silent on dealing with that issue. Is it their view, when three medical persons come to a conclusion no matter what way we structure this, that there should be a procedure put in place to deal with that from a legal point of view? In particular, there is a distinction between someone who is under 16 and someone who is over 16. I wonder would they clarify their own views as regards how we should go forward with that issue.

Mr. Brady used the quote from Mr. Justice McCarthy from page 82 of the Supreme Court judgment in the X case. It is important that I would quote what Mr. Justice McCarthy stated: "In the context of the eight years that have passed since the Amendment was adopted and the two years since *Grogan's* case the failure by the legislature to enact the appropriate legislation is no longer just unfortunate; it is inexcusable". That was 21 years ago. His criticism was about the lack of legislation. I am not clear on Mr. Brady's criticism this morning as regards what he thinks is the best way of dealing with this matter. The Supreme Court was quite critical of the Oireachtas for not having legislation.

Ms Simons stated there are alternatives. I presume to what she refers is that there should be no legislation and it should be by way of guidelines. I may have misinterpreted her view. I am wondering under what existing legislation is she talking about guidelines. For guidelines to be put in place, there has to be legislation. Perhaps she might outline alternatives to the way we are dealing with this.

Chairman:

Dr. Mills may want to start. There are eight other members who have indicated.

Dr. Simon Mills:

In fact, I can deal with a couple of the questions in a way that I hope will respond to two or three of the Deputies and Senators at once, and I mean no disrespect if I do not deal with each of the questions raised by individual members.

To deal with the first broad rubric which is that of capacity, and that arises from Senator Colm Burke's question, from Deputy Kelleher's question and from Senator van Turnhout's question. Capacity comes in two forms when it comes to medical treatment. The first is one's

mental capacity, that is, whether or not one has the cognitive ability to take the decision in question. The second aspect of capacity is one's capacity in terms of age - whether one was of sufficient age such that the law recognises one's ability to take a decision.

To deal with Deputy Kelleher's question first in relation to capacity and legal representation, it is a somewhat complex issue. In fact, capacity arises somewhat earlier in the process than merely heads 6 and 9 because one wonders what is the situation, for example, for a patient who may require a termination in a life-threatening emergency or who may require a termination under head 2 and who lacks capacity. How are such decisions to be taken? They are likely to be taken by reference to the mental capacity legislation, which is due to be introduced. It currently goes by the Title, assisted decision-making (capacity) Bill. It strikes me that a big part of the conversation we are having in so far as it concerns those who are vulnerable in terms of capacity can be answered by the prompt introduction of that legislation.

The question that flowed from that is, "What is the story then about representation when it comes to a review panel?" Again, the answer to that question starts slightly earlier. What is the right of review for a person who lacks capacity? If somebody lacks capacity - it has been suggested, for example, that she might well be somebody to whom head 2 applies and a decision is taken that head 2 does not apply to her - how is it determined whether that person has a right of review and how is that review to be exercised? It is something that the Bill might consider.

In terms of the specifics of representation, it seems that one of two approaches can be taken. The first is that the Bill would provide for a general right of representation such that a person can be represented if the person wishes. The alternative would be that some form of representation is guaranteed. One thinks about, for example, the model under the Mental Health Act 2001 where a person is entitled to a review of his or her involuntary detention and legal representation is appointed for him or her.

In regard to age, which Senator Colm Burke raised and which also touches on Senator van Turnhout's question, the law in relation to age is reasonably straightforward for over 16s. Once one is over 18, one is an adult and there is no issue. One has the right to consent to and to refuse medical treatment. If one is 16 or 17, section 23 of the 1997 Non-Fatal Offences against the Person Act, which is, perhaps, an odd legislative instrument in which to repose the right to consent to treatment but which is where it resides, gives those aged 16 and 17 the right to consent to medical, surgical and dental treatment. It does not give them the right to refuse, which is a significant omission that has been identified by the Law Reform Commission. We simply do not know what the legal position is in the case of under 16s. The Law Reform Commission has called for reform in this area and reform is certainly required. The United Kingdom has adopted a doctrine called Gillick competence, which confers on under 16s a limited right to consent to treatment. There is no such equivalent doctrine here, although the Law Reform Commission has recommended that one be adopted.

To deal with Deputy Seamus Healy's question, the three assertions that he makes are absolutely correct. It is worth observing that the three interpretations he invites us to agree with are also part of the bulwark which is, in effect, erected against many of the so-called floodgates arguments that are advanced, that however this Bill is ever to be interpreted, it is always to be interpreted against the backdrop of Article 40.3.3°.

Lastly, to deal briefly with Deputy Ó Caoláin's question about GP involvement, it may well be that there is a wider role for the general practitioner than that which is currently countenanced by the legislation. A GP is a doctor on the register of medical specialists. He or she is on the register of medical specialists as a general practitioner. The issue that I raise, I suppose, is the requirement that a GP shall be consulted where practicable raises at least the possibility of a bizarre procedural wrangle over the question of whether or not a particular decision is defective because sufficient efforts were not made to contact the GP prior to the termination being carried out. It strikes me that the rationale offered in the Bill, which, ultimately, relates to follow-up care, certainly places an obligation on doctors to liaise with the GP on follow-up care but it is not clear to me that there must be an obligation for certifying doctors to deal with a GP, although there may well be a role for a GP in the certifying process. I hope that answers all the questions that were put.

Mr. Paul Brady:

The Chairman indicated I have five minutes and I will try to do justice to the questions in that time.

Briefly, in response to Senator van Turnhout's question regarding children, I would echo much of what Dr. Mills said. The issue of consent to medical treatment of various kinds and children in Irish law is really a neuralgic point in Irish law because of various conflicting provisions, particularly the conflict between the definition of child in the Mental Health Act and also the provisions in section 23 of the 1997 Act. Given what we have heard about how this Act might be applied and who may be using it, it seems to me that this is an issue that probably needs to be addressed in a determined and focused way by the Oireachtas, perhaps before this other issue of termination of pregnancy is addressed. It is a stand-alone problem in its own right - consent and medical treatment for children. It should not be dealt with as a kind of tag-on to this issue. It deserves full consideration. It would be very problematic indeed if this legislative machinery is set up while that issue is left parked and unclear. It is a recipe for many problems ahead and unnecessary anguish, and perhaps cases before the courts. That might give pause for thought.

That issue should be dealt with first and properly before the current Bill is pushed through.

As regards Deputy Ó Caoláin's and Deputy Kelleher's questions, I will take them together. To be clear, what I regard as inexcusable in my final line, and I am paraphrasing Mr. Justice McCarthy who used it in a different context - and I acknowledge that, of course - is that there is a perception that the Oireachtas is bound to legislate for threatened suicide as a grounds for termination of pregnancy on the basis of the X case decision. What I am trying to point out in my submissions is that that part of the decision was based on a concession made by the parties at the start. It was not argued and therefore it was not decided. That is not an esoteric point, it is a well-established point in constitutional law. I have given some quotations in my submissions. I cannot really do better than to quote that short extract from Mr. Justice Brian Walsh, whom Professor Joe Lee referred to as being one of the leading, outstanding legal reforming minds of his generation. He was a member of the European Court of Human Rights, the Irish Supreme Court and the Irish High Court. He was also chairman of the Law Reform Commission. In 1992, shortly after the X case decision, he said that Article 40.3.3° confers no immunity for taking life, and that its stated objective is the preservation of and respect for life.

It is perfectly consonant with the idea of safeguarding the woman's life without intentional and direct intervention to terminate the life of the foetus. The claim that it admits of direct termination has never been fully argued. In the X case it was conceded. There was no *legitimus contradictor* to argue against such a construction and therefore the court's decision can only bind the particular case as it was based on a conceded and unargued construction. It is well established that neither a constitutional provision nor even a statutory provision can be construed on the basis of a concession if it were to be binding *in rem*.

It is unfortunate that in discussing this issue, and having had the benefit of so much expert opinion in January and over the last few days, legislators should feel under some strait-jacketed legal obligation to bind themselves to what was a concession in that decision. I am making that point purely as one of legal analysis. As lawyers, we should be allowing members of the committee as great a freedom as possible to do what they think is right as regards a good, evidence-based law, and not to feel that with a heavy heart they have to legislate for something they think is unwise, imprudent or not beneficial because they feel they are under some over-bearing constitutional obligation in that regard.

Of course, legislators are under a constitutional obligation to comply with the Supreme Court and to interpret the Constitution appropriately, but I would say they also have freedom to explore options in this regard. When it comes to the question of options, there has been a failure to explore creatively the great scope that is given to a contracting member in the Council of Europe in how we responded to the A, B and C case in Ireland. The expert group set out four possible options and dealt with them in a cursory way. In fact, all four of the options given - guidelines, regulations, legislation, or legislation and regulation - could have provided a route for what the European Court was seeking. The expert group defined guidelines as exclusively non-statutory, but guidelines would have some statutory basis and there are various mechanisms by which that could be done. The Government has made a decision that it wishes to go with legislation and regulation. As to what that encompasses, my point is that we should not feel under an artificial strait-jacket in that regard. Legislators should be able to do what they think is best on a substantive basis and not on some procedural basis.

Mr. Tony O'Connor:

I will deal with the questions that arose from each member of the committee as they were put. Forgive me if I do not get to them all. Deputy Kelleher mentioned conflicts of interest and legal representation. On a pragmatic front, I believe the evidence which has been given to this committee by people like Dr. Mahony, Dr. Boylan and others, shows how doctors deal with this. They are not out there to terminate the life of the unborn. It works well but in a perfect world there should be a procedure, something like the mental health tribunals, in cases where a conflict is identified. If the committee does not mind me saying so, I think it should be lawyer-free as much as possible. We are here to help but we do not want to end up in the courts when we can avoid it.

I agree with the Deputy's perspective on criminalisation under head 19. I think it needs to be more focused. He mentioned the point about the constitutional obligation to legislate and that is undoubtedly the case. It must be accepted by everybody that we are now 21 years on from the X case and there cannot be any further delay in implementing legislation.

I thank Deputy Ó Caoláin for his comments on the draft and I note that he will consider that. He also made the point about the failure to legislate for 21 years. It is time to proceed.

Mr. Brady raised the issue concerning the capacity of children to make the decisions. He suggested that perhaps the legislation would be delayed pending the legislation on capacity both for children and vulnerable adults. My own view is that we have waited long enough and we should get on with it. However, this committee certainly should send a message concerning the legislation on the capacity of children.

Senator van Turnhout mentioned Dr. Maeve Doyle's evidence, which I did not read. However, it is a matter that perhaps this committee should forward to the relevant Oireachtas committee and ask it to get on with the legislation about capacity for vulnerable adults and children.

I agree with all the points that Deputy Seamus Healy made, including that this law will comply with what he has sought to explain.

Senator van Turnhout mentioned the obligation of a doctor to explain a conscientious objection. This legislation does not provide for that, but it is my understanding that the evidence already before the committee is that in its code of conduct the Medical Council has provided that it should be. The new code is to be introduced with the new Medical Council and that point should certainly be made to the Medical Council.

Senator Colm Burke asked a very relevant question on under-18s. There is a deficit there but the doctors have shown the committee how it is working. However, for legal certainty, I would urge the committee to send the message out that legislation is required.

Ms Caroline Simons:

Picking up on the point that my former classmate, Mr. O'Connor, has just made, we are not obliged to bring in legislation. Mr. Brady has made that point very well. We do not have to bring in legislation to give effect to every expression of an unenumerated right in the Constitution. For instance, there is a right to bodily integrity but we do not have legislation bringing that into effect. In my own submission, I referred to Kenny's decision in The People *v*. Shaw in which he said that the word "laws" in Article 40.3 "... is not confined to laws which have been enacted by the Oireachtas but comprehends the laws made by judges and by Ministers of State when they make statutory instruments or regulations". Therefore, we are not talking about something that is not entirely clear. This is a feasible alternative and might very much get one out of the difficulty concerning suicide, if the committee feels that is a difficulty.

Senator van Turnhout's question concerned who could exercise the right to conscientious objection, whether the woman could, and whether she would be entitled to know if a doctor has a conscientious objection to the treatment she is requesting. I agree that she is entitled to that information. However, I am a little wary of the suggestion that has arisen in the discussions over the last few days that there might be some kind of a list made of conscientious objectors. I feel that is a little sinister. I do not like the sound of that.

I do feel that the list of people to whom conscientious objection is afforded under the Bill is very limited. It is just given to midwives and doctors.

We must appreciate that under Article 9 of the European Convention on Human Rights, conscientious objection is not something that is limited in the sense that freedom to manifest religion is. I found the explanatory notes a little confusing in that regard and I will tell members the reason. Under Article 9.1 of the European Convention on Human Rights, the freedoms are expressed in an absolute way. These are the freedom of conscience, thought and religion, and when one then considers Article 9.2, the freedom to manifest one's beliefs and one's religion is limited. However, there is no express limitation in respect of conscience. Conscience is something that is, if one likes, bigger than any religious objection one might have. One need not have any religion in order to have a conscientious objection. A religious objection is something that comes from the tenets of a particular faith of which one is a follower, whereas conscience is a different thing altogether. Consequently, it is something that is very important and it is important that it be protected in the highest and most noble way for people who have a difficulty, particularly in the area of abortion, which we have found throughout the world in any legal text one might look at in this regard.

I suggest members extend the application of the right to conscientious objection not just to doctors but to trainee doctors, trainee nurses, pharmacists and anyone else who could be involved with the assisting or facilitating the process by which an abortion is carried out. I refer members to a decision that was made in recent weeks in the Doogan case. It is a decision of the Scottish Court of Session in which two midwives were relieved of any obligation to supervise nurses who were participating in abortion on the basis of their own conscientious objection. This is a good example for us to follow and I will leave it at that for the present.

Senator Jillian van Turnhout:

Briefly, on the question on the merging of heads 2 and 4, Dr. Mills indicated he would revert to that question and I specifically asked that.

Chairman:

Okay, I will ask them to reply when he responds.

Senator Colm Burke:

My question to Ms Caroline Simons was to clarify under what legislation guidelines can be brought in.

Chairman:

I will ask Ms Simons to reply at the end.

Deputy Caoimhghín Ó Caoláin:

Perhaps she might also clarify the claim in respect of the contributions back in January on the presentation that they were all of a particular view. It does not stand either in terms of the scrutiny or in their own views as expressed strongly in this Chamber last Friday.

Chairman:

Ms Simons may reply at the end when she comes back in again.

Ms Caroline Simons:

May I come back to that question straight away because it is rather important?

Chairman:

Very well, go ahead.

Ms Caroline Simons:

If one looks at what I have said in my statement, it is to the effect that abortion has never been shown to be an appropriate treatment and it is not prescribed for complications of pregnancy in which the psychiatrists who have expressed opinions have expertise. In response to Deputy Ó Caoláin, I believe this still to be the case. The evidence that has been given on how the psychiatrists now are feeling about their participation in the certification process, in particular over the past day, has given greater substance to this point. I was particularly interested when listening to the testimony from both the College of Psychiatrists of Ireland and Professor Veronica O'Keane yesterday. Professor O'Keane described the function of the psychiatrist as quite simply being a certification function and that it was not anything to do with treating suicidality. She stated, in respect of the legislation, that psychiatrists will assess risk and will certify eligibility or otherwise, but it is the woman, not the psychiatrists, who is requesting the treatment. The psychiatrist is only determining eligibility and, therefore, psychiatrists do not treat suicidal intent with abortion. A woman chooses this treatment for herself.

Chairman:

Go raibh maith agat.

Ms Caroline Simons:

I also was concerned that when we considered what the College of Psychiatrists of Ireland was saying in that respect, it presented us with the situation as to what one should do with a woman who was suicidal because of her pregnancy but who does not have any underlying mental illness or psychosis. She has preordained the treatment she wants, which is a termination under head 4. In the absence of any mental illness, she is presumed to have capacity to make this decision and she is in a position to refuse anything that is offered to her by the psychiatrist. This then would mean the only tool left in the kit that could address her suicidal ideation or suicidal intent is in fact abortion. This leaves the psychiatrists in a very difficult position, which was acknowledged clearly yesterday in the testimony.

Chairman:

Eight speakers have indicated and I again ask members to co-operate. Deputy Fitzpatrick, Senator Bacik and Deputy Naughten are the next three speakers.

Deputy Peter Fitzpatrick:

First, I thank the witnesses for their attendance and presentations. I have a few questions for them. In the event of a later stage termination being carried out under head 4 at 24 weeks where there is a known high risk of disability and where the child is born disabled as a result, will the State, the HSE or the doctors be liable if the child or either parent subsequently takes a civil action? In the event of a later stage termination being carried out under the legislation and where the child lives, who will be responsible under the law for the subsequent care of the child? In a case where a woman has undergone an abortion under head 4, the risk of suicide, and where she subsequently regrets this action and suffers a psychiatric illness, will the State, the HSE or the doctors be liable if the woman takes a civil action on the basis she was not competent to make such a life-changing decision at the time? In the event of a later stage termination being carried out under the legislation and where the child lives, will the biological father be liable for the costs in bringing up a child or will the mother be similarly liable? If the taking of civil litigation by either a surviving child or mother is possible, what records will be available under the proposed legislation to assist a court in making a judgment? In the event of a later stage termination being carried out under the legislation and where a child lives and if the biological father or a biological family member wishes to take over the care of the child, will this be permitted or will the mother be given complete control over the fate of her baby? In the event of a woman presenting with suicidal ideation because of the baby's gender, under head 4 will she be entitled to an abortion? Finally, is there any evidence to suggest that abortion is good for women?

Senator Ivana Bacik:

First, I thank those witnesses who engaged with the terms of the heads of the Bill as members of this committee are required to do. Since the Oireachtas is required to legislate for the X case in accordance with the judgment of the European Court of Human Rights and as the Government has decided to legislate, it is helpful to have submissions that engage with the heads of the Bill, as witnesses were asked to do.

Chairman:

If we could all engage with the heads of the Bill, it would be absolutely beneficial to us all.

Senator Ivana Bacik:

I will do that and I thank the Cathaoirleach.

Chairman:

It would be a blessing.

Senator Ivana Bacik:

I wish to ask Dr. Mills and Mr. O'Connor in particular about the issue regarding the general practitioner, GP. I take the point about the current wording, "where practicable", being rather vague. Would it be helpful to include a specific requirement that the GP be consulted with the consent of the pregnant woman? In a second point on definitions, Mr. O'Connor picked up on the definition of "patient". However, looking through the heads, I note the word "patient" is only used in head 4(4) and head 2(5) and elsewhere throughout the rest of the Bill, the term "pregnant woman" is used. This might answer Mr. O'Connor's issue in that rather than being

obliged to define "patient", one could simply not use that term but instead could use the clearer term "pregnant woman". I seek his comments in this regard.

In respect of head 1 and the definition of the unborn, this is something to which Dr. Mills referred in January. At present, it appears to me as though this definition goes further than is required by Article 40.3.3° and appears to cover, for example, both where there is no prospect of life outside the womb and where the foetus is in fact dead. Should the definition of "unborn" at least be restricted to exclude this particular aspect, in accordance with what representatives of the Institute of Obstetricians and Gynaecologists told the joint committee last Friday, which was that in this instance, they do not regard it as coming under the definition of "unborn"? Finally, I was glad to hear both Mr. O'Connor and Dr. Mills state that head 19 is too broadly drafted. I had taken the view that it is so broadly drafted, it would in fact be inconsistent with the Constitution, in line with the precedent in King *v.* Attorney General that it is too vague and covers too broad a range of activities. I am grateful to both witnesses for pointing out the excessive broadness. In particular, should members consider not criminalising the pregnant woman, in line with the Criminal Law (Suicide) Act 1993, where the person who attempts suicide is not him or herself criminalised? This is the Act referred to as a model in the notes to head 19. I believe everyone is in agreement there should be some sanction for the doctors or persons who aid and abet outside of the legislation, at least within the terms of the Constitution.

Chairman:

Thank you.

Senator Ivana Bacik:

However, should the pregnant woman herself be criminalised?

Deputy Denis Naughten:

I thank the witnesses. In their evidence to the joint committee this morning, both Mr. Brady and Ms Simons stated the heads of the Bill as currently drafted would allow for the termination of life of the unborn baby. They should clarify this point because my interpretation of head 4 is that the consultant psychiatrist must come to a reasonable opinion that there is a risk and that it can only be averted by the medical procedure. However, the definition of "reasonable opinion" states there must be due regard to the need to preserve the unborn life, where practicable. Based on this definition, how can they state it would be legally possible to terminate the life of the unborn baby? I ask them to clarify their interpretation in this regard.

In his initial contribution, Dr. Mills made the point that the threat to life will be on the basis of probability.

We had evidence yesterday from some eminent specialists that a 5% threat to life is a significant threat and in those cases they would feel it was a sufficient threshold for the mother to consider a termination of the pregnancy. I would welcome clarification on that point.

In the C case, which related to a rape victim, the High Court set out a very low threshold on the test for a real and substantial risk of suicide - far lower than is currently drafted in the legislation. Do the witnesses believe that if the legislation is challenged in the Supreme Court or there is an Article 26 referral, it will stand up to the challenge?

Deputy Robert Dowds:

I thank all the expert witnesses. Is there any way the criminalisation provisions in head 19 are a danger to a person who is trying to operate within the confines of the Bill, assuming it is enacted?

Is it possible to write a provision into the Bill to cover consent in the context of girls aged under 16? It is clearly a difficult area because part of the problem nowadays is that people mature physically before they mature in other respects. Would it be possible to come up with a wording to cover the issue?

My final question is prompted by my colleague Deputy Regina Doherty. It is directed to Mr. Brady in particular. How does the judgment of the Supreme Court differ if it is conceded as opposed to argued? Was this particular judgment unanimous and how does that position affect the judgment?

Deputy Mary Mitchell O'Connor:

I thank all those who presented to us today. Dr. Mills mentioned conscientious objection in passing. He referred to the freedom of medics in terms of the woman's right to be granted a termination. What are his views in that regard and does he have concerns? I address the same question to the other expert witnesses who have spoken.

Ms Caroline Simons:

On Senator Bacik's question on the obligation to legislate, I refer her to page 6 of my submission, in which I deal with the obligations on us under the European Convention on Human Rights and Irish constitutional law. I refer her in particular to the decision of Mr. Justice Murray in the case of McD *v.* L in 2010, in which he said that national law always takes precedence over international law. He continued by saying that the obligations undertaken by a Government that has ratified the convention arise under international law and not national law. Accordingly, those obligations reside at international level and in principle the State is not answerable before the national courts for a breach of conventions or obligations unless provision is duly made in national law for such liability. Thus, contracting states may in principle, in so far as the effect of the convention at national level is concerned, ignore the decisions of the court. Although I do not advocate that, I have pointed out in my submission that we are exemplary in our observation of decisions that are made in regard to us - much better, in fact, than Germany, Italy and other countries that I cited in the text.

On the question on head 4, which is where we find the idea that perhaps this Bill and the X case would allow termination of life rather than termination of pregnancy, if one looks at paragraphs 36 to 38 of Judge Finlay's decision in the X case, one will see his consideration of the test that was proposed by the Attorney General, namely, that the life of the unborn could only be terminated if it were established that an inevitable and immediate risk existed. The judge said that the formula proposed by the Attorney General insufficiently vindicated the

mother's right to life. In a later case, in the matter of Article 26 of the Constitution and in the matter of the Regulation of Information (Services Outside the State for Termination of Pregnancies) Bill, 1995, Judge Hamilton said the case of Attorney General *v*. X established that, having regard to the true interpretation of the Eighth Amendment, termination of the life of the unborn is permissible if it is established as a matter of probability that there is a real and substantial risk to the life, as distinct from the health, of the mother and that risk can only be avoided by the termination of her pregnancy.

Where we are talking about a situation in which a woman who does not have a mental illness but who is suicidal because of a pregnancy requires treatment - namely, her suicidality is to be addressed - it will not be enough to deliver her so that she is not pregnant. It may be the continuing existence of the baby that is causing her suicidality. There is room to see in the judgments that she could look for a termination of the life of the unborn. It would be reasonable to think that most people who would avail of the procedure would wish that result. We do know that in 2005 in the UK 66 babies survived NHS abortions. That figure was published in 2008. Following that, the Royal College of Obstetricians and Gynaecologists introduced a guideline which required that once a woman who had elected for an abortion was 21 weeks and six days pregnant she was entitled to have a foeticide either before or during the termination. Those are the kinds of things the members will have to think about. As lawyers we have to tell the committee about the possibilities that are raised by the heads of the Bill, which must take cognisance of the decision in the X case, so there is room for manoeuvre.

In response to Senator Bacik and others who have inquired on the matter of the criminalisation of women in abortion law, it is still a crime in the UK and the 1861 Act still applies there. Members are probably aware that last autumn there was a successful prosecution of an abortionist in the UK and in recent times there was a prosecution of a woman who aborted her baby at 30 weeks' gestation. She was given eight years by UK courts. It is easy to say we do not want to criminalise women but there may be cases in which that is appropriate, and it would be unwise to remove the law.

Mr. Tony O'Connor:

Deputy Fitzpatrick's questions related to matters that are outside the scope of the Bill, but I am open to correction in that regard. They were theoretical questions about civil actions and biological fathers which would only prompt me to again advocate that the committee encourage the Legislature to introduce legislation on assisted human reproduction. That is an area in which I have a particular interest and I take the opportunity to suggest that if the Deputy has an interest in it he should deal with it. I do not mean to be dismissive of his questions.

Senator Bacik raised a number of points and I hope to deal with all of them. I agree that the consent of the patient to go to a GP is important in the context of what we are talking about. I also accept her point that the term "pregnant woman" is used in other areas of the Bill and perhaps the term "patient" could be married with that. I acknowledge her expertise, particularly in the criminal law area. She is correct in stating, about head 19, that the phrase "It shall be an offence for a person to do any act with the intent to destroy unborn human life" is too broad and will not stand up to scrutiny. It needs better definition.

Dr. Mills has dealt with the broadness of the term "unborn". I have had a discussion with him on the matter of whether it covers ectopic pregnancies. If one wishes to be clear then why not take the opportunity now to make sure it does not?

Deputy Naughten did not address a particular question to me, but I understand his concerns. The legislation has been awaited for 21 years and we must get on with it.

The practice is there and this reflects it.

Deputy Mitchell O'Connor asked about conscience. I reiterate my earlier remarks, the guide of the Medical Council requires doctors to disclose a conscientious objection to the patient. Senator van Turnhout raised this issue as well, so perhaps that message can be sent out. It should be addressed but it am not sure it is appropriate for primary legislation.

Mr. Paul Brady:

Senator Bacik's point goes the essence of one of the points I am trying to make in as far as I respectfully disagree with the Senator that we are required to legislate for the X case by reason of the A, B and C *v.* Ireland decision. I do not think that is an accurate reading of the A, B and C *v.* Ireland. I have put into my written submissions detailed references to some of the jurisprudence of the ECHR regarding the implementation of its decisions.

A decision of the ECHR is primarily a declaratory judgment, it is not like a judgment in a domestic court, which generally gives a declaration as to who wins and states what the losing side must do about that. Unless it is under a pilot scheme judgment, which was not the case in A, B and C *v.* Ireland, the court is declaratory. That discretion of a contracting member state to implement a decision is increased when it comes to the implementation of a positive obligation. The breach in A, B and C *v.* Ireland was a breach of the positive obligation on the State towards the third applicant under Article 8, not a negative obligation, to facilitate accessible and effective procedures to a woman in the situation of Ms C. When implementing a decision regarding a breach of positive obligations, there is an even greater area of discretion. That has been played down in how these matters have progressed.

This leads to the second point raised by Deputy Naughten regarding my view as to how, in the case of head 4, a termination of the life of the unborn as opposed to the pregnancy, could occur after viability. This comes down to the application of the test of real and substantial risk beyond physiological conditions. In the case of a medical condition arising due to a physical aspect of the pregnancy, there will be a distinction between terminating the pregnancy and terminating the life of the child in that the death of the unborn child itself will avail nothing. It may well be, however, that it occurs in the context of a procedure designed to assist the woman, whereas in the case of suicidal ideation or intent, as proposed under head 4, it is conceivable that the refusal of an abortion itself may be the cause of suicidality. That was a possibility canvassed by many of the psychiatrists. In those situations, to say that we will induce an early delivery is not responding to the threat to the life from suicidality on the grounds of that pregnancy. The requirement in the Bill to have due regard to human life as far as practicable was also the test the Supreme Court was applying when it allowed for a direct termination of the life of the unborn on the grounds of suicidality. It is not safe to assume that simply because at the moment best practice is not to do anything post viability that would directly end a life, that will continue under head 4. I do not think head 4 requires that at all.

To go back to the significance of the conceded point made by Deputy Doherty, Mr. Justice McCarthy, who other members referred to, in the course of the X case judgment himself at page 77 of the report referred to an earlier decision of SPUC *v*. Coogan and said he disagreed with that decision. He was in the minority because he did not consider the point to have been decided in an earlier case which the court was referring to. He applied the doctrine I raised, that an unargued point is not a decided point and is only binding for the case. It leaves room for action, therefore, if the will be there. That is not my business, but it is my business to point out if an artificial constraint has been put upon a person when that person is in fact free to make decisions.

Dr. Simon Mills:

On the question of merging heads 2 and 4, there are a number of ways of looking at this. They can be dealt with separately but if they are to be dealt with separately it should be done by the application of the same legal test, whatever the threat to life of the mother. No distinction was made in the X case and no distinction is made in Article 40.3.3o to the effect that with due respect to the life of the mother, except for those threatening suicide. By that logic, once it is accepted, and I perfectly understand that there are those who do accept this view, there is no ground for discrimination between those threatening suicidality and those whose threat to health is physical, save for the expertise of doctors who may be called in aid when it comes to the provision of medical expertise. It does not seem to me that the distinction stands up.

That becomes clear when we look at head 4. It asks for two consultant psychiatrists and a consultant obstetrician and gynaecologist. It leaves open the prospect that two psychiatrists might form the view that suicidality is present such that it poses a threat to the life of the mother only to be vetoed by the consultant obstetrician and gynaecologist. That is a vanishingly unlikely prospect but it is a curious prospect to have in the legislation. Mr. Brady and Ms Simons talked about this earlier. What are the consequences of the rules the Bill is laying down? That is one consequence.

Mr. Brady mentioned that head 4 changes the law. I think the position is precisely the contrary. To exclude suicidality is to change the law because the law as it currently stands is the law as laid down in the X case by the Supreme Court in its interpretation of Article 40.3.3o. When that argument is put forward, there is curious burden shift that is not being dealt with in these hearings, which is that when the burden is all of a sudden about changing the law to exclude suicidality, that burden requires a heavy onus to be discharged by those looking to change the law. It is for the committee to decide if that onus is being discharged.

Deputy Fitzpatrick asked about consequences of delivery. I agree with Mr. O'Connor that it lies with the discussion of the heads of the Bill as they stand, save for one observation that might commend itself to the committee and the Oireachtas, whether or not there is a requirement, as there is under the Mental Health Act 2001, to deal with questions of civil liability that may arise from acts done in good faith under the provisions of the Bill. It may be that some such section would be appropriate.

Senator Bacik asked three questions. She referred to the scenario where there is no fetal heartbeat and whether some form of clarification is necessary. Once that is the scenario, one is talking about a wholly different medical phenomenon, missed miscarriage, and that falls to be treated in the way that a missed miscarriage would ordinarily be treated. There is a half-

way scenario that relates to the question of the inevitable miscarriage of the non-viable early pregnancy. That remains a grey area.

On the question of consultation with the GP and the woman's consent being required, that is a difficulty created by the introduction of the world "shall", saying doctors "shall" consult with the GP. The requirement for the consent of the woman is atomised by that requirement. She does not have an entitlement to give or withhold consent. That might be a problem.

On the question of attempting a termination and whether it should be criminalised, the confounding element is Article 40.3.3o itself, which contains an obligation to have regard to the life of the unborn. It may well be, therefore, that an attempt to terminate the life of the unborn should be regarded as a criminal act.

While that is obviously a matter for the Oireachtas, I certainly believe that head 19, as currently structured, needs to be broken down very minutely to deal with different aspects, possibly with different penalties.

Deputy Naughten asked a question about probability which, with the greatest of respect, confused two issues. Noting that if the test to be applied must be whether, on the balance of probability, there is a real and substantial risk to the life of the mother, the Deputy asked about those doctors who are saying that a 5% risk is enough. That is to confuse two different things. On the one hand, there is the question of whether a risk is present that could be termed a real and substantial risk to the life of the mother. This is where the balance of probability emerges. The first consideration is whether a risk is present. The second question is what measure we apply to determine that the risk that is present is real and substantial. It may well be that 80% of something that is not especially serious is not a real and substantial risk, whereas 2% of something potentially catastrophic may be real and substantial. It will be a clinical judgment made in all of the circumstances of the case. The first question to be asked, however, is whether there is anything that, on the balance of probabilities, can be characterised as a real and substantial risk present. One then goes on to analyse the risk.

The penultimate questioner asked whether head 19 could criminalise acts carried out under heads 2 to 4, inclusive. As currently drafted, the answer is "Yes" because clearly there is a termination that could be carried out under head 2, 3 or 4 which has, as its intention, the destruction of unborn human life. The scenario outlined is certainly perfectly possible. While it may not be directly intended, it may well be an intention. If that is the case, some kind of saver needs to be inserted in head 19 referring to acts carried out under heads 2 to 4, inclusive. I addressed this issue in my written submissions.

I will briefly address the question put by Deputy Mary Mitchell O'Connor because she is my local Deputy and I want to keep her on side. There is a requirement for a balancing act. On the one hand, one has the right of the doctor to his or her conscientious objection while, on the other, one has the right of the woman to exercise her right to obtain a termination in certain circumstances.

Chairman:

Could we have one speaker at a time, please? Members should show respect.

Dr. Simon Mills:

These rights must be balanced in every circumstance. This goes back to a question asked by Senator van Turnhout on whether there would be a requirement to disclose at the outset of a doctor-patient relationship. While I do not believe that would be the case, the disclosure obligation arises when a difference arises between what the patient wants and what the doctor is prepared to do. There is a tension here but it is one that has been resolved in many other jurisdictions.

Chairman:

As there are only 14 minutes left in this slot, we will not have time for all four remaining speakers. I call on Deputies Catherine Byrne and Robert Troy and apologise to the other two speakers.

Deputy Catherine Byrne:

This Bill is about conscience and the judgment we will make having listened to the evidence over the course of the committee's hearings. The witnesses are all experts in medical law. I ask them to answer with a "Yes" or "No" to be helpful to me and others outside the proceedings. Will the passing of the Bill result in widespread termination of pregnancies? Will the Bill legalise the killing of babies?

Deputy Robert Troy:

I will repeat a question I asked last week to which I did not receive a reply. Perhaps the legal professionals will be able to reply today. Does the inclusion of a separate head on deliberate self-harm create a rebuttable presumption that mental illness is a reason to carry out an abortion? On the capacity of a person to make an irrevocable decision, whether based on a state of mind or being a minor, perhaps the legal professionals will clarify whether it would be better to address this issue before the legislation goes before the Oireachtas?

Senator Jim Walsh:

Should the law reflect section 21.1 of the Medical Council's guidelines, which requires that due regard be had to clinical research in the area of psychiatry? On an issue that arose in the discussion with psychiatrists yesterday, a person who is not suffering from a mental disorder and cannot, therefore, be forced to undergo any treatment may well present herself for an abortion. If abortion is considered the only outcome that can be offered to such a person, would there be an automatic obligation to provide the abortion purely on those grounds?

Ms Caroline Simons:

On the earlier suggestion that the law was not being changed by the proposed Bill, what the Bill will do, if one likes, is activate the X test. It may not change the law but the law has not actively been practised in terms of medical practice. The Bill will change medical practice and abandon the two patient model, which has been used. Having heard Deputy English being congratulated on Friday, and as I know myself, there may be even more than two patients in a pregnancy. The two patient model will go out the window if the legislation is implemented. As I stated in January, doctors, in this case psychiatrists, will for the first time be faced with a request for abortion to treat suicidal intent or ideation. They would not have considered abortion a treatment previously and still do not appear to consider a treatment.

Obstetricians will also be asked to carry out terminations of pregnancy on physically healthy women. These are profound changes in the practice of medicine in Ireland.

On whether we believe the passing of the Bill will result in widespread abortion, while we cannot look into crystal balls, it would be very foolish not to have regard to what has occurred in other jurisdictions where abortion has been introduced on grounds similar to those provided for here. I am already hearing from lawyers in the United Kingdom where abortion is allowed on the basis of risk to a woman's mental health. Suicide brings something that is incapable of prediction. As we have been told by psychiatrists, abortion is not a treatment. This legislation is potentially wider than that in place in the UK but we will have to wait and see. I will not predict in the matter.

Does the legislation legalise the killing of babies? There is a very fair argument to be made that this is something that is understood by the breadth of the X case decision. Again, it would be unrealistic of us not to look at what it is a woman wants when she says she is suicidal and wants an abortion. There is certainly enough ground in the X case and the heads of the Bill to allow her to look forward to that.

On Senator Walsh's question as to whether the psychiatrist would be obliged to certify for an abortion, as psychiatrists have stated in recent days, they would err on the side of caution. Where there is nothing else they can offer and the woman is competent and perfectly entitled to refuse what they are offering, they would be in difficulty in relation to this.

Mr. Tony O'Connor:

Deputy Byrne put the issue very well. She should be a lawyer asking "Yes" or "No" questions. She can answer her question on whether the passing of this Bill will result in widespread terminations as well as I can. My answer, however, is "No" as one would need a change of law in relation to it. On whether the Bill would legalise the killing of babies, it will not do so any more than that which exists at present.

Senator Walsh asked whether the Bill should refer to section 21.1 of the Medical Council guidance. While I have not considered the issue in any great depth, I believe that to do so would complicate matters. Unfortunately, I did not get the other question asked.

Deputy Robert Troy:

I asked about creating a rebuttable presumption for mental health as grounds for abortion by including it in a separate head.

Mr. Tony O'Connor:

If I understand the Deputy's point correctly, the mental health presumption provides for a presumption of capacity. Is that the question?

Deputy Robert Troy:

Does the inclusion in the legislation of a separate head on mental health create a rebuttable presumption that mental health is a ground for abortion?

Mr. Tony O'Connor:

I will have to consider the question as I do not fully understand it. I ask the Deputy to excuse my ignorance. I will return to it if necessary.

Mr. Paul Brady:

I will answer Deputy Byrne's two straightforward and direct questions. I do not believe the legislation will lead to widespread termination of pregnancy, although it is hard to make predictions in these matters.

I do not think that is the question. The question I am suggesting, as a lawyer looking at the draft legislation, is whether it will permit more than is intended. Will the Bill permit more than people are legislating for? In that sense, head 4 gives false comfort, having heard how it will operate in the absence of mental illness. If a woman presents with suicidality and no accompanying mental illness, there is no other option for a psychiatrist in terms of what can be done in those circumstances. Effectively, by framing the request in those terms, it becomes self-fulfilling because one cannot look behind the expression or double-think the situation. The presumption is that the woman will be believed. That is what we have heard or at least, that is the testimony that was given. Therefore, effectively, there is no other option but to certify. Professor O'Keane said that she would not be prescribing it or advising it but if a woman asks for it, she will certify it in those circumstances.

Senator Ivana Bacik:

That is not what Professor O'Keane said.

(Interruptions).

Chairman:

Quiet please. I will chair the meeting and if I want help I will ask for it.

Mr. Paul Brady:

Sorry, I will clarify what I just said.

Chairman:

Can we all take a deep breath and calm down? It is a bright, sunny morning. Let us all relax and allow the expert witnesses to give their testimony.

Mr. Paul Brady:

In case there was any misunderstanding, I said certify as opposed to prescribe and not certify simply because the request was made; that is obviously not what Professor O'Keane said. However, she did refer to circumstances where there was no underlying mental illness and other expert witnesses have said that they believed that the majority of women presenting under head 4 would be women with no mental illness, which makes this a real issue in terms of what that will mean in practice.

To answer the second question as to whether this Bill is legislating for the killing of babies, as Deputy Byrne put it, I would say that by moving the test for real and substantial risk to the grounds of suicidality and away from physical issues, if the woman's threat is based on the existence of the child and the continuation of the pregnancy, whereby she says that if she has to give birth to the child she will kill herself, then what that woman is looking for is an abortion and not some other form of treatment. In that sense, therefore, it can only be a fair reading that the Bill legislates as the Deputy has suggested.

In response to Deputy Troy, the position is that there is a presumption being stamped here that the legislature will create a statutory pathway, a formal legislative framework, whereby one can access a termination of unborn life on grounds of suicidality. That would seem to suggest that the Legislature regards that as a valid proposition, a worthwhile end and something that needs to be done and in that sense, it does create such a presumption.

I have mislaid my note on Senator Walsh's question but will respond to it later, if I may.

Dr. Simon Mills:

I agree entirely with the answers given by Mr. O'Connor in response to various questions. I wish to deal with only one issue, namely the assertion that by legislating for mental health in similar ways, other countries have somehow found themselves on a slippery slope. I would simply observe that I am aware of no country that has introduced a test along the lines that is being proposed in the 2013 Bill. I am aware of no country that has introduced a test that is as restrictive. The 1967 Californian legislation, which has been advanced as some sort of analogue a number of times, was a paragon example of bad legislative drafting. Whatever else about this legislation, it is precise in what it is aimed at. The California legislation was scatter-gun in its approach and involved a bowdlerised application of a legal test intended for other purposes. The text of the penal code was at odds with the text of the statute and the Act was struck down for vagueness. The English test is a far vaguer test than the one proposed in this jurisdiction. The assessment that an analogy can be drawn between the proposed Irish scheme and other schemes introduced in other jurisdictions is flawed. No one has been able to point to a statutory principle identical to that set out in the 2013 Bill that has been introduced in another jurisdiction and has, in fact, been abused in the way that is so often contended.

Mr. Tony O' Connor:

My apologies to Deputy Troy for not initially understanding the question he raised. If I understand him correctly, he is asking whether the legislation creates a presumption. My view, which may well differ from his own, is that it is representing the existing law. It may be putting it into a statute, but it is the existing law.

Mr. Paul Brady:

I said that I would come back to Senator Walsh's question. He asked whether the Bill itself should include an expressed requirement that the decision should be based on evidence. I recall from my preparatory work for this meeting that it was a recommendation of the Medical Council that the diagnosis should be evidence-based and that a requirement for same should be included in legislation and/or regulation, but I do not have a view on that.

Chairman:

We are now moving on to time allocated for non-members of the committee. There are 13 non-members indicating that they wish to speak and the time allowed is 30 minutes. Therefore, not everyone will have a chance to contribute and I apologise for that in advance. I ask Members to speak to the heads of the Bill and to be as brief as possible, which will allow as many members to contribute as possible.

Senator Fidelma Healy Eames:

I welcome and thank the panellists. I am very grateful to Mr. Paul Brady and Ms Caroline Simons for clarifying that we are absolutely not obliged to legislate for the X case. This has become a mantra in this debate. No sooner had Mr. Brady said it than there was an intervention by Senator Bacik that it was a requirement---

Chairman:

Excuse me, with all due respect to everyone, I ask the Senator to allow for a divergence of views and to speak to the heads of the Bill.

Senator Fidelma Healy Eames:

Indeed. My first question is directed to Mr. O'Connor and Dr. Mills. Are we, as legislators, obliged to legislate for the X case, a Supreme Court judgment that is now 21 years old, given that there is now unanimity among all the psychiatrists, as shown again yesterday, that abortion is not a treatment for a suicidal pregnant woman? Indeed, Dr. Janice Walsh said that there was nothing new in the Bill to improve practice in the case of pregnant women with cancer, which was, of course, the C case.

My next question is directed to the entire panel. Bearing in mind the separation of powers, where does my duty lie as a legislator? I realise that the Government wants us to legislate but where does my duty lie? Am I to be enslaved by a 1992 judgment that is now out of date or am I to give due regard to best practice for pregnant women and the unborn and to reflect section 21.1 of the Medical Council guidelines, which ask me to give due regard to clinical-based research? Can we, as an Oireachtas, satisfy the requirements of the European Court of Human Rights without legislation or by excluding head 4, which is clearly problematic? Indeed, as Dr. Mills acknowledged at the outset, should head 4 survive? If so, what is the way forward that the panellists would propose? Are there other examples of Supreme Court judgments that have not been legislated for? If so, I ask the panellists to list them. Has the Oireachtas acted unconstitutionally for the past 20 years by not legislating for abortion on the grounds of suicide? I ask for a "Yes" or "No" response to that question.

Deputy Terence Flanagan:

I have two questions for Dr. Mills. Does he think that the evidence presented in the X case would have been sufficient to justify a termination under this draft Bill? I ask him to comment on the testimony of Dr. Sam Coulter-Smith, the Master of the Rotunda Hospital, that the inclusion of suicidal intent as grounds for a termination was not evidence-based. He said that it posed major ethical dilemmas for obstetricians and could lead to an increase in women seeking terminations. In that context, are there any other areas in medicine or medical

law that Dr. Mills has come across where a treatment is legislated for that is not effective and that leads to an increase in the suicide rate?

My next question is a general one for all of the panellists and I ask that they give me a "Yes" or "No" answer. The question relates to conscientious objection and head 12. Earlier today the patient was mentioned, as were the doctors and midwives, in the context of conscientious objection. Does an institution have a right to conscientious objection, as endorsed by the Council of Europe?

Should head 12.3 be removed? I seek a "Yes" or "No" reply.

Deputy Bernard J. Durkan:

On the suggested lack of obligation on the part of the legislators to introduce legislation following the X case decision, I ask Mr. Brady to elucidate whether he has argued in the past for the introduction of legislation when the courts have identified a void or lack of legislation in order to facilitate them in their procedures.

To what extent must the legislators and the courts have regard to the decision of the Supreme Court in the X case regarding the degree to which conscientious objection can prevent particular procedures or treatments from being made available to women or unborn babies?

Is it permissible for the Government or legislators to introduce legislation that they know to be in breach of a constitutional court's decision - the Supreme Court's decision - regarding a particular issue in legislation in which the court has already decided, notwithstanding the time lapse in the intervening period? I, as a legislator, am not a member of any organisation, either pro-choice or pro-life, but I would feel I am a reasonably-----

Chairman:

I ask the Deputy to address the heads of the Bill.

Deputy Bernard J. Durkan:

This is part of our discussion. Is it possible that in some instances people can be tainted in their judgment by virtue of their predilection to a particular opinion?

(Interruptions).

Chairman:

We will have one speaker.

I will take the first seven names on the list because that is what the norm has been in terms of the numbers who have spoken at this session. I know that may be a bit uncomfortable for our experts, but I want to get a balance. I call Senator Bradford.

Senator Paul Bradford:

I welcome all the witnesses and thank them for their very interesting contributions. One of the phrases very strongly used by the people who genuinely are proponents of this legislation is that there is no new law and no change in legislation. I believe that was said by the Taoiseach in Boston yesterday. As I believe Ms Simons has already addressed the matter, I direct my question to Mr. Brady. Does he believe new law is being proposed? Does he believe this is a change in legislation? If so, what are those changes?

Among all the interesting documentation we have received and read, sometimes one little sentence will jump off the page. Dr. Mills made a very fine contribution this morning in addressing head 19. His submission contained the following statement, on which we need to reflect and on which I have a question: "To claim that such terminations ... are not intentional destructions of the foetus is a legal ... fiction." That is important. I fully agree with him that claiming it is not intentional destruction is a legal fiction. How does the proposed legislation stand regarding the constitutional right to life of the unborn?

Chairman:

I call Deputy Mathews. If he could be equally brief, we might get more in.

Deputy Peter Mathews:

I am delighted to have heard the truth as I see it, and as I have informed myself, from Ms Simons and Mr. Brady. I am less confident about the presentations of Dr. Mills and Mr. O'Connor. I feel they were too wordy and did not get to the essence of the point.

Chairman:

I ask the Deputy to respect the witnesses who come in even if he does not agree with them. They came in voluntarily to give of their time. All I ask is that he show a bit of respect to the witnesses.

Deputy Peter Mathews:

I am allowed to express my feelings about what I have heard. I reiterate what I said yesterday. I think that-----

Dr. Simon Mills:

May I respond?

Chairman:

No. I chair the meeting. I will protect the witnesses and the members.

Dr. Simon Mills:

I think there is a simple way of protecting myself, Chairman.

Chairman:

I will let Dr. Mills come back in and he can reply then.

Deputy Peter Mathews:

For instance, one of the proposed amendments refers to the inclusion of certification that regard has been had to the right to life of the unborn. This wordiness is just the sort of stuff that justified things that happened in other horrific memory-----

Chairman:

Thank you.

Deputy Peter Mathews:

-----where legislation couched and presented what essentially was wrong.

Chairman:

Go raibh maith agat.

Deputy Peter Mathews:

It is obvious that we want to introduce good law if we are introducing law. The practice has been excellent. The guidelines and regulation have been excellent.

Chairman:

Thank you.

Deputy Peter Mathews:

We need to ensure that political vanity does not get in the way of doing what is right.

Deputy Michelle Mulherin:

I thank the witnesses for their presentations. We have heard from all the medical professionals, including the psychiatrists, who, while they might not agree on some aspects of the heads of the Bill, agree that abortion is not a treatment for suicidal intent or a suicidal pregnant woman. My question - courtesy of Deputy Timmins - is as follows. Are we now actually legislating for abortion to be a treatment for a suicidal pregnant woman? Is that what the legislation asks us to do?

I wish to address the situation of the viable child. At 22 or 24 weeks, where this decision comes to be made, there could be an early delivery of a child with a disability that he or she will have to live with for the rest of his or her life. Who is protecting that child? I know Mr. O'Connor declined to answer some questions from Deputy Fitzpatrick. Given that we are discussing heads of a Bill and not specific clauses, I respectfully suggest we are entitled to consider everything that flows from this. Who will stand up for and protect this child from any such injury or disability with which he or she might have to live for the rest of his or her

life? Would the child potentially have a cause of action against his or her own mother, the surgeon or the people who made the decision?

How robust is the requirement to have the professionals to assess this? We have already heard obstetricians say that it is a psychiatric decision.

Chairman:

Go raibh maith agat.

Deputy Michelle Mulherin:

I wish to ask about the composition of the panel. We have heard two extremes. Notwithstanding the profession of psychiatry and all the assurances we got, I am very sure right now I could name one particular type of case where there is not a mental illness involved and there is a pregnant woman who is suicidal, in which two psychiatrists would say completely opposite things where that woman is looking for an abortion.

Chairman:

Thank you.

Deputy Michelle Mulherin:

We had a suggestion yesterday that two psychiatrists were too many and that only one was needed. I want to know how robust it is. Mr. Brady said they would have no option but to certify.

Chairman:

Go raibh maith agat.

Deputy Michelle Mulherin:

Can we address this through some sort of rephrasing or reframing of the legislation to address the concern that there is another option?

Deputy Michael Creed:

I thank the witnesses for their presentations. I wish to focus on three areas. In his opening remarks on head 4, Mr. Brady said we should not be under any illusions that we are creating new law. Law emerges in many forms - through statute law, court interpretation, precedent, etc. Section 21.1 of the current Medical Council guidelines states:

> Abortion is illegal in Ireland except where there is a real and substantial risk to the life (as distinct from the health) of the mother. Under current legal precedent, this exception includes where there is a clear and substantial risk to the life of the mother arising from a threat of suicide.

My reading of that is that the current law, to which medical practitioners are obliged to have regard, states that there is a legal entitlement to a termination on the grounds of suicide. Is that not the current law? If it is, is it true to hold the view that we are creating new law?

Ms Simons stated that to proceed with head 4 is effectively to abandon the two-patient approach.

Does she see any contradiction in her holding that view and her earlier praise of the contribution made yesterday by Dr. Janice Walshe, consultant medical oncologist, who clearly stated she felt that the operation of this legislation would not in any way adversely impact on her obligation to pursue the two-patient approach? It appears to me that to praise Dr. Walshe on the one hand and on the other not have reference to what she clearly stated in terms of the impact of the legislation is slightly contradictory. I would welcome if she could address this.

On head 6, the debate on the issue of capacity has been informative. While that debate dwelled on the issue of under-age minors, such as Miss X, and diminished capacity in terms of vindicating or accessing rights, I would like to discuss the issue of capacity in a slightly different context. Head 6 makes provision for the pregnant mother who may in her original application have been denied a termination on the grounds that she is suicidal to access an appeals process. I do not have a difficulty with that. However, in terms of the legal capacity to vindicate one's rights as outlined in Article 40.3.3° in relation to the unborn in that situation, is it not a clear and flagrant deficit in terms of the heads of Bill as drafted that there is no authorised officer of the State empowered to vindicate the rights of the unborn in a situation where the woman is granted permission to terminate the pregnancy? Do the witnesses see any reason, in terms of the content of Article 40.3.3° and due regard to the equal right to life, an authorised officer of the State should be empowered to vindicate the rights of the unborn?

Chairman:

The Deputy is way over time.

Deputy Michael Creed:

My next question relates to head 4. Section 18 of the Offences against the State Act provides for a renewal mechanism of that legislation on an annual basis. In the context of head 4 and the considerable concern about whether what is provided therein will open the flood gates, do the witnesses believe the Oireachtas should, following a defined period following enactment of this legislation, review it by way of a provision similar to that provided for in the Offences against the State Act to see if a consequence of its enactment has been an opening up of the flood gates, as some have argued will be the case?

Ms Caroline Simons:

Because it has not been asked before I would first like to respond to Deputy Flanagan's question on the right to conscientious objection of institutions. I refer to page 18 of my written submission wherein I point to a number of cases of the European Court of Human Rights which deal with that very issue. In one case, Rommelfanger *v.* The Federal Republic of Germany , the court held that a hospital was entitled to dismiss a plaintiff because he took

ethical positions which were contrary to those of his employer. This would confirm that a hospital is capable in law of holding ethical positions. That case was then confirmed in Lambardi Vallauri *v.* Italy in which it was held that a Catholic institution can limit the rights and freedoms of other people in order to protect its ethos. I have also appended at the back of my written submission an extensive survey of the laws in the various states of the United States of America in relation to conscientious objection. Members will note that many of them do afford a right of conscientious objection to institutions. There is no difficulty at all in providing for that.

On Senator Healy Eames's question of whether we are obliged to legislate for the X case, in my opinion, we are not, most particularly in light of the evidence that we received in January and during the past couple of days from the psychiatrists. I believe it would be unwise and that members of the joint committee, as legislators, have a duty to the people they represent to implement good laws which are representative of the best of medical practice and evidence-based. The degree of dissatisfaction among the doctors, as expressed over the past few days, should be a considerable cause of concern to members. The division which seems apparent among the ranks of the psychiatrists would appear to be an ideological one rather than one based on medical evidence. It might have been more appropriate for the institute to have made a representation on its own behalf, similar to the Law Library and solicitors-----

Chairman:

I ask that Ms Simons not stray into that area.

Ms Caroline Simons:

A number of questions were posed to all of us. I will try to respond first to those specifically addressed to me. On Deputy Creed's question in relation to the two-patient model, I believe there will be a change in this regard and for the following reason. Currently, if a woman who is suicidal in pregnancy presents she is given appropriate treatment, including counselling and so on. It appears that this is to be abandoned. We heard from the perinatal psychiatrists in January that in their combined 40 years of experience they had never prescribed abortion as a treatment for suicidality and they did not consider such to be a treatment. It is now proposed as a treatment under the heads of this Bill. With respect, I suggest that for that very reason - at least in relation to head 4 and suicidality - the two-patient model will be abandoned. I will hand over at this point to my colleagues but am happy to respond later to any further questions.

Mr. Tony O'Connor:

Senator Healy Eames asked about the obligation to legislate for the X case. Mr. Justice McCarthy stated in respect of the X case that there was a deficiency and it was up to the Legislature to legislate. The Legislature can abdicate its responsibility and leave it to the courts to decide issues as they arise. However, my personal view is that the Legislature should legislate. Senator Healy Eames also asked about other examples where the Supreme Court may have been critical of non legislating. There are quite a few cases, the most recent being the case involving Roche, in which parties had to go to the High Court and Supreme Court to vindicate their rights. There are many instances. I note the Senator is nodding in agreement.

Although not directed to me, Deputy Flanagan asked if the view of the psychologist in the X case would be sufficient under this legislation. The answer to that question is, "No, because there was only one person involved." If I understood him correctly, Deputy Durkan asked if the obligation to legislate was in contravention of the Supreme Court or if the Legislature takes it upon itself to legislate contrary to what the Supreme Court suggested. That is dangerous territory. I am not sure if the Deputy is advocating that. The Supreme Court is the ultimate arbiter of the Constitution. If the Constitution has been ruled upon by the Supreme Court the Legislature cannot ignore that.

Deputy Mathews, my local representative, referred to the six line recommendation I made as being too wordy. It is only a suggestion. Members may feel free to amend it. I do not believe Deputy Mulherin was overly critical. Deputy Fitzpatrick asked a number of questions. Each case, particularly in terms of negligence and duty of care, what loss will be compensated by doctors and so on, will have to be considered on its own merits. I cannot give a general answer to that question. It is worthy of a good article. I could not understand all of the facts which the Deputy provided but I am more than happy to sit down with him and to advise in relation to each of them. The Deputy will be aware that each case must be looked at on its own merits. As regards the relevancy of this to the heads of the Bill, my understanding is that the heads of the Bill do not deal with negligence and duty of care.

Deputy Creed asked some interesting questions. I will try to address his question on whether, in terms of capacity and under-age, there is a deficit in there being no authorised officer to vindicate the rights of the young mother or unborn child. There is a deficit. I suggested at the beginning of my presentation that the joint committee send out the message that we need legislation to cover capacity and representation for other parties. There are examples in other jurisdictions. The Law Reform Commission report on vulnerable adults and under-age provides examples. The Deputy also referred to the sunset clause provided in other legislation, whereby legislation falls after a specified period.

My answer is that it is a political decision. If members want a sunset clause it is up to them to introduce one. As legislators, they can also decide that the Act is not working as they anticipated. I am putting the onus on them to do that.

Mr. Paul Brady:

I apologise to members if I am unable to answer their questions. It will not be possible to address all the valuable and important questions raised. I will group the questions together.

On the obligation to legislate for the X case, which was raised by Senator Healy Eames and Deputy Durkan, Mr. O'Connor put it very well when he said his personal view was that the Legislature should legislate. That is the only position a lawyer can take on this issue. If a judge points out a gap in the law it is important that we note it. In most cases it is absolutely something to be remedied. However, I do not think that creates a legal or constitutional duty on members to the effect that they do not have to consider whether they wish to legislate. I do not think anyone is suggesting that is the case. They are left with the duty of deciding what they think is best. We hope that in most cases our Supreme Court will make decisions with which all of us are happy. If it does not, the Legislature has various options, such as to propose a referendum, but it does not have to follow every judicial statement seeking further legislation. It is certainly not a legal obligation.

As regards whether one's own views can taint legal advice, it is fair to say that is a standing fear or problem on any issue and in any profession. All I can say is that if barristers are asked to provide legal opinion on a set of papers they will not get far if they insert their own personal opinions instead of what they consider the law to say. As lawyers we are trained to stand back from our own personal views to provide an opinion on the law. I hope that is taken at face value by everyone here.

Senator Bradford and Deputy Creed asked about changing the law. There are ways in which this is implementing the judgment on X and other ways in which it is changing the law. It is changing the law because it is repealing a statute and creating a new offence. Many of the reservations expressed about section 19 would not make sense unless changes were being proposed to the law. It is inaccurate to argue otherwise. Regarding the substantive issue, a statutory framework is being created, with tests, procedures and particular personnel identified, and this has not previously been the case. With respect to where the onus lies, this is clearly a debate which will go back and forth but the Supreme Court decision on X was based on a concession between the parties rather than an articulated point. If it had been argued, the court would have had to consider various implications regarding treating suicidality like any other medical condition but it did not decide on that basis. The onus has never been discharged in so far as it was decided on a concession.

Deputy Creed referred to the right of the unborn and asked whether it should be represented. A number of parallels have been drawn with the Mental Health Act 2001, including the suggestion that only a GP and a psychiatrist should be required under head 4 on the basis that such a combination was provided for under the Act. However, that overlooks the fact that four doctors are involved under the Act. One GP can recommend and one consultant can admit but an automatic review process takes place within 21 days under which a second opinion is sought from a consultant and a tribunal which includes in its membership another consultant. Up to four doctors may in fact be involved because the patient's constitutional right to liberty is at stake. The expert group recognised the logic of arguing that two constitutional rights are at issue in these decision making processes, one being the right to life of the unborn. Encapsulating that is a political decision but I do not think it is legally unfounded.

As regards a sunset clause, I agree with Mr. O'Connor that it is ultimately a political decision but against what is such a clause is to be benchmarked? We know from Dr. Rhona Mahony's estimate that between ten and 20 procedures may take place under head 2. As I do not know if any number has been suggested under head 4, what benchmarks will be used if there are two procedures per year or 50 procedures per year? Will such figures been seen as a success or a failure of the restrictions? The current lack of figures may feed into the question of whether the policy is viable.

Dr. Simon Mills:

As with Mr. O'Connor, Mr. Brady and Ms Simons, there is a limit to the number of questions that I can answer in the time available to me. I will start with Deputy Terence Flanagan's questions. He raised an interesting issue pertaining to conscientious objection by institutions. There is a tension in the Bill between the conscientious objection granted to individuals and the assertion that institutions are not entitled to conscientious objections. If no institution is entitled to a conscientious objection, what happens if every individual in that institution exercises a conscientious objection? It could possibly lead to the bizarre scenario of an add-

on question at job interviews along the lines of how the applicant feels about the Protection of Life During Pregnancy Bill 2013. That is not necessarily an absolute tension and there may be flexibility in terms of the provision of medical services but it strikes me as a tension none the less. The Deputy and I did not agree about much during on the last occasion we discussed these issues but I think we can agree that head 12 creates a certain tension.

However, I disagree with Deputy Flanagan on the question of suicide and termination. I do not accept the premise of his question on the indication for prescribing a treatment that increases the rate of suicide. The evidence to support that assertion is simply not available because the group of women we are discussing for the purpose of this Bill have not been studied in the way suggested by the Deputy. His question does not bear the weight of its closing premise.

A problem that has bedevilled this issue is the assumption that because the area has not been thoroughly studied - the difficulties in doing so have been identified repeatedly - the ensuing absence of evidence can be flipped on its head to be used as evidence of absence. What witnesses have in fact said is that we are discussing a tiny cohort of women for whom the threat of suicide in pregnancy is a problem and the number of those for whom the question of termination might arise. The presumption that because this tiny group has not been studied, no conclusions should be made about them and they should be excluded from the protection of the Constitution, which is the logical conclusion of what is proposed, is a stunning assertion.

Senator Healy Eames asked about my reference to the exclusion of head 4. She seemed to believe I was making some sort of concession that suicide would end up being excluded. That is not what I meant when I said "excluded". I meant excluded in the sense of being merged with head 2, which is a very different matter.

This brings me to something Mr. Brady said. He opened his contribution by stating that the law is being changed when it comes to head 4. In his closing contribution he changed his position to state that the change in the law relates to the way we are legislating for the 1861 Act.

Deputy Peter Mathews:

He did not say that.

Chairman:

I will chair the meeting.

Dr. Simon Mills:

I do not think it is a contention but if I am wrong on that I apologise.

Deputy Peter Mathews:

I do not think -----

Chairman:

I am chairing the meeting. When Deputy Mathews is in the Chair in the Dáil he does not permit interruptions. Please respect the Chair and observe the same rules and behaviour he asks others to follow in the Dáil.

Dr. Simon Mills:

I will come to Deputy Mathews' question in a moment.

Chairman:

I will protect Deputy Mathews too.

Dr. Simon Mills:

I referred in my written submission to a legal fiction arising by reason of a tension between head 19 and heads 2 to 4, inclusive. I used the phrase "legal fiction" as a term of art simply because it is not hard to envisage circumstances in which a termination is carried out under heads 2, 3 or 4 where part of the intention of the procedure is the carrying out of a termination of human life.

That is part of the intention of the procedure. It may not be direct and intentional. It may be indirectly intentional to use other philosophical fictions that are sometimes used. It remains the case, however, although Mr. Paul Brady has observed that an exception is created under heads 2 to 4. I am grateful to him for that observation. It may be that the tension I identified does not exist.

Two matters arise from Deputy Mathews's contribution, in which he accused Mr. O'Connor and I of wordiness but during which, ironically, he never got around to asking a question.

Deputy Peter Mathews:

The Chair prevented me from doing so.

Chairman:

Let the record show that-----

Dr. Simon Mills:

I wish to offer an invitation to Deputy Mathews. He indicated at the outset of his submission that he was delighted to have heard the truth from Ms Caroline Simons and Mr. Paul Brady. There is an unfortunate implication which arises from what the Deputy said.

Deputy Peter Mathews:

Do not infer-----

Chairman:

Sorry, Deputy Mathews-----

Dr. Simon Mills:

If Deputy Mathews has any concerns regarding the truth or probity of the evidence I have given today or to the effect that any of the answers I have provided have been wordy, indirect or did not address the questions asked, I want him to put them to me in writing - by e-mail or letter - and I will be happy to deal with each and every one of them. The Deputy can then use the answers I will provide to inform the debate going forward.

Mr. Tony O'Connor:

Likewise. I join in issuing that invitation.

Chairman:

We have exceeded the time for this session by five minutes. I apologise to those who could not contribute or make interventions. I am obliged to take people on a first-come-first-served basis. I extend my sincerest thanks to Ms Caroline Simons, Mr. Tony O'Connor, Mr. Paul Brady and Dr. Simon Mills for attending. We will now suspend proceedings.

Sitting suspended at 12.05 p.m. and resumed at 12.20 p.m.

Constitutional Law

Chairman:

This is the tenth session of the Joint Committee on Health and Children dealing with the heads of the protection of life during pregnancy Bill. I remind all members that we should be temperate and moderate in the phraseology, terminology and in the language we use. I ask members to please be conscious of time as well.

I very much welcome our expert panel of witnesses for this session, Professor William Binchy, Dr. Maria Cahill, Mr. Frank Callanan and Mrs. Justice Catherine McGuinness. You are all very welcome to our hearings and I thank you for attending. I remind members that all four of our expert witnesses are voluntarily giving of their time to be here today to assist us in the analysis of the heads of the Bill and I thank them for that most sincerely.

Before we commence, I remind witnesses and members regarding privilege. Witnesses are protected by absolute privilege in respect of the evidence they are to give to the committee. However, if you are directed by the committee to cease giving evidence in respect of a particular matter and you continue to do so, you are entitled thereafter only to qualified privilege in respect of your evidence. You are directed that only evidence connected with the subject matter of these proceedings is to be given and you are asked to respect the parliamentary practice to the effect that, where possible, your should not criticise or make charges against a person or persons or an entity by name or in such a way as to make him or her or it identifiable. Members are reminded of the long-standing parliamentary practice or ruling of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make him or her identifiable. With that, I will allocate 12 minutes to each of our opening speakers. Professor Binchy, you may begin.

Professor William Binchy:

It is a great honour and privilege to be among the committee members. I was delighted to be here last January and it is a privilege to be here again today. It is the third day of the committee's deliberations, second time around, as it were, so I will not weary the committee with a reiteration of points the committee will have heard many times before. However, in the few minutes I have I would like to concentrate my opening remarks upon the suggestion by the Taoiseach, Mr. Kenny, that it is a necessary requirement that we introduce legislation to deal with the European case and, specifically, that we introduce legislation in accordance with the X decision, the Supreme Court decision. I wish to challenge both of those propositions and I hope we will have an opportunity during questions to address in more detail the points that I would wish to make on those two points.

First, do we need to implement the X case through legislation as a result of the European Court of Human Rights decision? The answer is emphatically "No". If one listens very closely to the Government, it will concede that point. No legal argument has been put forward that I am aware of which argues that we are legally obliged as a result of the A, B and C *v*. Ireland decision, to implement that decision simply through the process of legislation. There are many other ways that we can implement that decision. What that decision requires is clarity in the law and also an assurance that if an individual, a woman who is seeking an abortion, gets a "No" that she has some system whereby she can, as it were, appeal that decision to get a second view or second opinion on the matter. Essentially, that is what the European Court of Human Rights requires. It does not require us to implement the X case decision and it does not require us to take any position whatsoever in terms of constitutional law as regards the fundamental policy of the State. I will say more on that matter at a later stage but it is a crucially important point because it means that the Oireachtas, far from being constrained into having to introduce this legislation, actually has a range of options to introduce clarity into our law.

The second point I make by way of a side-point. When one actually reads this legislation it is clear that it does not introduce one ounce of extra clarity into the law in the sense of actually giving specific medical content to decisions that doctors have to make. Doctors have to make decisions every day in the context of pregnant women, but also in the context of non-pregnant women and men. They make judgments about medical treatments. The committee members will note when they read this particular Bill that it does not contain the details of medical treatment. Rather, it contains a principle which was already there, a principle which is contained in the amendment itself, that is, in Article 40.3.3° of the Constitution.

The third point I wish to make is that the Supreme Court decision, of course, represents the law of the country. It gives the authoritative constitutional interpretation of this country. Of course it is true to say that one cannot defy a Supreme Court decision, which is part of the law of the land. However, that is only the beginning of legal analysis rather than the end, as the Government would suggest. This is because sometimes the courts get things wrong. Sometimes the courts get things in ways that frankly are either out of sync with the science or out of sync with fair, reasonable values. In this particular case, the decision of the Supreme Court over 20 years ago sadly got it wrong on the science, on the medicine, on the psychiatry and also in terms of a fair human rights protection.

This is because what the Supreme Court did in that case, as the committee is aware, was to authorise the intentional taking of the life of an innocent human being during pregnancy on

the basis of suicidal ideation. We would immediately reject that proposition in respect of any other human being, a born human being, for example, however pressing the circumstances, and we can think of very pressing circumstances where suicidal ideation might occur as a result of a close dependency relationship in regard to people who have been born. That proposition is unstatable, unthinkable in regard to children who have been born. However, the Supreme Court embraced that proposition as an interpretation, a wrongful interpretation, we would suggest, of Article 40.3.3° in the decision. Therefore, far from being a decision that the Oireachtas must follow, I would respectfully say it is a decision that the Oireachtas must not follow, because if the Oireachtas were to introduce that decision into law through legislation, it would be introducing bad medicine, bad psychiatry and a violation of human rights. It is absolutely not the way for the Legislature to go.

What are the options for the Oireachtas in these circumstances? The first thing the Oireachtas can contemplate is simply in the exercise of the separation of powers and in the exercise of the legislative powers of the Oireachtas so as not to make the mistake of going down the wrong scientific route and the wrong route as far as human rights protection is concerned. It is the entitlement and the prerogative of the Legislature not to implement a bad law. Would that put the Oireachtas in conflict with the Supreme Court decision? Not necessarily, as it happens, because the Supreme Court decision decided the case on the basis of the facts as presented to it. As the committee is aware, the facts as presented to it did not involve any expert psychiatric evidence from a psychiatrist, none at all.

In other slightly less contentious or controversial cases the Supreme Court has accepted that it makes judgments on the basis of the evidence presented and it does not purport to have the last scientific word. If I may, I will mention a case to the committee. It is a case that some committee members may remember, namely, Best *v*. Wellcome Foundation, which involved the question of whether a vaccine had caused brain damage to a little boy. The Supreme Court came to the conclusion in that case that the vaccine had caused damage to the plaintiff. In that case the Chief Justice, Mr. Justice Finlay, made it plain that when it comes to a decision on a scientific matter it was not purporting to make a final scientific or authoritative scientific judgment. Rather, it was simply making an adjudication on the basis of the evidence presented to it. In that case there was a very understandable and appropriate judicial modesty as to the court's role in regard to matters of science.

We now come forward 21 years. The committee has heard the evidence from the psychiatrists. The committee has heard that to introduce this particular ground would be highly controversial from a psychiatric point of view. The science has not been with the Supreme Court over the past 21 years, but that is not its fault. It received no scientific evidence and no psychiatric evidence. As I will stress to the committee during the questions and the discussion, there is no obligation to implement the Supreme Court judgment as it articulated that principle in the context of the facts in that case. The Legislature is perfectly entitled and, I would suggest to the committee, absolutely obliged in conscience on the basis of human rights protection not to go down that route.

I wish to point to another aspect of the X decision, the Supreme Court decision which the Government is very unwilling to talk about. I have been watching, listening and waiting to hear a considered analysis from any Government member during the past six months - indeed, I put it to the committee, any Government member in the past 20 years, but that is another matter - but specifically now as we are actually putting forward legislation. I would love to hear the Government case in the context of an issue that has arisen. Indeed, it is an

issue that has always been asserted by the pro-life campaign, namely, that the Supreme Court decision in the X decision does provide for abortion during the nine months of pregnancy. It sounds like a horrendous and horrific proposition. One must ask would the court, if it actually had to address the matter again, take that particular position in terms of its normative preference? Who knows? The actual normative preference, the way the court approached the issue of suicidal ideation in the X case is as follows: essentially, it stated that if a woman is suicidal in circumstances that the only solution is to terminate the life of the child, one terminates the life of the child.

I refer the committee to the general principle stated by the Chief Justice, Mr. Justice Finlay, in paragraph 36 of his judgment.

The Government is saying it does not actually mean that, that it actually means just simply terminate the pregnancy. A number of the judges talked about termination of pregnancy and Chief Justice, Mr. Justice Finlay, did so in the following paragraph, paragraph 37. There is nothing in that case to support, and no fair reading of it would support, the argument that it means that the Supreme Court has a sophisticated view that when viability occurs, it will protect the life of the unborn child. The notion of practicability in those circumstances, to do what is practicable to save the life of the child, might not be sufficient in the case of a particular suicidal ideation.

Psychiatrists say that these hypothetical suicidal ideations can be better dealt with by other means, but let us assume for a moment the hypothesis of head 4 of the Bill. It is premised on the fact that these cases do arise and in that context it is not fantastical to put forward a proposition where a woman says, and the psychiatrist believes, that the very existence of her child is in itself a source of suicidal ideation for her. She is not concerned about the pregnancy *per se*, she does not just want to get this child relocated elsewhere out of her body. The very existence of that child, for some particular circumstances associated perhaps with the child's conception or the circumstances of the child's health - we can fill in our own hypothesis on that - is the reason that woman wants to kill herself. In those circumstances, removing and relocating the child geographically outside her body unfortunately will not remove the suicidal ideation. I suggest that the principles on which the X case was decided in that situation will allow for the termination of such a child in late pregnancy.

Let us imagine if we were to heed what the Government says in this area. To the extent that it has said anything, the essence of what it has said is that there is nothing to worry about because we will do our best to save the life of the child. At what point are the psychiatrists entitled to stop saying, "Please terminate the life of the child", and at what point are they obliged to say, "Please do your very best to keep this child alive"? The Government is totally silent on that point. For example, if we imagine a situation at 21 weeks of gestation, what is the situation in terms of the psychiatric edict? Is the psychiatric edict to terminate the life of the child, not to terminate the life of the child, to give birth in those circumstances or induce a birth at an early stage and do what one possibly can for the child who may well suffer disability at this particular stage? These are not theoretical or academic questions. These are very real consequences of the legislation. It is not attributing any bad face to anybody, not to the Supreme Court or to the Government of the day, but it is to suggest that the thinking on this particular point has not gone as far as it should. Frankly, the unthinkability of late abortion, which I think would be shared by probably all Members in this room, is also qualified or enhanced by the unthinkability of the taking of an innocent life in the earlier stages of pregnancy. The general principle which the Supreme Court adopted in the X case is

a principle that is not acceptable for legislation.

I will conclude my remarks by saying that the two points I wish to stress to the committee are, first, there are other ways that the Legislature can go which would be entirely compliant with the European Court of Human Rights and, second, to implement the X decision would be a disaster in term of human rights protection and contrary to science and good medicine.

Chairman:

I thank Professor Binchy. I call Dr. Maria Cahill.

Dr. Maria Cahill:

Good afternoon. I am delighted to be here and I thank the Joint Committee on Health and Children for its invitation to be a witness before the members today. My interest in the legislation is as a constitutional lawyer who works on the institutions of Government, separation of powers and, in particular, on the relationship between national law and supernational or international law. I am also keen to ensure, as we all are, that the fundamental rights guaranteed in the Constitution are upheld and vindicated fully. All of us come to this question from different perspectives with different professional expertise to offer as well as different personal experiences, but as a constitutional lawyer speaking to the members as legislators, our Constitution is our common ground and the starting point for this conversation and discussion today.

It is a Constitution that is uncompromising in its defence of human life. According to Articles 40.3.1°, 40.3.2°, 40.3.3°, 15.5.2° and 28.3.3°, the direct and intentional taking of a life is prohibited. The Constitution prohibits the taking of innocent life but it also prohibits the taking of guilty life by banning the introduction of the death penalty in the strongest possible constitutional terms. If we were to assess the compatibility of this legislation simply with the text of those articles of the Constitution, it would be very difficult not to conclude that head 4 is unconstitutional. That is because it targets a specific subset of those who are guaranteed a right to life under the Constitution and makes the direct and intentional taking of their lives permissible under certain circumstances. A court faced with that kind of scenario would apply a proportionality analysis, examining the legitimacy of the infringement on the right in question in the light of the rationality of the means chosen to pursue that infringement. Head 4 would fail parts 2, 3, and 4 of the test for failing to choose a means that is rationally connected to the ends sought, for failing to impair the right as little as possible, and for being disproportionate to the ends.

The genesis of head 4 is not to be found here in Leinster House but rather in the Four Courts in the decision of the Supreme Court in the X case. In seeking to uphold the Supreme Court decision, head 4 succeeds in replicating the conditions of the test laid down in the X case. Where there is a real and substantial risk to the life of the woman which can only be averted by abortion, reading head 1 in conjunction with head 4, we find that human life can be ended at any time following implantation until such time as it has completely proceeded in a living state from the body of the woman.

In its detail, the legislation is faithful to the test laid down by the X case. It appears, however, not to be cognisant of the fact that there has been a development in the X case test in later cases that deal with suicidality. One of those is the 2006 case of Cosma *v.* Minister for Justice

in which a woman sought that her deportation order be quashed on the grounds that if she were to be deported, she would commit suicide. The Minister refused to allow her to stay even after he had seen two psychiatric reports that detailed the strong possibility that she would commit suicide, and the court upheld the Minister's decision. In this case the High Court adopted and developed the test from the X case of real substantial risk to life in a decision that was not overturned by the Supreme Court.

There are three important findings from that case to which I want to draw the members' attention. The first is that the High Court held that the absence of a treatment plan for a presenting psychiatric condition and the fact that a person was not undergoing therapy for counselling are relevant factors in determining just how real is the real and substantial risk to life. Second, the court held that the fact that a claimant has not seriously considered another option and has not considered removing the risk to life by treatment or by some other means is relevant to considering whether the risk can really only be averted by the means she prefers. Third, the Minister, the Minister for Justice and Equality in this case, was entitled to take into consideration arguments of public policy. He had argued very strongly in submissions that he should be allowed to take into account that "to permit the threat of suicide to act as a stop on the execution of administrative decisions, such as deportation, would be to open a Pandora's box of potential abuse with possible effects of paralysing administrative activity in any given area of Government".

On the basis of the Cosma decision's reading of the X case test, head 4 would fail to meet the necessary standards because it basically violates those three findings that I mentioned. It does not require evidence of a treatment plan, it does not require that there should be serious consideration of other means to end the risk to life, and it does not take into account, as the Minister had insisted we should, the arguments of public policy that would lead to an opening of a Pandora's box which would, ultimately, if carried to the extreme, undermine the rule of law.

The first point I am making, therefore, is that head 4 is out of line with the recent developments in the X case test in the Cosma decision from 2006.

Turning now from the detail of the test to the principle behind the test, head 4 is premised on the principle that abortion is legally permissible in a case of a threat to life by suicidality. At this point I am sure there is not one member who is not aware that the judges in the X case did not hear psychiatric evidence. They heard evidence given by one clinical psychologist with six years experience in child psychology who met the young woman at the centre of the case on one occasion and who, according to his testimony, had never dealt with a situation like this before. None the less, when he was asked in Question 78: "Is it your professional view that she would destroy herself if matters continue as they are?", his answers was, "I would not have taken it on myself to leave that girl alone". Later he said, "My recommendation would be she was not safe unless under supervision". He did not argue in his evidence that abortion was an appropriate treatment for her suicidality. As members know, the court did not hear any psychiatric evidence to that effect, and the court also did not hear any legal arguments on that question. What happened was that counsel for the Attorney General conceded that point and therefore all medical, legal and public policy arguments one could make either for or against the proposition were not given consideration by the court.

Going back to an earlier precedent, in the 1965 case of the Attorney General *v.* Ryan's Car Hire Ltd, the Supreme Court held that where a point has been entirely overlooked, or

conceded without argument, the authority of the decision may be weakened to vanishing point. As members know, the doctrine of precedent is central to the operation of our legal system and any legal system but it is central to that doctrine that the court must rule on the question. If the point has been conceded, it is not part of the decision of the court. If something is not argued by counsel before the court, it cannot be held by the court. The precedential value of the X case, therefore, as an authority for the proposition that it is legally permissible to allow abortion in the case of suicidal ideation is weakened to vanishing point, according to the Supreme Court. This point, which is not my idea, and I believe the members have heard it already this morning, was made in 1992 by Mr. Justice Brian Walsh who served as Supreme Court judge for 29 years. I posthumously promoted him to Chief Justice in my written submission but he was the greatest Chief Justice we never had.

Many members have heard many times, as I have, that they are compelled to legislate for the X case but there is no theory of precedent that supports that rhetoric. I hope I have expressed these points clearly to members. I am happy to take questions at the appropriate time but, in summary, my two messages for members are, first, that head 4 is not faithful to the recent developments of the X case test in the Cosma decision and, second, that members are not legally compelled to legislate for a principle that has been conceded at law. The members are not impotent. They have a choice and, above all, they have a duty and a responsibility to legislate to uphold the Constitution and respect the human right to live.

Chairman:

Go raibh maith agat. Our next expert witness is Mr. Frank Callanan. Mr. Callanan has 12 minutes.

Mr. Frank Callanan:

I thank the committee for allowing me to make a submission to it. It is 21 years since the Attorney General *v.* X was decided and it is useful to recall the order of the High Court. That was restraining the first defendant from leaving the jurisdiction for a period of nine months or from procuring or arranging a termination of pregnancy or abortion either within or without the jurisdiction. That was the order appealed from. There had been an earlier *ex parte* order which resulted in X and her parents returning from London where they were arranging for the termination of her pregnancy.

There has been a great deal of talk about the fact that there was no psychiatrist in the case. There was what is described as a very experienced child psychologist whose evidence was of an extremely cogent kind, most strikingly as set forth in the judgment of Chief Justice Finlay. He had told the High Court that when he had interviewed the girl he wanted to have a continuing discussion with her parents but did not have anybody available to sit with her in his waiting room. His view, on his past experience, of the risk of her committing suicide was so real that however inappropriate it might have been he asked her to remain in the room while he discussed the problem with her parents.

It is well also to recall that the judgment of Chief Justice Finlay, contained in a single, plain, unadorned but forceful paragraph, invokes the preamble to the Irish Constitution where it is stated:

> We, the people ... seeking to promote the common good, with due observance of Prudence, Justice and Charity [which Chief Justice Finlay emphasised], so that the dignity and freedom of the individual may be assured, true social order attained ... Do hereby adopt, enact and give to ourselves this Constitution.

In the passage leading into the formulation of the test, Chief Justice Finlay said the court must, among the matters to be so regarded, concern itself with the position of the mother within a family group, with persons on whom she is dependent, with, in other instances, persons who are dependent upon her and her interaction with other citizens and members of society in the areas in which her activities occur. He went from that to formulate the test of a real and substantial risk to the life, rather than the health, of the mother. That is how Chief Justice Finlay dealt with what he characterised as the intimate human problem of the right of the unborn to life and its relationship to the right of the mother of an unborn child to her life.

Some pro-life advocates have strenuously denied that Attorney General *v.* X was correctly decided, particularly in extending the principle of a real and substantial risk to the life of the mother to suicide. That is an argument which they are perfectly entitled to make. However, I do not believe, and this separates me from Professor Binchy and Dr. Cahill, that a lawyer who believes that Attorney General *v.* X was wrongly decided can credibly or responsibly approach the question of the constitutional position in Ireland in relation to abortion on the basis of a denial that the decision of the Supreme Court in Attorney General *v.* X represents at the present time, until such time as it is departed from by the Supreme Court or there is a further amendment by referendum of the Constitution, an authoritative statement of the constitutional position. This might seem a fine distinction but it is clear. One is perfectly entitled to disagree with the judgment of the Supreme Court but that does not entitle a lawyer to deny that the law in Ireland is as expounded by the Supreme Court in Attorney General *v.* X, that is to say that the termination of the pregnancy is constitutionally permissible where it is established as a matter of probability that there was a real and substantial risk to the life of a mother if the termination was not effected. The obligation to accept that this is at the present time the constitutional position is something that is bound up with the sovereign, independent and democratic nature of this State.

The decision of the Supreme Court in Attorney General *v.* X was affirmed in the clearest terms three years later in the reference to the Supreme Court under Article 26 of the Constitution of the Regulation of Information (Services Outside the State For Termination of Pregnancies) Bill 1995. That was the Bill that sought to prescribe the conditions under which information relating to services lawfully available in another State could be provided as contemplated by the fourteenth amendment. In the single judgment of the Supreme Court given by Chief Justice Hamilton, the judgments of the Supreme Court in Attorney General *v.* X, particularly that of Chief Justice Finlay, are relied upon throughout.

The court was specifically invited in that case including with reference to the fact-----

Chairman:

Five minutes remain.

Mr. Frank Callanan:

No psychiatrist gave evidence in the X case. The single judgment of the Supreme Court of Chief Justice Hamilton, given on an Article 26 reference, specifically affirmed the correctness of the decision in the X case. There has never been the slightest suggestion that the X case was wrongly decided. Moreover the State has itself elected to rely on the X case in resisting challenges brought against it under the European Convention before the European Court of Human Rights. This is particularly true with regard to the argument successfully advanced by the State in D *v*. Ireland that the applicant had failed to exhaust her domestic remedies. This entailed the State arguing, as it did based on the opinion of counsel, that there was at least a tenable argument that a foetus suffering from a fatal abnormality was not an unborn for the purposes of Article 40.3.3° or that even if it was an unborn, its right to life was not actually engaged as it had no prospect of life outside the womb. Of course it goes further than this.

Constitutional amendments which sought to exclude suicide were rejected by the people in 1992 and 2002. In 1992 in rejecting the exclusion of a risk of suicide the people adopted the 13th amendment which provided that Article 40.3.3° did not limit freedom to travel and the 14th amendment which provided it did not limit freedom to obtain or make available information relating to services lawfully available in another state. The 13th and 14th amendments can be seen as responses by the people to the facts of the X case and to the judgments of the Supreme Court. The judgment of the Supreme Court in the X case is to this extent not merely something that is established in law; it is woven into the fabric of modern Irish democratic politics. The reason this is a point of importance which is necessary to emphasise is there is a concern, and the committee can see the reality of this concern from what we have just heard, that behind the argument, which I struggle to comprehend, that legislation of the character contemplated in the heads of the Bill is not necessary, lies a mute refusal to accept the position in Irish law as enunciated by the Supreme Court in Attorney General *v*. X and Others that the X case is part of the Irish constitutional *acquis*.

There are several dicta in case law which illustrate the difficulty of leaving a lacuna in Irish legislation. In A and B *v*. Eastern Health Board, District Judge Mary Fahy and C, Mr. Justice Geoghegan asserted it would be wrong to turn the High Court into some type of licensing authority for abortions. In A, B and C *v*. Ireland the European Court of Human Rights held the court does not consider the constitutional courts are the appropriate fora for the primary determination as to whether a woman qualifies for an abortion which is lawful in a state. In particular, this process would amount to requiring the constitutional court to set down on a case-by-case basis the legal criteria by which the relevant risk to a woman's life would be measured and further to resolve through evidence largely of a medical nature, whether a woman had established this qualifying risk. The court went on to state it would be equally inappropriate to require women to take such complex constitutional proceedings when their underlying constitutional right to an abortion in the case of a qualifying risk to life is not disputable.

I wish to comment on the heads of the Bill which will be dealt with in due course. The scheme of the Bill is conceptually conservative. It seeks to translate into legislation and give legislative effect to the decision of the Supreme Court in the X case without either widening the category in the X case or adding to the categories in the X case. It might appear a Bill which is so conceptually conservative and so restrictive is of little consequence in that it does not add to what is already established by the X case. I do not think this is right. It is not simply that it introduces a scheme which gives effect to the rights established in the X case. It is true we are obliged to legislate for the X case because of the decision of the European

Court of Human Rights in A, B and C *v*. Ireland. The introduction of the Bill seems to be none the less a momentous event in the sometimes turbulent journey of Irish statehood. On the enactment of this legislation the rights enunciated by the Supreme Court are no longer external to, or divorced from, the Houses of the Oireachtas. The Bill achieves the repatriation of this fraught and deeply divisive question to where, subject to the Constitution, it primarily belongs.

Mrs. Justice Catherine McGuinness:

I thank the Chairman and committee members. I am very much honoured to be asked again to discuss the questions arising out of the heads of the Bill. I noted in the letter the Chairman sent inviting me that witnesses were asked to discuss the actual heads of the Bill and go through them rather than go back over the same arguments we had the last time. I am disappointed to find we are going through the same arguments about picking over the analysis of the X case. As I made very clear the last time I was here, my strong belief is the decision in the X case is the law of the land and it is necessary to introduce legislation.

Dr. Binchy stated we have a range of options. This comes a bit strangely from the mouth of someone who, since 1983, has been trying to reduce the range of options available to legislators to deal with the question of abortion by the very introduction of the amendment in 1983 which, for instance, means one cannot legislate for the question of what happens in the case of rape which is, according to present opinion polls, approved of by 75% of the Irish people, and which may indeed be more easily dealt with than the question of suicide, which is a complicated question I perfectly well acknowledge.

We also see the point made by Archbishop Diarmuid Martin and again by Dr. Binchy about the dangers of late abortion. It brings the whole question of abortion into a human rights area. Where one puts it into the Constitution one creates this question of constitutional rights of the unborn and the constitutional rights of the mother. The arguments can be very readily made that one cannot put a time limit on constitutional rights and the Government is probably right in saying this. Therefore, one cannot do what Dr. Martin suggests in the last line of his letter is done in other jurisdictions; one is not free to introduce a time limit.

We must remember when we speak about a range of options that this range of options is dealt with by what happened in 1983 much more than merely the Supreme Court's interpretation of what happened in 1983 in the X case. I should state when giving evidence here I am a member of the working group established by the standing committee of the General Synod of the Church of Ireland which has already made written submissions to the committee and I am in general agreement with these submissions.

I appreciate and entirely agree with what Mr. Callanan stated about the legal interpretation of the X case and the fact it is the law of the land. The Government is constitutionally constrained to bring forward this legislation, and in framing the general scheme of the legislation. By and large I am in general support of the heads of the Bill as set out and it appears they are consonant with the provisions of the Constitution as interpreted in Attorney General *v*. X and Others.

As I stated in my previous oral evidence, I see myself as expressing the middle ground in the debate which has surrounded the proposed legislation, and therefore I do not stand for either extreme side in the argument.

On the whole, the heads of the Bill have been carefully drafted to try to provide for the termination of a pregnancy where it is constitutionally permitted and to clarify the position of medical personnel. I can deal with other aspects in more detail later, but I wish to make a number of remarks.

I am disappointed that the definition of the unborn and the way in which heads 2 and 3 are drafted do not allow for the situation of the foetus that is incapable of independent life, where the mother may have to continue the pregnancy of nine months knowing that the child is dead within her or will die almost immediately upon birth. In D *v.* Ireland 2006, the State asserted that there was a reasonable chance that termination would be allowed in such cases. It should be allowed for in the legislation.

I have a concern about the reference to the general practitioner, GP. I understand that, while it may be desirable to refer to the woman's GP, that it is "shall refer" apparently means that a reference to the GP and discussion of the woman's position can be done without her consent. In all medical situations, it is important that a person should give consent before her or his medical records can be discussed with a third person. This issue should be considered. Perhaps a substitution of "may" for "shall" would be sensible.

Head 4 is the most controversial of the heads. We must consider these matters from a human point of view as well as a practical one. It seems that, as the legislation has set up such a conservative and difficult procedure through which to have a pregnancy terminated under head 4, suggesting it will open the doors to a significant number of abortion is unrealistic. From a practical point of view, it could well be argued that the procedure is so rigorous that women in this situation would be most likely to choose the option of going abroad for a termination rather than even applying under this head. Discussion on the medical aspects of the head is best left to the medical profession. As written by Ms Miriam Lord in this morning's *The Irish Times*, it appears that the end result will be "Doctors differ, patients fly". I understand that this poses a difficulty for legislators but I suggest that they view it from the human point of view. People make legal arguments about the X case judgment being flawed or not flawed, as the case may be, but what precisely would they do if faced with a 14 year old girl who had been raped by her neighbour? They discuss the law in a theoretical way, but let us consider what we do with human beings.

There is a certain illogicality in the argument that head 4 will open the floodgates. On the one hand, it is strongly asserted that Irish people in general reject abortion and that the various forms of public lobbying demonstrate the idea that the Irish people reject the idea of introducing legislation, particularly under head 4. On the other hand, it is argued that, if the door is even slightly opened to the obtaining of a termination of pregnancy, even in the extremely narrow terms of the proposed legislation, there will be a flood of Irish women seeking abortions on false excuses, supported by a flock of doctors willing to collaborate with them. Who are these supposed women if they are not the Irish people, too? Where are these doctors if they are not the caring doctors who have appeared before the committee to date? Is there not an inherent contradiction in this? The floodgates argument is an assumption about reality, namely, that there is a large proportion of the Irish public who want wider access to abortion and will get it unless they are legally prevented by a minority who oppose it. The results of public opinion polls on the subject may be relevant to considerations in this regard. For example, 75% of people are in favour of abortion in rape cases. While considering all of the ins and outs of head 4 and so on, legislators should keep in mind the reality of life in this country. They and I know that thousands of Irish women avail of abortion in other

jurisdictions. This legislation is at least an effort to regularise the situation and make a sensible reply to what is a human situation as well as a legal one.

Chairman:

We now move into members' time, which is 70 minutes. I remind Members of the Houses that their language and terminology should be temperate and moderate. Members do not need to use all of their three minutes. I want to allow as many Members, both of the committee and beyond, to contribute as I can. Eleven speakers have indicated. I call Deputy Kelleher.

Deputy Billy Kelleher:

I welcome our witnesses. Since the Government has decided to legislate, that part of the debate is over. However, the debate on whether the Oireachtas supports the legislation is not over. For this reason, we as Oireachtas Members are trying to go through the legislation.

I assume that no Government could present legislation to the Houses if the Attorney General advised that it was unconstitutional. Experts on both sides can make their arguments, but we as Oireachtas Members must assume that, given the fact that the Bill has been presented to the Houses and in light of the Attorney General's role as the Government's legal officer, the legislation is at least constitutional. Subsequently, we can argue in the abstract about the other issues.

Some witnesses have stated that, under this legislation, the intentional destruction of the unborn could occur up until the time of birth. They assert that the Bill will not vindicate the life of the unborn. I am referring to intentional destruction as opposed to the termination of a pregnancy. Is this not at variance with Article 40.3.3° of the Constitution?

The issue of term limits has been mentioned. In this context, we are discussing heads 2 to 4, inclusive, rather than just head 4. Where a pregnant woman beyond a certain term quickly becomes sick, presenting a medical emergency, having a term limit would mean that her life could not be vindicated. Will the witnesses elaborate on these issues?

The broader substance of the matter has been debated and expert witnesses have appeared before the committee. We cannot dismiss the fact that suicide in pregnancy is a real issue. It has happened in rare circumstances and we must be conscious that this fact has been stated at our hearings. While there may be varying opinions on the matter, most witnesses accept that it happens. Whether a termination is a treatment for suicidality is the issue most in dispute.

Deputy Caoimhghín Ó Caoláin:

I thank the panel. In Professor Binchy's presentation, he stated: "In some cases the very existence of the child may be the basis of the suicidal ideation". He also stated that, in such circumstances, "the goal must be to terminate the life of the child".

I must ask Professor Binchy whose goal he means because such an intent will not be served by this Bill. Not one of the health professionals who have attended and presented at these committee hearings would serve such a goal. Irrespective of their range of strongly held views given in evidence, all are cognisant of and accept the fact that the constitutional protections of Article 40.3.3° still stand and are unchallenged by this Bill. There is a subtext

to much of this. I am an Opposition spokesperson on health yet I do not believe for one moment that such a goal, as Professor Binchy so describes it, forms any part of what the Government is seeking to address in this legislation.

I refer to Dr. Maria Cahill's contribution, specifically to point 4 of her executive summary. She seeks to make the case that there is an inequality in the treatment of a woman presenting with mental illness as against that of a woman presenting who is suicidal. I am concerned by the point made in the opening of point 4, on page 2 of Dr. Cahill's presentation. She describes the right to equality of women who are treated under head 4 as "jeopardised" because, under head 4, a woman officially certified as being suicidal will be offered no psychiatric treatment of any kind for her life-threatening condition. Dr. Cahill goes on to describe this as discrimination as, of course, it would be but this has not featured anywhere in all the engagement we have had. Throughout yesterday we spoke with people from the psychiatric profession, including those who specialise in the prenatal area, and on Friday we spoke as with obstetricians. According to all the care professionals there is no way such a woman would not be treated, supported and given due cognisance of her circumstances. I find it difficult to understand how Dr. Cahill can suggest she would be offered no treatment of any kind.

The clock is ticking and my three minutes is less time than any others have had. I refer to Mrs Justice Catherine McGuinness's point, in which she regretted that some of the historic situation relating to the X case had come into the presentations in this Chamber. I wish to thank Mr. Callanan, and also Mrs Justice McGuinness for her written contribution, because we have been subjected, including this morning, to the continued assertion that all of this is based on a poor judgment and flawed decision of the Supreme Court 21 years ago. I thank Mrs Justice McGuinness very much for her submission today, which properly clarifies that.

Deputy Mattie McGrath:

I welcome our guests. Head 11 of the Bill removes freedom of information from the ambit of the proposed Bill. Nobody proposes that individuals' names and addresses be mentioned in any official record keeping yet head 11 goes much further than that. Bearing in mind the seriousness of what this Bill proposes, and the political and cultural struggle with matters of transparency, do the witnesses believe the breadth of what is proposed in head 11 is an unwelcome aspect of the Bill? It also seeks for the law to provide a register of pro-life psychiatrists so that these persons would not be able to make abortion more difficult. In the interests of equality, and bearing in mind the various procedural abuses recorded in the UK by pro-choice psychiatrists, should a register of pro-choice psychiatrists also be provided to ensure that access to abortion will not be widened in a way that would be contrary to the spirit and letter of the law?

I have some questions for Professor Binchy. Is there a definite constitutional obligation to legislate for every higher court decision? Has the Oireachtas acted unconstitutionally for the past 20 years by not legislating for abortion on grounds of suicide? Should the law affect section 21.1 of the Medical Council guidelines which require that due regard be given to clinical research in the area of psychiatry? A person who is not suffering from a mental disorder as defined by the Mental Health Act 2001 cannot be forced to undergo any treatment against his or her will. In light of the X case, which attested that termination of pregnancy should the only means of averting the risk to the life of a mother, does it follow that abortion will become the only means available if the woman refuses all other interventions?

Chairman:

I will take two other speakers in this section, Deputy Ciara Conway and Senator Jillian van Turnhout.

Deputy Ciara Conway:

I thank the contributors on this issue. I have a question for all of them. In recent days we have heard from some of the medical professionals, in particular some of the college obstetricians, about the amalgamation of heads 2 and 4 which would mean we would not differentiate between the health threats to a woman's life and would not distinguish between the threat from suicide or from a physical illness. Late last night we heard from a cardiologist who said this will change matters for some of the patients he treats, and that no longer will women who suffer with life-threatening heart defects have to suffer the stress and stigma of having to go to the United Kingdom to have a termination, He stated that things will be changed for the better for those women. Is that something about which we should be cognisant? Should we give serious consideration to amalgamating heads 2 and 4?

I have a final question on criminalisation for which I seek some input. The Bill stands to criminalise women and girls who procure abortions, for whom there would be a sentence of 14 years. That has a chilling effect. Medical personnel are also involved. In reference to the Suicide Act, I have stated before that although a person who dies by suicide is not criminalised those who aid and abet the person are sanctioned. Is that something we should replicate in this Bill?

Senator Jillian van Turnhout:

I will not get into a debate on Supreme Court judgments. My role as a legislator is to uphold the Constitution. I refer to head 4. Many legal debates occur about the X case but I am very conscious that it was about a 14 year old girl. That is what we are discussing. As Mrs Justice Catherine McGuinness noted, it is about that human life. In regard to head 4, to exclude suicidality is to change the law. As Mr. Callanan stated, the people voted in referendums in 1992 and 2002. In Article 40.3.3° no distinction is made. The application of whatever is the threat to the life of the mother needs to be the same in all cases. Should we merge heads 2 and 4 in order to ensure the application of the law is the same?

Adding to Deputy Conway's question, I refer to head 19 and the scope of the offence, which is extremely broad. It deals with the criminalisation of any act that has the intent to destroy human life. We need to be clearer and more precise about the activities that would be covered and on this I ask for the opinion of the witnesses.

Chairman:

Panel members have five minutes each to respond and then there are eight further speakers. I ask Mr. Callanan to begin.

Mr. Frank Callanan:

The issue of term limits, raised by Deputy Kelleher, has been a source of much concern. The answer on that point relates to the absolute constitutional imperative to preserve the right to

life of the unborn, even in an X type situation, if the unborn is viable or on the cusp of viability. The reason this is a matter of great public concern is the Irish abhorrence of regimes in other jurisdictions which are believed, rightly or wrongly, to permit abortion on demand. The scheme of this legislation to give effect to a constitutional right is entirely different. For that reason, I do not believe the inclusion of prescriptive time limits is called for. Inclusion of such limits also opens up the unwelcome prospect of a constitutional challenge on the grounds that the legislation infringed the equal right to life of the mother as construed by the Supreme Court in the X case.

Deputy McGrath raised the interesting question of whether the Oireachtas could be said to have been in breach of its obligations since 1992.

I do not think anybody would take that position. However, it is worth mentioning that while it is an unexplored area of constitutional law, it may not simply be a matter of the European Court of Human Rights holding that the State is in violation of the convention, although one could perhaps envisage circumstances in which that argument was made under the Constitution.

On the question of the amalgamation of heads 2 and 4, as both Deputy Conway and Senator van Turnhout suggested, one can see some merit in that. The justification advanced by the Minister is related to the subjective nature of a diagnosis of suicidal intent and that, at least, provides an argument for what is not a radically different regime under head 4 as against head 2. Senator van Turnhout also raised a concern about the scope of the offence created by head 19, which is to replace sections 58 and 59 of the Offences Against the Person Act of 1861. Those sections will be repealed by head 18 and I would share the Senator's concern in that regard. The offence could be better crafted to correlate to the rest of the legislation and should probably be narrowed. One would have a slight concern at the very broad wording. The language is quite broad, and reads that it shall be an offence for a person to do "any act with the intent to destroy unborn human life". Given that this is such a vexed area, it would be desirable to avoid any argument that the offence under the Act could possibly encompass the advocacy of abortion rights.

Professor William Binchy:

The discussion has been very interesting and the questions that were raised have advanced the progress of the debate. Both Deputy Kelleher and Deputy Ó Caoláin raised the question of late abortions. It is very interesting to listen to my colleagues who take a different point of view and who are here as experts today. I hope I am not misrepresenting Mrs. Justice McGuinness or Mr. Callanan, but they seem to advocate no time limits. That is what the Bill has - no time limits, right up to birth. Indeed, Mr. Callanan said that if there were time limits, there could be a constitutional challenge to the legislation. This is worth looking at because everybody agrees that in the late period of pregnancy, if some disastrous or life-threatening condition arises for the mother, the doctors must do everything they can. This is not a point of disagreement; it is a point of complete agreement. The doctors will do whatever is necessary and sometimes there will not be a safe delivery of that child. Sometimes that child will die and that is absolutely, as it were, the way it has to be. There is no dispute about that. It is necessary, in that context, that term limits in this area continue right up to birth so as to allow doctors to intervene at all stages during the pregnancy in order to protect the life of the mother. That is absolutely clear.

However, Mrs. Justice Mc Guinness - I hope I am not misrepresenting her, and she will have the opportunity to clarify her position if I am - takes the view that the X case provides for the termination of pregnancy and, indeed, the termination of the life of the child at all stages during pregnancy. That brings us back to the suicidal ideation situation, which is quite different. It is not about removing the child from a danger zone, from the mother, but about terminating the life of the child. That is what the suicide issue raises. The mother says, in these circumstances, "If this child lives, I die." Doctors in these circumstances are faced with a stark choice. It does not matter how many obstetricians come in here and tell the committee that they will not terminate the life in such circumstances; if the law requires them to do so, subject to conscientious objection, they will have to do so. They will have to do so, for example, at 20 weeks, it is agreed. They will have to terminate the life of that child. That is agreed, so the question is, how many weeks more will they have in which to terminate the life of the child? I repeat - and this issue has not been answered by my colleagues here today or by the Government - that the basic principle of the X case decision is that suicidal ideation, on the basis of the very existence of the child, requires terminating the life of that child, not relocating the child. It is important to get an answer from the Government on that particular point. That is my primary response to the contributions today.

Dr. Maria Cahill:

I will start with the question posed by Deputy Kelleher on the constitutionality of the legislation. I am sure the Deputy is aware that it is the duty of the Legislature, under Article 15.4, not to legislate in a manner that is incompatible with the Constitution. It is not a duty of the Attorney General but of the Legislature itself. None the less, there are two options provided under the Constitution whereby, if the Legislature fails in that duty, the legislation in question can be challenged, under Articles 26 and 34. I am not a legislator so I do not start with the assumption that the Bill is constitutional. Certainly, all of these issues can be raised. I raised the Cosma decision to illustrate that what the Government is doing under head 4 is not compatible with what was done in the High Court in 2006. That must be taken seriously in order to be sure that the Legislature wants, in this instance, to trust the advice given.

On the question of late-term abortion, the Deputy is right that abortion fails to vindicate the right to life of the unborn under Article 40.3.3° in all circumstances, including pre-viability and post-viability. I am sure the Deputy, and indeed most people, would like to prevent the possibility of late-term abortions or partial-birth abortions and that is also indicated in the explanatory notes. However, when it comes to interpreting the section, the Supreme Court is not going to ask for the personal views of Deputies or look to the explanatory notes. It will look to the text of the legislation as provided. The text allows, under the definition in head 1, that an unborn is a person post-implantation until the moment that he or she has been successfully delivered from the mother's womb. That is what we are dealing with as a matter of law. I just wanted to make it clear that, as a matter of law, that is where we stand.

On the question posed by Deputy Ó Caoláin, I am not calling into question the integrity of psychiatrists or the care that they would give. What I am saying is that under head 4, there is no provision for an ongoing psychiatric relationship between the person who is being certified as suicidal and the professional who can help her with that suicidality. Again, perhaps that is something that has been overlooked, but there is no provision in head 4 for an ongoing treatment plan or for ongoing counselling and care of that woman. That is my concern as a woman and as a lawyer.

Finally, I will refer to the human element, because it has been raised a number of times. It just so happens that I am not much younger than the girl who was at the centre of the X case. It was, in fact, the first time my parents had to explain to me both what had happened to her and what she wanted to do. I am in no way impervious to the gravity of her situation and to the human element involved in her life and the lives of many other women in this country.

Mrs. Justice Catherine McGuinness:

In response to Deputy Kelleher's question on the constitutionality of the legislation, in a way one must start from the fact that governments produce legislation all the time, legislation is passed and when that legislation is before either the High Court or the Supreme Court for interpretation, there is a very strong presumption of constitutionality. While I have held some legislation to be unconstitutional in my time, there is a very strong presumption that the courts should not be lightly arguing with the legislators. We can take it that when the legislation is brought forward, it done so with the best legal advice that the Government feels it can obtain.

On the question of term limits and the difficulty of introducing them, as I pointed out, once one starts bringing this into an argument about constitutionality, which basically is as a result of the insertion of the original amendment into the Constitution, it is that itself that is creating the problem about term limits.

If the freedom suggested by Professor Binchy allowed the choosing of one's own legislation, there may be the idea that this is a legislative rather than constitutional matter and term limits could be arranged. One must also consider what will happen in real life, and the doctors have replied to that element. They will not set out to kill viable babies; we are talking about real Irish doctors rather than some type of legal concept.

With regard to Deputy Ó Caoláin's question, I know he has heard over and over again that the X case is a flawed judgment. Personally, I do not consider it a flawed judgment by any means and it was a very careful and harmonious interpretation of the Constitution with - as noted by Mr. Callanan - emphasis on the other Articles of the Constitution which stress the importance of the mother in the home and the people dependent on her. All of this was considered, particularly by Mr. Chief Justice Finlay. It was not a flawed judgment, although the discussion is in a sense irrelevant, as whether the judgment has its weaknesses, it is the law of the land and it is in accordance with that judgment that the heads of Bill have been produced. The Government has made a genuine effort to stick to constitutionality and the laws interpreted by the Supreme Court.

With regard to comments from both Deputy Conway and Senator van Turnhout, I also have considerable concerns about head 19 and the level of the maximum sentence which applies to all cases. A distinction should be made between somebody running a "brothel mill" or doing the sort of things for which the doctor in America was convicted - who would deserve a heavy sentence - and an individual woman and doctor who may have stepped outside the law but who had better intentions. It should be made clear that good faith should be a defence, to some extent at least, with a distinction. I also agree with Mr. Callanan's comments on whether the definition of the offence is broader than the 1861 Act. We really thought we would do something more modern and sensible than the 1861 Act. I can leave it at that.

Chairman:

There is a long list of speakers and we will not get to everybody, for which I apologise.

Senator Colm Burke:

I thank each of the panel for coming forward and giving evidence today. Professor Binchy and Dr. Cahill expressed dissatisfaction with the X case judgment and referenced Cosma *v.* Minister for Justice, Equality and Law Reform. In the X case a psychologist report was produced while in the case of Cosma *v.* Minister for Justice, Equality and Law Reform there were two psychiatric reports produced. The legislation we are discussing would necessitate three medical reports. The argument is that by having legislation where there must be evidence from three experts, there is clarification of the issue. Professor Binchy seems to be very concerned that the X case was a wrong judgment. Is the argument not that there is nothing preventing the Supreme Court from getting it wrong again and even widening the interpretation of what was intended by Article 40.3.3°? Dr. Cahill states in the submission that the "courts have determined, therefore, that a medical opinion on the existence of a real and substantial risk is not the same as legal determination of that criterion" and that they are free to depart from the opinion of a medical expert. Is that not more reason for legislation?

I have raised a point with all the people who have come before us over the past two days. This is the matter of people who are under 18 and the lack of any reference to them in the heads of the Bill. In what way should that be clarified so as to deal with expectant mothers who are under 18? If we go forward without legislation, there is a proposition for guidelines and regulations. I asked the question this morning but it was not answered by those four people so will the witnesses tell me under what legislation can we bring in those guidelines and regulations?

Deputy Eamonn Maloney:

I have long held the view that any woman who finds herself in a position with an unwanted pregnancy is in a difficult and dark place. A woman with an unwanted pregnancy and with additional suicidal tendencies, I am sure we would agree, is in an even darker place. That is the challenge for us as legislators, with all due respect to the people on my left, as well as the medical witnesses yesterday and the witnesses who attended on Friday. As has previously been said, this does happen, although it may be rare. Some of those who attended on Friday described the occurrences as very rare, which is a good and welcome fact. Nevertheless, this is the reality and as legislators we must deal with it.

I cannot get into all the arguments because of time constraints but one of the main reasons given for not introducing this proposed legislation is the terrible question of "floodgates". The floodgates have been open since the mid 1960s, and the accumulated figure is shameful. It takes in our neighbours and friends. The floodgates have opened but we are not dealing with them.

To paraphrase Mr. Callanan, he indicated that this was a "conservative" Bill. I am one of the people who will vote on it and I see it as a very conservative Bill because it is dealing with a very restricted area. That may change. If, for the sake of argument, the legislation passes in July and if somebody finds themselves in a position of having an unwanted pregnancy with suicidal tendencies, do we really believe the person will go a GP, psychiatrist or get a draft of the Bill from a politician? That person will not do so but she will travel to England instead.

Deputy Peter Fitzpatrick:

I thank those present for the presentation and making themselves available today. The Supreme Court X case decision facilitates the introduction of abortion legislation but is there anything in the Constitution that makes the introduction of such legislation an obligation? Does the definition of "reasonable opinion" in head 1 give significant weight to the duty of care towards the unborn and the equal right to life under the Constitution? In the event of a later-stage termination being carried out under the legislation and where the child lives, will the child have a legal right to know the circumstances of his or her birth and the identity of his or her mother? If a patient is a minor, suicidal and suffering mental health problems, how will she be able to give permission for an abortion in accordance with head 4? Can a well-founded reasonable opinion as defined in head 1 be formed by a medical practitioner where a patient is suicidal but not suffering from any mental illnesses? Will the proposed legislation create a legal precedent in making something legal that would otherwise be illegal merely because of the threat of suicide?

Under the Constitution, the unborn has an equal right to life to that of a person. Will the proposed legislation create a legal proceeding whereby the right to life of a person could be diminished in circumstances where there is a conflict of rights?

Deputy Denis Naughten:

I thank the speakers for their evidence. I ask Mr. Callanan to comment on Dr. Cahill's evidence on the Cosma *v.* Minister for Justice case and give us his perspective on that. Both Mr. Callanan and Mrs. Justice McGuinness have said the legislation before us is quite conservative and Professor Binchy made the point that the Supreme Court decision on the X case allows for the termination of the life of the unborn rather than terminating the pregnancy right up to term. In light of that, does head 19 not restrict that right in that it makes it illegal to kill the unborn as set out in the legislation? If so, is it the case that the legislation before us does not go far enough and could be unconstitutional on that basis? If the legislation, as it is framed, does not provide for late terminations on the grounds of suicide, does that raise constitutional issues regarding the ability of a woman to avail of the legislation and does it raise issues for the decision of the European Court of Human Rights? Senator Colm Burke raised the issue of guidelines and regulations without primary legislation. Would that not facilitate a mechanism of regulatory creep regarding what is allowed depending on the Minister of the day? Could someone clarify that for me?

Senator Ivana Bacik:

I thank in particular to Mr. Callanan and Mrs. Justice McGuinness for their comments on head 19. I share their concerns about the over-broad drafting of that criminal offence. Could I ask them both specific questions about this Bill being conceptually conservative, in particular in head 1 in respect of two definitions? I agreed with Mrs. Justice McGuinness when she said she regretted that the proposed legislation does not exclude a situation where a foetus is already dead or has no capacity for life outside the womb. In that instance it seems overly conservatively drafted compared to Article 40.3.3° of the Constitution and it should at least exclude that situation. Also under head 1, the definition of "reasonable opinion" is probably too conservative in that it makes no reference to the right to life of the pregnant woman, only to the need to preserve unborn life. Some balance is required there.

I am amazed to hear Dr. Cahill suggest the Cosma *v*. Minister for Justice case is in any way relevant to an interpretation of the X case. Cosma was a 2006 decision of the High Court in the context of deportation proceedings in which the High Court did not accept that the evidence established a risk of suicide. I utterly refute the suggestion that it is relevant to an interpretation of the X case. Professor Binchy raised the issue of time limits, and that was dealt with very clearly in Friday's hearings. Mr. Callanan's submission points out that when a foetus is viable, or on the cusp of viability, it is constitutionally mandatory that every effort must be made to protect the life of the unborn. That is very clear and it is current clinical practice.

I have a final question for Professor Binchy. As one of those responsible for drafting Article 40.3.3°, the amendment from which this derived, does he not accept that the amendment was flawed? In 1983 Mary Robinson and others predicted that a case like the X case would arise and that ultimately we would be left with a situation where this matter is in the Constitution, where it does not belong, and the Legislature is therefore, as Mrs. Justice McGuinness has said, utterly constrained in its ability for legislate for the real needs of the thousands of Irish women who are travelling abroad every year for abortion, as Deputy Maloney has said.

Under head 4, do Professor Binchy and Dr. Cahill have any compassion for or trust in the young women and girls who are actually going to be affected by this, in particular the girls who are unable to travel because they are in the care of the HSE? It was accepted in yesterday's evidence that these are the real people who will be affected because any other woman is going to travel rather than put herself through these utterly restrictive procedures. Do they have any compassion for those girls or trust in them and their psychiatrists?

Senator Jim Walsh:

From a legal perspective, if the Oireachtas were to pass legislation providing clinicians with full legal clarity, excluding suicide - by which I mean not prescribing for suicide but leaving it as case law - is it possible the Supreme Court could deem it to be in line with Article 40.3.3° having regard to the up-to-date evidence from the psychiatric profession? Former Chief Justice Cearbhall O'Dálaigh said a point not argued is a point not decided, and this doctrine goes for constitutional cases. Mr. Justice Brian Walsh, the best Chief Justice we never had, according to Dr. Cahill, said therefore the court decision can only bind the particular case as it was based on the conceded and unargued construction. The Government is arguing that women are currently entitled to abortion under the X case, so it is obviously not taking that position, and that it is only codifying the law, which is currently allowed. Is the Government correct in that presumption?

The unborn has, *inter alia*, a constitutional right, the equal right to life. Head 4 deals with suicide. All the evidence before us from the psychiatric and medical professions is that it is very difficult to predict suicide. The heads allow for a review where abortion is refused and that review is confined to the mother making the application for the review. Given the equal constitutional right of the unborn to life, is the constitutional right of the child not entitled to advocacy in that scenario, or are we in fact depriving the child of its constitutional right by allowing for no advocacy on behalf of that child in that process?

Mrs. Justice Catherine McGuinness:

I take the points made by Senator Colm Burke. One leaves it open for the Supreme Court to get it wrong again if one argues that the Supreme Court was wrong in the first place. This seems like quite a logical argument but it is unforeseeable and that is one of the reasons legislation is necessary. Otherwise one is leaving it as it is. The Supreme Court has repeatedly said it does not want this to be left in its hands to be decided on a case-by-case basis. This also comes refers to what Senator Walsh said, that a point not argued is a point not decided. This is one of the difficulties about saying the Supreme Court decided abortion could take place right up to the end of the pregnancy. Those were not the facts before the Supreme Court, and courts really do decide on the facts and the cases before them. While it may be inferred that the Supreme Court meant that if it had been asked that at the time it may not have agreed to that at all. This whole argument that the Supreme Court had decided that one could have a termination right up to the ninth month is unrealistic in a sense. It is also clear from the medical evidence before the committee that cases would be dealt with in a way that would preserve the life of the child in so far as that was possible at all.

I appreciate what Deputy Maloney said. It seems to me too that the gateway and referral path put up in head 4 is so complicated and lengthy that the likelihood is that anyone who has the means and the understanding to be able to go abroad, will go abroad. On the other hand, as was mentioned, we are probably dealing with the case of the under-18s and we need something more about that in the legislation. We also need to deal with the area of people who have not got proper capacity to consent to medical procedures of any kind and that should be dealt with by the enactment of the assisted decision-making (capacity) Bill, which is being prepared by the Department of Justice and Equality and was produced by the Law Reform Commission, if I may refer to it.

I very much hope that Bill will be passed relatively quickly because that would be a great help in dealing with those with lacking capacity, which is an important issue.

In fact, what has happened is that it is the cases of minors who are in care that are the cases that have come up before the High Court, in the cases where we do not have written judgments necessarily but we have had the situation where a child in the care of a health board or the HSE has been permitted to go to England for a termination. Anybody who practises in family law or in public law child care cases knows that this has happened on a number of occasions but, because it has been held that it is following the X case, the court has not felt it necessary to issue a written judgment. I believe we should deal with that. I would agree with much of what Senator Bacik stated and her emphasis on the younger persons in care, as I have just said.

We were asked should the child have advocacy. That raises an enormous number of questions of procedure, etc., and I really do not feel competent to deal with that in detail. It could be argued, I suppose, but I think it would have to be left to be decided as a constitutional question. I think I have dealt with most of what was asked.

Dr. Maria Cahill:

To start with something that must not have been clear in my presentation, I am not saying that the X case is a flawed decision. I am saying it is a non-decision on the question of whether suicidality can be treated by abortion. The court did not hear arguments on that point and it did not make a decision on that point. I am not saying it made a mistake; I am saying it did not decide. That is the first point.

I thank Senator Colm Burke and Deputy Ó Caoláin for taking the time to look at the written submission as well as my oral comments, and for the question that Senator Colm Burke raised on the reasonable opinion of the psychiatrist. Now, with the heads of Bill, the Minister is adding in three medical experts. What I want to draw to the attention of the committee is that in the X case the expert, who in this situation was the psychologist, stated that he would not leave that girl alone and the court decided the opposite, that she should have an abortion. In the Cosma decision, the two psychiatric reports stated there was a strong possibility this woman would committee suicide and the court disagreed, stating it thought the real and substantial risk to her life had not been established. What happened there on both occasions is that the court has found the opposite of what the expert has found. One matter on which one must be careful in the definition of reasonable opinion is the fact that the legal test laid down in the X case was to be determined at law whereas in the heads of Bill one is only determining that as a medical question which means that there is also a constitutional vulnerability and a professional vulnerability for psychiatrists who would make determinations of that kind. I thank them for raising that.

I did not discern a question from Deputy Eamonn Maloney for me. Deputy Fitzpatrick asked is there an obligation to legislate. To take it back to the start, what the Constitution does is give Members an enormous privilege. One of the matters that this debate is about is the role of the Oireachtas. It gives Members an enormous privilege to legislate. What the Oireachtas is bound to do is legislative within the terms of the Constitution. Sometimes what comes up in the rhetoric is that the Oireachtas is bound to legislative for the X case, even though the X case, as I stated, did not decide the question of whether suicidality could be treated by abortion, and the Oireachtas is bound to decide by reference to the two referenda that were failed. The Oireachtas is not obliged to legislate for what the people did not put into the Constitution. What the Oireachtas is given is the possibility and the constraint that is on the Oireachtas is the Constitution, and fundamental to that constraint in this situation is Article 40.3.3°.

On Senator Bacik's questions, of course, I am not saying that the Cosma decision is of relevance to the X case because that would be time-travelling. On the other hand, in the High Court, Mr. Justice Hanna, in the Cosma decision, decided that the X case was highly relevant to his determination. He used it verbatim. He analysed the different elements of the X case test very rigorously. What I am saying is that the Cosma decision has built on the X case and now it is relevant as the Oireachtas goes forward to legislating in respect of the heads of this Bill.

Finally, on the question of what is my concern about children under head 4, I think everybody under head 4 is vulnerable. All of those who will come under head 4 will be vulnerable persons. We should be concerned about all of them, both over 18 and under 16.

On the last question on advocacy rights,-----

Senator Jim Walsh:

I think-----

Chairman:

I will chair the meeting. I thank the Senator.

Dr. Maria Cahill:

-----procedure rights and advocacy for the unborn is not mentioned anywhere in the legislation.

Professor William Binchy:

Following on the questions by the Senators and Deputies, it is a little unfortunate that Senator Bacik raised the question of the compassion of my good colleague, Dr. Cahill. I must defend Dr. Cahill. Maria is the most compassionate person. Maria is compassionate about mother and child. She cares deeply about both of them. Senator Bacik has been debating-----

Chairman:

In fairness, that comes across today from Dr. Cahill's presentation. We do not know her at all, but she has that personality about her. We will not defend the indefensible.

Professor William Binchy:

Let us not go there, but it is unfortunate that we had that comment made.

Let us look at the way the debate and the discussion has developed. We have the privilege here of having with us a former Supreme Court judge, who was in the courts for many years and on the Supreme Court for a number of those years. It is worth examining what she said on the question of late abortions because the Government has said nothing other than that there is no problem. Let us examine what Mrs. Justice McGuinness has said in order to enlighten us in terms of the analysis here. Mrs. Justice McGuinness stated that she was confident that doctors would do the right thing. As I say, obstetricians would wish to do the right thing but if legislation constrains them to carry out an abortion in circumstances where they do not wish to do so, their only strategy in those circumstances is conscientious objection.

Mr. Justice McGuinness also stated we are not dealing with a kind of legal concept. Sadly, that is exactly what we are dealing with. We certainly are dealing with a legal concept. The legal concept in question here is the legislation which allows for abortion from the very beginning of implantation up to birth. We are dealing with a legal concept. What is striking is that neither of my two colleagues here who are advocating in favour of the legislation have presented any argument that, in fact, the legislation does not embrace the termination, which means the intentional termination, of the unborn child in the latter stages of pregnancy based on suicidal ideation where the mother says the very existence of this child is intolerable for her. This is a crucial question and it is interesting that the two speakers who have come along to advocate for the Bill have, as it were, supported our analysis as lawyers rather than contradicted it in any coherent way. I think that is a fair point.

On that issue, I would like to say - because my remarks have been, perhaps, a little concentrated in that area - we are not in favour of time limits. Time limits is absolutely the wrong way to go. Mrs. Justice McGuinness more or less made the argument it is unfortunate we have to start here because it is all the fault of the original pro-life amendment. I would suggest that, perhaps, the difficulty lies in the Supreme Court decision, but we have to start here. We very definitely have to start here.

The question is: do we implement the Supreme Court decision which allows for abortion throughout pregnancy or do we take a different course of action? In the light of the changed information - the 21 years of scientific experience so that we can test that particular issue - the Legislature is perfectly entitled and would be very well-advised to take a different course. The Constitution does not require the Legislature to implement the X decision. It has a range of strategies.

The common ground here is that all necessary medical treatment should be given to women during pregnancy. That is not a question of contest. The contest is on the suicidal ideation issue.

On the suicidal ideation issue, we have had support today, rather than contradiction, to the proposition that the opponents of the Bill have put forward, which is, that this allows for suicidal ideation being a ground for termination, not only of pregnancy but of the life of the unborn during the currency of the pregnancy. That is a startling proposition but, nonetheless, it is a legal concept. With respect to Mrs. Justice McGuinness, it is one that the legislators have to contemplate and, I would respectfully say, they should decline to implement that type of legislation.

Mr. Frank Callanan:

Senator Colm Burke made a valid point on what head 4 provides in regard to psychiatrists. I have to say we seem to keep coming back to the point of there being no psychiatrist in the X case. It is hard to see how that, in any event, would affect the correctness of the principle that was annunciated in the decision in the X case.

Senator Burke also referred to the position of children under 18, and the age of consent for medical treatment going to 16 years under the 1997 Act. That is something that in practice, between the courts and parents, I do not think has given rise to a great deal of difficulty.

Deputy Maloney made some valid points on the floodgates argument in terms of what actually happens to women travelling out of the jurisdiction for terminations. Deputy Fitzpatrick raised the issue of the obligation to legislate which had come up earlier. The argument has never really been made that the Oireachtas had to legislate and could not leave a vacuum. As Justice McGuinness has said, judges have frequently lamented - not least in this particular area - the absence of legislation. It is at least theoretically conceivable that one could make an argument that it was incumbent on the Oireachtas to legislate on a particular subject and, irrespective of the content of the legislation, that there was a pure obligation to legislate. It has never come to that, but it would give rise to complex separation of powers issues. However, I suppose it is at least a theoretical possibility.

Deputy Naughten asked about the Cosma judgment. I was quite surprised at Dr. Cahill's reliance on the Cosma decision with which, I have to say, I am not that familiar. It seems inconceivable that one could argue that a High Court judgment on an immigration matter could be considered to have overturned the X case judgment. I do not think she was suggesting that it superseded X, but was suggesting that it represented some sort of new norm of which X was deemed to fall short. However, that is an untenable argument. One might as well Google "suicide" and use whatever comes up to say that it must remove X and take it off the field. I do not know where that argument comes from.

Senator Bacik referred to the need in the "reasonable opinion" to refer to the life of the woman. It might assist but I am not sure it is necessary because the legislation will be construed in the context of the Constitution.

Senator Walsh raised the issue of the advocacy of the position of the unborn, which is a very complex matter. Certainly in so far as legal proceedings are concerned - and I appreciate the purpose of the Bill is to get away from legal proceedings - it is something that has been addressed from time to time by the courts. For example, in the Article 26 reference in the information Bill there was counsel for the unborn. It is something that will be required as a matter of rarity.

Chairman:

There are 11 minutes left and four members of the committee have indicated. If they can be very brief I will take them. They are Deputy Regina Doherty, Deputy Robert Dowds, Senator John Crown and Deputy Mary Mitchell O'Connor.

Deputy Regina Doherty:

What has been determined for me over the past few days is that there are definitely two sides to this issue, which are presented exceptionally eloquently. There is a constant thread from one argument - that we do not need to enact legislation and that we could do exactly what the Supreme Court wanted us to do by use of regulation. From a lay person's point of view, can the witnesses explain what the difference is with regard to the Constitution? If we actually enshrined a woman's eligibility for a termination in regulation, as against enshrining it in law, what difference does that make under the Constitution today, if any? Perhaps it does not make any difference.

Deputy Robert Dowds:

I have one question for Professor Binchy. How should a girl under the age of 18 be treated, who is pregnant and - suicidal or not - has been a rape victim?

Chairman:

I call Senator Crown.

Senator John Crown:

I beg your pardon, a Chathaoirligh, I have some ocular infirmity.

Chairman:

If Senator Crown can be brief it would be appreciated.

Senator John Crown:

I will be as brief as I can, so I will have to speak quickly. Article 34.4.6o of the Constitution states that: "The decision of the Supreme Court shall in all cases be final and conclusive." Our gardaí, soldiers, judges and our Uachtarán all swear oaths to uphold that Constitution.

Many of our gardaí have died defending it against people who did not recognise the Constitution. We might not like it but we agree to live by it. If there are things in it we want to change there are ways we can change it within the law.

Professor Binchy and Dr. Cahill have both basically told us that the Supreme Court decision was flawed. It is an interesting point but irrelevant. It is the law and it was passed by the Supreme Court. If they wish to change the Constitution there is a way of doing it. As well as that, we have heard an extensive discussion by Dr. Cahill on something about which she has precisely zero qualifications.

Chairman:

I would ask the Senator to avoid that kind of terminology and language, if he does not mind, and focus on the heads of the Bill.

Senator John Crown:

I am sorry but this terminology is a fact.

Chairman:

I know, but please.

Senator John Crown:

If Dr. Cahill has qualifications to speak about psychiatry, I will be delighted to be corrected.

Chairman:

Dr. Cahill came here voluntarily to give her opinion and advice to us.

Senator John Crown:

I do understand that but her-----

Senator Rónán Mullen:

The Senator can-----

Chairman:

I am sorry, Senator Mullen. You will have your chance in a minute and you are not a bit shy about talking.

Deputy Peter Mathews:

John is a doctor of law.

Senator John Crown:

It is singularly disingenuous to state that there has been a considered, unanimous body of opinion on the basis of evidence-based medicine, which tells us that suicidality will never be an issue which could be addressed by termination of a pregnancy. There has been a spectrum of opinions. I live by consensus medical opinions and the development of evidence-based medical guidelines, and we have not had it. The thing that is most extraordinary to me is that two people who have come here today as constitutional lawyers, can in their submissions and writings discuss this issue and never mention the fact that we have had two referenda.

In 1992, the question that was put to the people in a referendum was utterly clear cut. It was: do we exclude suicide or not? The answer was utterly clear cut - it was two to one. There was no ambiguity about this.

In 2002, in a highly nuanced and more controversial and complicated referendum proposition, which included other issues, the decision was closer but it was still carried by the people. I would like to know by what authority do those who believe we should thumb our noses at the Constitution of this land, think we should act in contravention of the Constitution, in excluding suicide from a Bill where we have been mandated by the highest definitive court in the land, and twice by the people, not to exclude it?

Chairman:

I call Deputy Mitchell O'Connor.

Deputy Mary Mitchell O'Connor:

My question has already been asked.

Chairman:

I ask Senator Colm Burke to ask his question quickly.

Senator Colm Burke:

The question I put to Professor Binchy was what legislation is currently in place where we can put in regulations and guidelines?

Chairman:

We will start with the witnesses again and they will have two minutes each.

Mr. Frank Callanan:

I was going to take up that point about regulation. It is not clear under what legislation it would be provided. One would then have a further set of arguments. A different set of legal principles in addition to constitutional law would apply concerning regulation. There does not seem to be any merit in the suggestion that one could proceed by regulation, rather than legislation.

Chairman:

Professor Binchy has two minutes.

Professor William Binchy:

On the point about regulation or legislation, what the European Court decision requires is clarity. Clarity and, indeed, that right of appeal that I mentioned, can both be provided without any legislation simply by a ministerial non-statutory scheme - for example, by the Medical Council, with as much detail as anybody would want. I again stress the fact that this legislation has not an ounce or iota of detail in terms of specificity or in terms of medical treatment. Therefore that can be done. It would also be perfectly possible for legislation, a facilitating Act, to be passed providing that the Minister for Health shall make regulations dealing with safety considerations during maternal pregnancy and some greater specificity in terms of what the Minister does concerning guidance regarding best practice.

Picking up on what Senator Crown said about best practice, it is guided by consensus but also open to new medicine as well as established old medicine. Senator Crown made two points.

The first was a point with which the legislators clearly would disagree - and have in practice disagreed - which is that simply because the Supreme Court has decided a particular matter, this means the legislators and people in general in the community must comply with that decision and do nothing about it. They must not think critically or think about the possibilities of a new way forward. A number of Supreme Court decisions have been so obviously and immediately bad, it was necessary to introduce a pretty immediate constitutional change. I will mention one in respect of adoption approximately 35 years ago, when members might remember the Supreme Court came to a particular decision and this course of action became necessary immediately in the light of that decision. While it was a relatively non-controversial, technical point about the nature of adoption, a constitutional change was put forward immediately. Senator Crown also made the point that as we have had two referendums, surely we are too tired to have a third. With respect, that is rhetoric, rather than actual sound, sophisticated historical analysis. As the pro-life campaign opposed the 1992 referendum, the very opposition from which Senator Crown seeks to derive support came in substantial part from our side of that particular argument. If I might also mention 2002, again-----

Chairman:

We have been there.

Professor William Binchy:

Has the committee dealt with this issue many times? I am sure it has.

Chairman:

We have moved beyond it.

Professor William Binchy:

The point in a single-sentence summary is that the idea one cannot go forward in this area, simply on the basis of two previous referendums, is historically unsound.

Chairman:

I call Dr. Maria Cahill.

Deputy Robert Dowds:

I wish to have it noted that Professor Binchy did not answer the human question.

Senator Jillian van Turnhout:

He had only two minutes.

Chairman:

I apologise to Dr. Cahill. Teaching is sometimes easier than this.

Dr. Maria Cahill:

Not that much easier but sometimes, yes. First, I find it alarming that Mr. Callanan would equate a Google search as having the same judicial value as a High Court decision. This appears to me to be not entirely in sync with what the Constitution requires. In response to Senator Crown, I repeat my statement about the X case, which was not that it was a flawed decision but that it was a non-decision. Moreover, for that I am relying on a Supreme Court decision. It should be borne in mind that the precedential value of court decisions is not determined by the Senator, the Taoiseach or the Minister for Health but by the Supreme Court. The Supreme Court has held that if a point is conceded, the precedential value of that case is vanished. The Supreme Court in 1965 has provided an answer to what has happened in the X case. It has stated that when the argument is conceded, the precedential value has disappeared to vanishing point. The person on whom I am relying and who first made that argument is a person with 29 years' experience on the Supreme Court. Consequently, I believe we can take what he says seriously.

On the point of referendums, I have heard the Senator making this argument many times and have been answering him on the television at home-----

Chairman:

Thank you.

Dr. Maria Cahill:

When we vote to reject a proposal to amend the Constitution, nothing happens. There is no change in the law and the Senator is not under an obligation to legislate for what is not included in the Constitution. That makes his job far too hard.

Chairman:

Finally, Mrs. Justice McGuinness has two minutes.

Mrs. Justice Catherine McGuinness:

The main question asked here is about regulation. One cannot approach the matter by regulation alone, because to be enforceable and to be part of the law, regulation must stem from another item of legislation. There must be a clause giving the Minister power to make regulations and the law is such that with regard to any act under that, the regulation must be within the power the Minister has been given by legislation. One can have a whole set of beautiful regulations but they are not, as it were, enforceable. They are mere guidance principles and while guidance principles are fine and lovely, had members listened over these many days to the arguments on both sides in this case, they surely would realise the task of someone setting out consensual guidance principles would be extremely difficult, because there is no consensus. There does not appear to be consensus at any level.

I must add that I think Dr. Cahill is entirely misinterpreting what was said by the clinical psychologist in the X case, when he stated he would not leave that girl alone, by which he meant the girl might commit suicide, were she left alone. Moreover, the Supreme Court's decision was to let her go with the consent and in the bosom of her family, with her father and mother and not alone, to England. This was a family decision and not akin to throwing the girl out of the window.

Chairman:

Go raibh maith agat. We now move to the time allocated to non-members of the joint committee. There are 30 minutes and again I ask Members to be brief and to ask questions on the heads of the Bill, as that would facilitate more than the norm getting in. I will start with Senator Mullen.

Senator Rónán Mullen:

Perhaps the experts would all agree with me that it probably is unfair to challenge an expert, given the pressure of time here, for allegedly ignoring the human element. Perhaps even Mrs. Justice McGuinness would agree with me that precise distinctions of law must be made sometimes to ensure the law is an instrument of compassion and not one of injustice, as that is what is at stake here.

On the housekeeping question I have asked of all witnesses, I note this morning Deputy Durkan raised the bizarre proposition that lawyers might sometimes be coloured by their personal opinions. I acknowledge that in his submission, Mr. Callanan mentioned he is a trustee of the Fine Gael Party and Professor Binchy has mentioned his long association with the Pro Life Campaign. However, purely as a matter of housekeeping, may I ask whether any witnesses present were consulted in the wake of expert group report, in the context of the preparation of these heads of legislation? Ought they, in the spirit of full disclosure, declare whether they have any party, political or past or present campaign or lobby group affiliation? This is not to judge anyone but simply to allow members to consider everything in the round.

Has Mr. Callanan misunderstood what Dr. Cahill is saying in respect of the Cosma case? As I understood it, she was not saying it subtracted from the X case decision or the real and substantial risk test but rather, that it specified, as it were, an interpretive key that must now be used and that what she had to say about the Cosma decision raises implications for Mr. Callanan's analysis of the heads of this Bill, in that they are not sufficiently specific in terms of establishing whether a person meets the real and substantial risk criterion. Perhaps he might comment on this point. A real issue that has emerged today, as in previous days, is the

huge difference of opinion among eminent people. In particular, it appears that the law is changing in one respect, in that the law of unforeseen consequences may apply in respect of the question of term limits and members may indeed be looking at a case in the future where this legislation could be challenged. I have not heard that proposition challenged but I invite Professor Binchy to comment briefly on Mr. Callanan's submission, both at page 3 and page 6, where, in respect of the former, he suggests the Supreme Court in 1996, in the Article 26 reference, did dispose of the argument that X was not properly decided by reference to the fact that medical issues were not fully canvassed. Is this a different question from stating it was not fully decided, in the sense expressed by Dr. Cahill?

Chairman:

Thank you Senator.

Senator Rónán Mullen:

Finally, I seek Professor Binchy's view of whether in fact it is required, as Mr. Callanan states on page 6, that we avoid putting the courts in charge of determining cases. This is a reference to the Strasbourg court decision.

Chairman:

I call on Senator Healy Eames and ask her to be brief to enable others to come in as well.

Senator Fidelma Healy Eames:

I again welcome the clarity achieved today that we are not obliged to legislate for the X case. I believe it is worth considering Dr. Maria Cahill's analysis of the reason the Bill might be unconstitutional. Members have heard warnings in the past and this possibility is worth considering. The evidence about the lack of a treatment plan is particularly relevant.

Chairman:

As the Senator is aware, we have not yet had a Bill. Consequently, she might change that term.

Senator Fidelma Healy Eames:

My question to Dr. Maria Cahill, Professor Binchy and Mrs. Justice McGuinness is whether the Oireachtas can satisfy the requirements of the European Court of Human Rights without head 4 of the Bill? After all, this is what the joint committee has been asked to do, namely, to offer such clarity to the European Court of Human Rights.

I also have difficulties with head 19, which I consider to be overly stringent with regard to criminalising the woman. In particular, I wish to raise the issue of time limits. Yesterday, Dr. Peadar O'Grady stated that eight to nine weeks was the critical or best time to intervene in a pregnancy. As the witnesses are aware, this Bill introduces no time limits. This next question is addressed to Mrs. Justice McGuinness because she has asked members to look at it from a human point of view, which I am doing.

:

It would be barbaric if we had to enact the Bill without time limits because we are quite literally saying that up to the third trimester, including up to 40 weeks gestation, a baby's life could be ended. My question to Mrs. Justice McGuinness is whether it would be unconstitutional to introduce time limits.

My final point is addressed to Professor Binchy and Dr. Cahill. Arising out of Article 40.3.3° and the equal right to life of the unborn and the woman and in view of the fact that there is a direct attack on the unborn in head 4, should the unborn be entitled to the right to legal representation and, if so, at what point?

Senator Paul Bradford:

I welcome the witnesses to the Chamber of Seanad Éireann. I wish to make an aside which I consider relevant. Professor Binchy mentioned the adoption referendum of 1979, which was necessary and was passed overwhelmingly. On the same day, the people voted to extend the Seanad voting rights to allow additional people to vote in Seanad elections. That was 34 years ago and we have not legislated for that particular proposal. Others now have an idea of legislating for another future for the Seanad.

Chairman:

Senator Bradford should refer to the heads of the Bill.

Senator Paul Bradford:

It again proves that we do not always respond by legislating for particular judgments or constitutional provisions.

Head 4 is the point of dispute. We like to be in a comfort zone politically. I certainly do. One likes to believe that one is doing something because one has to do it. That brings me back to the central divide between the witnesses before us now and the earlier witnesses on whether we are obliged to legislate. We can produce tomes and have legal presentations but it requires a "Yes" or "No" response to the question of whether we are obliged to legislate. I direct my question to Mr. Callanan and Professor Binchy. Could they indicate "Yes" or "No", not whether it is right or preferable, not the reasons for either position, but whether we are obliged to legislate.

Deputy John Paul Phelan:

I wish to refer to two areas and I do not wish to rehash what has been said. In the previous session Mr. Paul Brady strayed into the area of constitutional law. He made particular reference to the suicide grounds in the X judgment. Dr. Cahill made reference to it in her report. I will ask Dr. Cahill specifically and Mrs. Justice McGuinness as well to respond to me. If the suicide ground was conceded in the X case and was not argued and therefore is not binding other than on the specific facts of the X judgment itself, is that currently the legal position following on from the 1965 judgment to which Dr. Cahill referred in her presentation? If it has not been argued before the court, is it binding and is it correct that we should put an elaborate arrangement in the legislation, with 95% of which Members in both

Houses of the Oireachtas agree? The central issue is head 4. Should we build such an elaborate mechanism if the decision in the X case on that specific area is not binding?

My final question is specifically for Mrs. Justice McGuinness, whom I have observed for years. I was present in January for the three days of hearings and I have been present for virtually all of the current three days of the hearings also. She was asked directly in January about the question of fatal foetal abnormalities. I remember it distinctly and it stuck in my mind that she said to legislate would be unconstitutional. Perhaps I misheard her earlier. I have an infection at the moment which is affecting my hearing but I think she said that she regretted that the heads of the Bill do not include a provision to deal with the case of fatal foetal abnormalities. Perhaps I misunderstood or she was expressing the wish that the constitutional provision would be amended. Could she clarify the position please?

Deputy Terence Flanagan:

I join in the welcome for the expert witnesses before the committee. I wish to inquire about head 12 which relates to conscientious objection. Reference has been made to patients, doctors and midwives being allowed a conscientious objection, but does an institution have a right to conscientious objection, as endorsed by the Council of Europe? Should head 12(3) be removed? Could witnesses indicate a “yes” or “no” response?

Is there a definite constitutional obligation to legislate for every decision of a higher court? Deputy Mattie McGrath asked a question which was not answered yet by the panel on whether the Oireachtas has acted unconstitutionally for the past 20 years by not legislating for abortion on the grounds of suicide.

My final question is for Dr. Cahill. Could she explain why we are not compelled to legislate for the X case? Why does she think we have been told repeatedly that we must do so?

Deputy Billy Timmins:

I respect the expertise of our witnesses and their ability to cross-reference other experts. Time and again we have heard the claim that abortion is not a treatment for suicide. Everyone, including the medical experts, are weary of it. Could Mr. Callanan clarify, if we enact head 4, whether we are creating abortion as a treatment or measure to deal with suicidal intent? Could he also comment on Dr. Cahill’s point that if we are to legislate for the X case, we are legislating in defiance of science?

I wish to address two questions to Mrs. Justice McGuinness. It is unique that we have someone who has served for such a long period in the Supreme Court. I would like to get her general view on which she touched in her contribution about the concept of the intent of the Legislature and the literal meaning of the legislation. In Britain they call it the golden rule and the mischief rule. What is her view on the Supreme Court decision of 1992? Does she believe it interpreted the intent of the Legislature at that time or did it go along with the literal meaning?

In her contribution she also mentioned opinion polls and lobbying. It is important to point out that relying on opinion polls on social issues can be most unreliable. In the children’s referendum the poll was on 10 November. In a Red C poll of 19 October, 91% of people said they would vote but only 33.5% did.

Chairman:

Could Deputy Timmins stick to the heads of the Bill rather than referring to opinion polls?

Deputy Billy Timmins:

In fairness, you allowed a witness allude to polls and lobbying and it is important that I address the issue for the record. The Red C poll stated that 4% would vote “No” while on the day 42% voted “No”. Mrs. Justice McGuinness also referred to lobbying individual Members of the Oireachtas. I can only speak for myself but in so far as I was lobbied, I have been lobbied by those who are in favour of the legislation to a far greater extent than those who are against it. I can only speak for myself. I did not get elected to respond to lobbyists or to represent the will of the people. I got elected to do what I believe is right in the common good, as did most Members. I do not wish the myth to develop that some people might be responding to lobbying. I certainly am not.

Deputy Olivia Mitchell:

My question is to Mrs. Justice McGuinness and Mr. Callanan. It relates to the possible need to include some enhancement for the legislation. I refer in particular to a clear pathway to an assessment. Given the basis of the European Court of Human Right’s criticism of us was that we failed to provide such a path, that the legislation provides that the path will be established by specialists, and that the only way to a specialist assessment is by referral from a GP, who if one likes are the gatekeepers to specialist treatment, unless one is admitted to an accident and emergency unit; it seems that the legislation should be at pains to provide a clear path out of the GP’s surgery and how one establishes the right to eligibility. More importantly, there should be a clear timescale. There is clarity on a timescale, what happens and how it happens when one is making an appeal, but there is not clarity when one is trying to access the system.

I have concerns under both heads 2 and 3. In the case of head 2, the woman has no role until the very end.

She can respond to the decision others have made on her behalf. In the case of head 3, she can trigger the situation but the heads assume she will already be in the health system and under the care of a specialist. That is not what will happen in most cases and under head 2, a woman in the very early stages of pregnancy might have a pre-existing medical condition which may present a real and substantial threat to her life but that threat may not be imminent. Time is of the essence in terms of getting a non-invasive procedure.

For a woman's right to an assessment to be vindicated, we need a GP who is willing to participate in the process and to do so quickly. My worry is that if we pass this legislation without putting in place some very clear pathways, it will not meet the demands of the ECHR and we will be back where we started.

Chairman:

Time allocated for members is almost up. I will take Deputy Mathews and Senator Hayden, if they are very brief. That means a question, not a dissertation.

Deputy Peter Mathews:

I would ask all of the witnesses if they think it would be best if our Taoiseach and Tánaiste, who are promoters of this Bill, were here to listen to the testimony?

Chairman:

The Deputy is abusing the privilege I am giving him.

Deputy Peter Mathews:

That is a question.

Chairman:

I thank the Deputy and I call Senator Hayden.

Deputy Peter Mathews:

We have learned a lot about the constitutionality of where we stand.

Chairman:

I want the questions to relate to the heads of the Bill.

Deputy Peter Mathews:

On the constitutionality of the Bill, it is clear on a fair hearing of all the depositions that we are not obliged to legislate in terms we have been presented with in the Bill.

The psychiatrists have said that given the probability of the presentation of someone with strong inclination to suicide is so rare, they will become the qualified adjudicators for suicidal intent to such a degree that the mother's life is impaired and, therefore, they will be signing off that the baby must be killed.

Chairman:

I asked that people use language that is tempered and moderate and I ask Deputy Mathews to respect that.

Senator Aideen Hayden:

Irrespective of there being or not being any legal obligation on us to legislate, and I believe there is, would the witnesses accept there is a moral obligation on us to legislate, given in particular the evidence this committee has received in the last number of days, especially the evidence of the experts in the fields of both psychiatry and obstetrics?

I refer to an earlier question asked by Senator Bacik on the definition of the unborn. Would the witnesses accept that the definition of unborn should be extended to remove a situation where a foetus is clearly unviable or indeed where it is already dead? Would they accept that there is a need to ensure an adequate and effective procedure to access lawful abortion under the ECHR ruling?

Chairman:

I apologise to the panel for taking questions from all Members but they have been here for the entire day.

Mrs. Justice Catherine McGuinness:

There was a range of questions and I will try to deal with as many as I can. With regard to the question from Senator Mullen, which is trying to flush out whether we have any dire back-up here, I do not belong to any group of any kind on this. I have already made it clear in my initial statement that I am a member of the Church of Ireland and was part of its working group to frame its statement on this, which clearly takes the middle ground in saying it is very much opposed to abortion but accepts there are cases of strict medical and other necessity in which it may occur. Members all received that submission.

Perhaps I should, to make clear what my position might be to Senator Mullen, repeat what was stated by the standing committee of the General Synod of the Church of Ireland in 1983:

> In our opinion a proposed amendment to the Constitution and a referendum will not alter the human situation as it exists in this country, contribute to its amelioration or propose a responsible and informed attitude to the issue of abortion. We gravely doubt the wisdom of using constitutional prohibitions as a means of dealing with complex moral and social problems.

I still agree with what was said in 1983 but we must deal with what we have now. That is my background for Senator Mullen, but I have no political background. He has a religious background as well.

Senator Rónán Mullen:

We all have our own.

Mrs. Justice Catherine McGuinness:

I appreciate there is that difficulty about term limits but as I said before it arises from the sort of constitutional law we have. Senator Healy-Eames asked if we can satisfy the A, B and C *v.* Ireland judgment without head 4 or the Supreme Court decision in X and I do not think we can. Is it unconstitutional to introduce time limits? Perhaps the Oireachtas should try it and see if it is ruled unconstitutional. It might be something the Oireachtas could consider but, as things stand, it is difficult. The Government probably does not want to introduce new difficulties that are going to make constitutional challenges practically a certainty but it might be worth a go.
I entirely agree with Dr. Binchy that it is possible to change everything by referendum. Perhaps the reason we feel wary of the idea of a referendum is the level of virtually abusive lobbying that goes on every time there is a referendum and every time this issue comes up. Perhaps we should be looking at the psychological care of the various, particularly Fine Gael Deputies, who have been subjected to this kind of lobbying. Perhaps they are the ones who should be looking for psychological care.

Senator Rónán Mullen:

Does Mrs. Justice McGuinness have a reason for thinking that?

Chairman:

Mrs. Justice McGuinness should include Senators in that statement.

Mrs. Justice Catherine McGuinness:

And Senators.

As regards to the question of the Oireachtas having acted unconstitutionally in the past, I do not think that can be said. It has acted neglectfully in not bringing in legislation but that was not unconstitutional. It is free not to legislate. The situation changed, however, after the A, B and C *v*. Ireland case and because the present Government decided it was time to bite the bullet.

Was X in accordance with the intent of the legislation? That does not arise because there was no legislation at the time. The Supreme Court was only looking the Constitution, not the legislation and therefore could not refer to it.

We should improve the pathways to treatment and the fact many of the people who will be involved in these procedures, apart from the emergency situation, but particularly under head 4, are those who have little money and cannot avail of the services offered abroad. They are often, as shown in Dr. McCarthy's evidence, involved in the drugs scene, young and unmarried. Those people might not have a GP.

On the other hand, it is made clear in the report on suicide published in recent days that 60% of the people who committed suicide were already being treated by the health system. As to the arguments about treatments and so on, treatment may or not work. That is probably as much as I can deal with at the moment.

Dr. Maria Cahill:

To respond to the housekeeping question, I am not involved in any political party and I have never campaigned, although today makes me want to do so.

Senator Healy Eames asked whether it would be possible to legislate to satisfy the requirements of the European Court of Human Rights without head 4. The answer to this question is to be found in rule 6 of the rules of the Committee of Ministers for the supervision of the execution of judgments and decisions of the European Court of Human Rights and the terms of friendly settlement. Countries are supposed to legislate to prevent the recurrence of the breach which gave rise to the violation that was found in the relevant judgment. In that circumstance, one is dealing with a woman, applicant C in the A, B and C *v*. Ireland decision, who discerned herself, by means of a Google search, that there was a risk to her life and wanted to have this risk recognised. It was a physical, medical risk to her life and does not, therefore, come under head 4. For this reason, it would be possible under the legislation to remove that head and still be in conformity with what the European Court of Human Rights decided. In general, as was reiterated on 10 April this year, the principle that the Committee of Ministers uses is the principle of subsidiarity under which a member state should choose how it wants to become compliant with a decision of the European Court of Human Rights.

To respond to Deputy John Paul Phelan, that is the Supreme Court decision on the X case.

Deputy Terence Flanagan asked whether the Oireachtas had been acting unconstitutionally for all these years. I agree with Mrs. Justice McGuinness that is not the case. On the constitutional obligation to legislate for every Supreme Court decision, there are several Supreme Court decisions, for example, the *re* a ward of court case, the P.K.U. test case, the Ryan *v*. the Attorney General case and the Kennedy case, where the Oireachtas has not legislated for the rights that were recognised. It cannot be said, therefore, that there is a constitutional obligation to legislate for every decision or right that has been recognised.

I ask myself if I dare to restate my position on the X case. My position is that the court did not determine the question of whether suicidality could be treated by abortion and, therefore, suicidality is not part of the judgment of the court. I do not know why Members of the Oireachtas have been told so often that it is necessary to legislate. That view must be based on non-legal considerations.

Professor William Binchy:

To answer Senator Mullen's inquiry, in the 1960s, when I was young, I was a member of the Labour Party at a time when it was committed to justice and the protection of all human beings.

Chairman:

I ask witnesses to refrain from those types of remarks, please.

Professor William Binchy:

It is important to note that this is about remembering all human beings because if we forget that we are discussing all human beings, including unborn children, the debate becomes restricted to a narrow medical question, regardless of the wider issues. The basic question was whether we should legislate. I compliment Mrs. Justice McGuinness on her open and honest contribution. We should listen closely to what this former Supreme Court judge stated because she essentially confirms the argument being made by this side of the argument, namely, that legislation is not necessary and that the Legislature has not been in breach of the Constitution since 1992 in not legislating. I suggest that to legislate now on the basis of the X decision, which was based on absolutely discredited medical and scientific evidence, would be wrong.

When one considers the totality of the contributions of the speakers today, they support the argument we have been making. They have been met by silence from the Government, except for one rhetorical statement that nothing has changed and one need not worry. We have put the argument that this legislation extends throughout pregnancy and Mrs. Justice McGuinness has not contradicted that position. It is interesting to show dilemma in which the Government finds itself if it is seeking to legislate in accordance with the X case. Mrs. Justice McGuinness stated that, in the term limit area, the Oireachtas might consider "having a go" - that was the expression she used - at putting forward legislation with term limits and see how it goes with the Supreme Court. I suggest a more radical course of action, namely, Members should have a go and, if they believe it is appropriate, introduce legislation dealing with the medical matters. These are matters of no dispute in the country and the Bill, as it is addressed in heads

2 and 3, does not give any specificity in regard to medical matters. These are areas of complete non-controversy. The single area of controversy is the suicidal ideation ground in head 4. In this context, to introduce that legislation would be a complete abnegation of the responsibility of the Legislature to protect the lives of human beings in this country. This is an important point. In recent years, the issue of principle has been one that has come before Members. It is of great significance but that does not mean abortion is the most important issue in the world - of course that is not the case. There are many issues of social justice that are hugely pressing. However, underlying this proposed legislation is a principle which contradicts the fundamental basis on which the Constitution is based, namely, respect for every human being.

Mr. Frank Callanan:

In answer to Senator Mullen's query, I had no involvement or input into the drafting of the Bill. On Cosma *v.* the Minister for Justice, Equality and Law Reform, about which a question was asked, that is for an entirely different statutory purpose as it is an application of the Attorney General and X judgment. It is very difficult to see how an application could somehow retroactively modify the judgment that was being applied.

As to whether there is an obligation to legislate for X, the short answer is "Yes". It is true that the European Court of Human Rights in the A, B and C *v.* Ireland case did not specifically state that legislation was required but it is difficult ti see what else arises in an Irish context. If one wants to think about regulation, one is looking, as Mrs. Justice McGuinness stated, at some sort of enabling legislation, followed presumably by the Minister, Deputy Reilly, making regulations. I imagine it would lead to political uproar if the enabling legislation was passed and it would be subject to a different set of constitutional objections.

In the Tysiąc *v.* Poland judgment - in case this is where Professor Binchy is suggesting we should be going - the attempt by the Polish Government to rely on pure medical regulation or whatever guidelines were in place for the organisation representing the medical profession was a failure.

Chairman:

I welcome the Minister of State at the Department of Health, Deputy Kathleen Lynch, who has been in the Visitors Gallery since the session commenced. For the benefit of Senator Mullen, other people who were before the committee in recent days did not declare an interest, a vested interest or membership of organisations. To be fair to Mr. Callanan he did so in his submission.

Senator Rónán Mullen:

Credit is due to him for that.

Deputy Ciara Conway:

On a point of order, other than the Labour Party, has Professor Binchy been a member of any other organisation or political party?

Professor William Binchy:

No.

Chairman:

I thank Mr. Callanan, Professor Binchy, Dr. Cahill and Mrs. Justice McGuinness for their attendance.

Sitting suspended at 2.50 p.m. and resumed at 3.30 p.m.

Medical Ethics

Chairman:

I thank everybody for attending this afternoon. I remind Members and witnesses to ensure their mobile phones are switched off for the duration of the meeting as they interfere with the broadcasting and sound recording equipment making it uncomfortable for members of staff. This is our 11th session of 12 in our series of hearings that the Joint Committee on Health and Children has been asked to conduct in the analysis of the heads of the protection of life during pregnancy Bill. I thank the members for their attendance in the past three days. I again remind everybody regarding time. I ask people to be cognisant of the language and terminology we use. We should be temperate, moderate and respectful of each other and in particular of our expert panel of witnesses who have come here voluntarily today to assist us in our analysis of the heads of the Bill.

I welcome Dr. Ciaran Craven, Dr. Ruth Fletcher and Ms Sunniva McDonagh. I thank them for giving of their time to assist us today. I remind members and witnesses about privilege. Witnesses are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to do so, they are entitled thereafter to only a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of the proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice or ruling of the Chair to the effect that, where possible, they should not comment on, criticise or make charges against either a person outside the Houses or an official either by name or in such a way as to make him or her identifiable.

I ask Dr. Craven to give his opening remarks.

Dr. Ciaran Craven:

I thank the Chairman and members of the committee for the invitation to present to it this afternoon. I know the members of the committee have heard a great deal in the past few days and I do not propose to delay them unnecessarily with what I have to say. Over the next few minutes I will give a very brief outline from an ethical-legal perspective in respect of the heads of the Bill. I will begin with the ethical issues, moving on then very briefly to the legal considerations that necessarily arise. I will then synthesise them regarding some general comments I wish to make in respect of the heads of the Bill.

As the Medical Council has made clear, good medical practice depends upon a relationship of trust between the profession and society at large. That requires the highest standards of professional practice and behaviour. That is the expression the council uses in its guidance. At the heart of this are the concepts of honesty, responsibility and accountability. To fulfil the duty the council defines for doctors requires that doctors seek the highest standards regarding their practice. A failure to meet those highest standards will attract opprobrium. It may either amount to professional misconduct on what they call failing below the reasonable standard test or indeed it may also amount to poor professional performance. However, that is a bit academic. At the heart of this is a requirement that proper professional standards be met and a failure to meet those standards is one that will result in certain sanctions, the nature of which do not actually concern us this afternoon.

At the heart of this is something simple - the safety of the public. It is about assuring that individuals receive the quality of care they deserve on the one hand. It is also about assuring that one can ensure that when that care is being delivered it is being delivered safely. I want to demonstrate that it is really not about matters of simple independent opinion. In other words there are objective standards that must be applied. Lest it be considered that this is simply an ethical matter which is of concern, in our legal order this is also given certain force. In so far as the law of tort is concerned, it used to be dealt with in the context of whether one followed, adhered to or subscribed to a general and approved practice, in other words one which was followed by a responsible, reputable or respectable body of professional opinion. That was the classical test and the classical formulation.

That seems to have undergone something of a transformation, particularly in recent years. I wish to reference two particular instances where this has occurred. The first was the case HM *v.* the HSE and a decision of Mr. Justice Charleton from July 2011. The case is significant because it actually incorporates evidence-based professional guidance into the appropriate standard of care. It is almost a reflex of incorporation and is virtually a definition of equipollence or equal power as between professional guidance which is evidence based on the one hand and then also the standard of care in so far as the law of negligence is concerned. That seemed to represent something of a shift in so far as the courts are concerned from this deference to clinicians in terms of what is or is not appropriate. That is hardly surprising given that over the past 25 years there have been very significant shifts in terms of evidence-based practice in general.

A further issue has also arisen. In its decision in the case of Kearney *v.* McQuillan, the Supreme Court went further in stating that health care professionals owe and always have owed a duty to patients to protect their constitutional rights. This in so far as our legal order is concerned has been elevated to a significantly higher level as well.

There is a question of an affirmative duty - an affirmative duty on the one hand which is imposed by the proper practice of medicine and secondly an affirmative duty which is then reflected in terms of what the courts have found and in particular the decision of the Supreme Court in the past 12 months or so.

Underscoring all of these it seems there is a requirement for some evidence in terms of one's practice. In other words, in order to fulfil the obligations that doctors have, be it at an ethical level or a constitutional or legal level, there must be some evidence in terms of what they do and that is about the only way the ethical injunction of *primum non nocere* - first do no harm - can actually be fulfilled.

That forms the backdrop to what I want to say in the context of the heads of the Bill. It would not be particularly useful for me to go through it head by head because the members of the committee and the Members of the Houses will have heard a great deal of that from other contributors and also previously. Suffice it to say that the heads of the Bill in terms of their philosophical approach having regard to those ethical-legal imperatives seem to have adopted an inverted approach in terms of what they seek to do.

When it comes to the question of certifying certain opinions in head 2, 3 or 4, in each case there is a requirement that the opinion be formed in good faith. With respect, when one is relying upon a good safety justification, that good safety justification as a matter of practicality will always succeed. Trying to demonstrate bad faith - *mala fides* - or even improper motivation in this area is virtually impossible. There is a whole series of cases where this has arisen under the old mental health legislation over the past 40 years. With respect it seems that this represents a very old-fashioned approach which is inconsistent with the ethical, now the legal and elevated to a constitutional duty that the courts have elaborated over the past two years in particular.

By incorporating some kind of objective standard or a reference to evidence-based practice, at least there is some template against which practice can be measured. That is simply not possible in the context of a statutory schema, which is predicated solely on the good faith of individual practitioners. I do not need to mention in this House the issues and problems that have arisen over the years in terms of individual practitioners - one would imagine acting in good faith - who were nevertheless damaging individuals in the most egregious circumstances.

A good faith defence in those circumstances would, under the terms of the scheme of this Bill, provide an absolute defence irrespective of how that behaviour might be considered to be referenced according to a template of evidence based practice. A good faith opinion which is accepted without any reference or is unsupported by any reference to evidence based practice is regressive and potentially dangerous. It represents an old fashioned approach, one which no longer finds favour with the courts or the regulatory body.

In that context, the question of the number of individuals who are required to review any particular decision is of academic relevance and significance because it presents the same difficulty or weakness in so far as it is simply based on bona fides. Some of the particularly bad scandals we have had over the past 20 to 25 years or so would indicate there must be a limit to the deference that any society must give to what amounts to clinical hegemony. If one wishes to write a recipe for abhorrent behaviour or clinical hegemony then the way to proceed is to carry on along this line and provide for a defence based solely on good faith.

The question of conscientious objection does not arise. When it comes to proper ethical practice, particularly one which is evidence based, there can be no issue in relation to conscientious objection. The model with which any doctor here is faced when presented with a woman who is pregnant is that he or she has two patients. It does not matter what one's view is on abortion on a personal or political level. The factual reality is that when a doctor is faced with a pregnant woman he or she has two patients and a duty to both. It seems to me that this is not necessarily flagged with particular significance in the Bill.

I am happy to respond to any questions from the Chairman or members of the joint committee.

Dr. Ruth Fletcher:

I thank the joint committee for the invitation to present. It occurred to me when passing my alma mater, Trinity College, that I have been teaching and researching in this area for almost 20 years. I am honoured to have this opportunity today.

For someone like me who works in the area of ethics and law the proposed legislation in terms of its recognition of a public obligation to implement an existing constitutional right to life-saving abortion, is welcome. However, it does not do enough to meet the ethical obligation to value women's lives. I will focus my opening remarks on four key points, including the definition of the unborn; the significance of risks under heads 2 to 4 justifying a termination of pregnancy; the limits on the rights to conscientious objection and the inappropriateness of criminalisation.

On the definition of the unborn, head 1 suggests that the unborn should be defined to mean following implantation, drawing on Roche *v.* Roche concerning frozen embryos as a precedent. With respect, the ethical arguments for choosing the point of implantation as a significant moment for legal protection of human life have not been adequately addressed. Given past failures to interrogate the assumed wrongness of abortion and, given the particular factual context of Roche *v.* Roche, it is open to this Legislature to consider more fully the criteria by which the unborn should be defined. The best ethical argument available to us from the literature and moral philosophy justifying protection of early forms of unborn life from implantation is that of potential personhood. This is the argument that from its earliest stages, subject to assistance from the pregnant woman, the embryo and foetus will go on to become a person. This future personhood argument does not apply, however, to foetuses with lethal abnormalities. Much to the anguish of their parents, they will die after birth and, therefore, they do not have a future as persons. That ethical argument does not apply in this case. Moreover, the State argued in D. *v.* Ireland that foetuses with lethal abnormalities could be excluded from the legal and constitutional definition of the unborn. Given that D lost her case before the European Court of Human Rights, partly because this was the argument made by the State and domestic remedies were not exhausted, there is, I would argue, more of a moral obligation on the Legislature to deliver on that argument and to address the definition of the unborn in a way that excludes foetuses with lethal abnormalities.

A second important aspect of this ethical argument for protection of early embryonic life from implantation is that it rests on the potential to become a person rather than on actual personhood. Potential personhood is best regarded as giving early embryonic and foetal life moral value because of what it will become in the future. This potentiality is obviously ethically significant but not as significant as the moral status we give to sentient forms of human life, namely, forms of human life that are developed to the point of feeling pain or pleasure. That is another stage of development with another set of capacities and another level of moral protection is due it. It is also not the same as the higher moral status which comes with full personhood, namely, the capacity to reason, communicate, will and act on our lives. A person's interest in her own bodily and moral integrity may justify limitations on the duty to sentient beings. This is because part of what makes life valuable is the person's ability to reflect on her life over time in particular factual circumstances and to make moral choices in that regard. That is part of what we value about being human.

To sum up, the following categories I would suggest provide a better ethical framework for the protection of unborn human life than does the assumed significance of implantation underpinning the legislation. First, pre-sentient embryonic and foetal life has moral value rather than moral status. It should be taken into account in moral decision-making but in itself does not impose harm-reducing duties on others. Second, sentient foetal life has moral status and may impose a duty on other persons to reduce harm to that sentient foetal life. Third, self aware personhood has a higher moral status than sentient life and this can limit the duties we owe sentient forms of life. They are the three ethical frameworks discussed in literature on medical ethics and law, which I believe will be helpful in informing the debate around protection of unborn life in its early stages.

My recommendation in this regard is that the unborn should be defined so as to exclude those foetuses which have lethal abnormalities and which will not have a future independent life. This possibility is open to the Legislature. It does have the power to do this. Also, the unborn should be defined to mean the foetus following the earliest moment at which sentience is possible.

On heads 2 and 4 and the risk of loss of life that justifies a termination of pregnancy, these heads provide for the kinds of risk to a woman's life which will legally justify a termination of pregnancy under the scheme. Others have commented more eloquently than I can on the need to remove obstacles in life-saving abortion care and on the troubling mistrust of women with suicidal ideation. I would like now to focus on the narrowness of the risk to life ground for termination of pregnancy. This ground has been drawn very narrowly, in part because it is assumed that Article 40.3.3° requires the life of the pregnant woman to be treated the same as the life of the embryo or foetus. Again, turning to ethical moral philosophy and legal theory, equality scholars have long argued that equality does not mean sameness rather ethical treatment requires the accommodation of actual differences between beings of all shapes and forms. Vindicating the life of the unborn with due regard to the equal right to life as directed by Article 40.3.3° should entail a full evaluation of all the interests that the woman's life entails, as well as all the interests of the unborn.

To state the issue concisely, women are conscious, sentient beings with moral viewpoints and responsibilities to other people. Foetuses are not quite that. They are the bearers of biological life and they will be future persons but this is not the same kind of life as that of the breathing, feeling and thinking woman. The current legal test treats women and foetuses as if they are the same, which I argue devalues both forms of life. It does not value their specificity and particularity sufficiently.

In regard to head 12 on conscientious objection, in principle the inclusion of a conscientious objection clause is defensible, subject to two conditions. First, it must be applied to individuals rather than to organisations and, second, it must only be applied in circumstances where alternative provision is available to a woman needing termination of pregnancy. If respecting human life includes respecting the personal choices which give life meaning, obviously health care practitioners may avoid performing health care that infringes their moral values. As the explanatory notes acknowledge, however, conscientious objection is not an absolute interest but is limited by the need to prevent harm to other people, pregnant women in this instance. In circumstances where a health care practitioner cannot arrange alternative provision without undue delay, the right to conscientious objection may be limited by the duty to prevent harm to patients. That is an issue of which we must be mindful in

legislating for conscientious objection. This recognition of health care practitioners' consciences is worthy but it is inconsistent with the lack of legal recognition of women's consciences in this context. If conscientious objection to the provision of abortion is legally acceptable, as in head 12, so is an equivalent objection to sustaining the embryo or foetus within one's body. If a woman's conscience tells her that terminating a pregnancy is the best moral resolution of all the complex issues that arise in a particular factual pregnancy, her conscience equally deserves recognition and accommodation.

Turning to head 19 and the new offence proposed to be created by the Bill, the criminalisation of women's decisions to end their pregnancies is a disproportionate and unfair response to the constitutional direction under Article 40.3.3o to vindicate the life of the unborn as far as practicable. It is disproportionate because it does not achieve the end of protecting foetal life. We know that hundreds of thousands of Irish women have had terminations of pregnancy. Criminalisation has not been successful in protecting unborn life. Furthermore, criminalisation as one form of legal regulation makes the situation worse because it stigmatises and punishes those women who find themselves needing to end a pregnancy. In making the situation worse, it also makes health care more difficult to access because, as we have heard, medical practitioners will feel the chilling effect of the criminal law.

The Legislature has other options under Article 40.3.3o. Criminalisation is not a necessary aspect of the Article and other, less punitive options could be pursued, such as regulating the terms on which abortion is accessible or adopting more positive measures to prevent the loss of unborn life through miscarriage by investing in pregnancy related care. In choosing to punish women rather than adopt more neutral or positive measures to support foetal life in pregnancy, the Legislature is acting unfairly because it is asking women rather than the State to bear the weight of the public duty to vindicate foetal life. In respect of the head 19, I agree that sections 58 and 59 of the Offences against the Person Act should be repealed but it would be harmful to adopt this new offence. If the Legislature is not prepared to go the full route of decriminalisation, which is open to it, at minimum the offence needs to be defined in much narrower terms than is currently the case. At present it is expanding the range of actions that could be a criminal offence with the phrase "any act with the intent to destroy unborn human life". This is too broad and may include acts which are ultimately unsuccessful in destroying unborn human life. The maximum penalty of 14 years is extreme and, at the very least, we should consider reducing it given that we are discussing the criminalisation of moral choices by women in difficult situations.

Chairman:

I thank Dr. Fletcher for travelling here to participate in our hearings. The next speaker is Ms Sunniva McDonagh, SC.

Ms Sunniva McDonagh:

I am a practising barrister, a member of the Mental Health Tribunal and a member designate of the Irish Human Rights and Equality Commission. I was also the editor of the Irish Reports at the time the X case was decided. We edited and prepared a special edition of the Irish Reports setting out the relevant arguments. However, anything I say this afternoon is entirely in a personal capacity. I want to make constructive criticisms of the Bill in a spirit of interrogating what might be possible. My criticisms should not be taken to suggest they will

inevitably come to pass but, as legislators drafting legislation, it is important to examine the provisions to determine what they actually provide for, bearing in mind that our purpose is to bring clarity to the rights of the mother and the unborn child.

As there is no presumption that the heads of the Bill are constitutional, we can proceed on the basis of criticising them in that way. I do not want to rehearse the arguments made by other speakers but I wish to speak about the drafting of the legislation. In regard to clarity, head 2 on necessary medical practice in the context of physical risk contains nothing new. Medical practice in Ireland has been excellent in treating both mother and unborn child over decades. I am not sure any additional substantive clarity is brought to the matter by this head, which is unobjectionable. An issue that remains unclear, however, is head 4 and the threat of suicide. In this regard, I want to mention what was decided in the X case because we cannot leave out of the picture the fact that the Supreme Court formulated the test without the benefit of medical evidence or best psychiatric practice. The court did not have to consider and weigh expert testimony or psychiatric evidence as to whether abortion is ever a treatment for suicide or if other treatments could be utilised to avert the risk. This is what members have been considering over the past several days.

On foot of the Supreme Court judgment in X, a superstructure is going to be imposed in order to meet the test, involving various medical professionals. An earlier speaker argued that X was wrongly decided. I will not argue that but certain matters were not considered in X because certain concessions were made. X is silent on some of the issues arising around the threat of suicide and it now appears that the best psychiatric evidence indicates that abortion is not a treatment for suicide. However, the structure we are examining proposes to put in place and medicalise what in fact was a legal test. It cannot be ignored that the evidence of a psychologist, who was not advocating abortion, meant that the X test was fulfilled. A question arises as to whether we are legislating on a flawed presumption or hypothesis. It seems to me, based on the best psychiatric evidence available, that is what is being proposed. The medical evidence indicates that abortion is not a treatment for suicide.

If, however, the legislation is to proceed on the basis of this structure involving the various medical professionals, then it is important to make a few points about the draft heads of the Bill. The first point is that having involved psychiatrists in the process, there is no actual requirement that a psychiatrist must examine the patient before giving his or her opinion. The legislation states that a psychiatrist should examine the patient. However, the words "should" and "shall" are not the same. The way the word "shall" is used in relation to consulting the general practitioner can be contrasted with that particular provision. In law, a mere exhortation that somebody should do something is not mandatory or enforceable. It is very understandable that there would be reluctance to subject a woman in distress to any rigorous or invasive procedures but the question must be asked as to whether this would be an adequate justification for bypassing best medical practice in respect of diagnosis and treatment. A court called upon to interpret this legislation will consider the words used and not the aspirations of its framers.

The framers of the Bill have made reference to the Mental Health Act 2001 and it has also come up for discussion before this committee. It has been seen as a model in the framing of the heads. However, it is important to point out that the involuntary detention of a patient under that Act requires two separate and distinct medical examinations of the patient. That must be a personal examination and it must be carried out by a general practitioner and a psychiatrist. Failure to conduct such an examination will mean that the patient is actually

unlawfully detained. In a recent High Court case, the judge described these examinations as vital, essential safeguards for the patient. This is altogether apart from the fact that under the mental health legislation, there is an automatic review of the detention at a later stage when two further medical professionals are involved. It is not clear why the framers of the legislation - in looking to the Mental health Act 2001 as a model - have failed to provide that there must be an examination of the patient if, in fact, there are diagnostic criteria for evaluating suicide, etc. Failing to provide that psychiatrists must examine patients leaves the Bill open to the suggestion that psychiatrists are being involved perhaps for optical or non-medical purposes.

A further consequence of not requiring a examination of the patient is to increase the likelihood for forum shopping by the patient or the doctors involved. I ask members - as legislators - when they are examining the Bill to carefully consider what is proposed under head 4. What is proposed is that the psychiatrists involved should be employed at a centre registered by the Mental Health Commission and that one of them must be attached to the institution at which the procedure is to be carried out. One must ask what is meant by the words "attached" and "employed" because although a psychiatrist must be registered in the general specialty of psychiatry, there are extensive freedom of movement provisions. As a result of the fact that the legislation is all about clarity - and we are quite entitled to ask at this point what is intended - it is important to interrogate what precisely is to be required of the psychiatrists. For example, would it be sufficient if they hold clinics once a month or if, in circumstances where they are resident abroad, would it be sufficient for them to provide opinions without actually examining patients. This is a matter which, again, should be the subject of careful consideration.

The next point I want to make involves the risk of self-destruction and the foetus and potential viability. What is proposed represents a significant change in medical practice. Under head 2, the treatment is not actually the termination of the unborn life. Under head 2, where there is a physical risk, the unborn life, as a consequence of the medical treatment, might die but for the first time in statutory provision it is being provided that the actual treatment is the termination of the pregnancy. The proposed treatment is, in fact, abortion. Nowhere under these heads are doctors mandated to terminate a pregnancy via a procedure which might ensure the baby would survive. It might be stated that this is the intention, that the Supreme Court would never allow that, etc., but the purpose of the legislation is to bring clarity to the position. The proposed legislation does not bring clarity to the position. It should not be forgotten that the threat of suicide can be established late in pregnancy by a woman saying, for example, that it is the very fact of being pregnant or of carrying a child with a severe disability which is making her suicidal. If she is going to have the treatment, then that is actually the termination of the pregnancy. There is no comfort in the legislation that this does not extend right up until birth.

There are some other safeguards which I may not have the opportunity to discuss in view of the time limits which apply. I wish to state, however, that if members look carefully at "appropriate location and public obstetric units" in the legislation, they will see there is nothing in the legislation which seems to prevent the HSE from entering into arrangements with private providers or with co-locating the resultant services in public hospitals. After all, they only have to be co-located with maternity and neonatal services. Many treatments - for example, oncology or cardiac treatments - will not be carried out in public obstetric facilities. When the Bill is eventually published, it may well have to be extended in order to include other private or general hospitals. On the appropriate locations, one should give careful

consideration to what may or not be permitted in this regard. I will be happy to answer any questions members may wish to pose.

Deputy Billy Kelleher:

My first question is directed to Dr. Craven. He referred to the Medical Council's guidelines, the importance of professional integrity in dealing with the public and the expectation that medical professionals will act in good faith. There is an obligation on such professionals in that regard and the Medical Council's guidelines are the essence of this. The 2009 edition of the guidelines specifically states, in the context of suicide as a threat to the life of the woman, that a termination is lawful in this country. Is Dr. Craven of the view that the guidelines in question are at variance with good medical practice?

My second question is directed to Ms McDonagh. In the context of the debate on the protection of life in which we sometimes engage, reference is made to the obligation on obstetricians, psychiatrists, cardiologists, oncologists and medical professionals in general to vindicate the life of both the mother and the unborn in so far as is practicable. Article 40.3.3° of the Constitution is specific in this regard. Where in the legislation is provision made for the intentional destruction of the unborn to safe the life of the mother? We can understand that in the event of an intervention prior to foetal viability, while it would not be intentional, the life will be destroyed. From where in the heads of the Bill did Ms McDonagh obtain the perception that there will be intentional interventions in order to destroy the life of the child and after viability as well? If an ability in this regard exists, perhaps she could enlighten us as to how we might tighten up the position. I do not believe any Members of the Houses or any professionals would like legislation to be put in place by means of which we would almost obligate or allow medical practitioners to intentionally destroy life. If we were to do so, would we not - at the very least - be passing legislation which would probably be against the spirit of Article 40.3.3° and also unconstitutional?

Deputy Caoimhghín Ó Caoláin:

In his summary, Dr. Craven made it clear that he does not believe the Bill to be fit for purpose and stated that it fails to reflect the ethical and legal imperatives and to recognise certain things, is philosophically confused, involves an old-fashioned approach, fails to reflect proper ethical-legal considerations and it is fundamentally illogical.

Dr. Craven's point in No. 39, immediately before his summary, is that if this Bill passes there can be no conscientious objection to ethical, legally permissible practice. In the event that the Bill does pass, is Dr. Craven arguing that there can be no provision for conscientious objection? We cannot have it every way. We are likely to have to face the passage of legislation of some form. Even though Dr. Craven has strong views I am sure that many who would share his position would be anxious that conscientious objection would indeed be provided for.

I thank Dr. Fletcher for her contribution. In respect of recommendation No. 3, Dr. Fletcher refers to removing the discriminatory distinction between the evidence requirements for a risk to life from a threat of self-destruction and a risk to life from a threat of physical illness. Do I understand from this that Dr. Fletcher is supporting a view already articulated here today, yesterday and on Friday that heads 2 and 4 be brought under a single heading? Would that be the direct translation of what Dr. Fletcher is arguing for?

I thank Ms McDonagh for her contribution as well. Reference was made to there being no requirement to examine the patient. Ms McDonagh refers to the provision that the specialist should examine the patient and then goes on to state, under the same heads, that the woman's general practitioner shall be consulted. However, that sentence concludes with "where practicable". The "shall" is not an absolute, it may not always be a possible situation. That represents exactitude in language. Ms McDonagh is very clear about the importance of that and its understanding.

Ms McDonagh stated that surely in the case of suicide risk an equally robust regime should apply. This was in the context of examination of the patient. Does Ms McDonagh have concerns that examination of the patient is not properly provided for in respect of medical circumstances as against suicidiality? Would Ms McDonagh like to elaborate on that? Generally, we would be of one mind that we want to see the patient examined, that the determination of the professionals is based on the very best opinion that they can arrive at. One would think that would include an examination of the patient.

Deputy Seamus Healy:

I thank the witnesses for their attendance and presentations. I will be brief, as usual. In respect of Dr. Craven's presentation I take it that he has difficulties with the Bill but that he is more of the opinion that the template of the Mental Health Act would be more appropriate, operable and practical in this area. Is that is the case? What is Dr. Craven's view?

Dr. Fletcher referred to the question of fatal foetal abnormality, an issue I raised early on in the first day of these hearings. I asked Dr. Tony Holohan of the Department of Health why this issue was not covered in the legislation, particularly in view of the State's case at the European Court of Human Rights. Will Dr. Fletcher clarify and expand on that point, please?

Ms McDonagh referred to the question of appropriate location. Again, I raised this issue on Friday morning. I take it Ms McDonagh has a difficulty with it. Perhaps the committee has a difficulty with it as well. Will Ms McDonagh confirm that the matter could be amended and clarified in the legislation?

Chairman:

I will take the Vice Chairman, Deputy Ciara Conway, at this stage.

Deputy Ciara Conway:

I thank the witnesses for their presentations this afternoon. In the course of recent days we heard from Dr. Anthony McCarthy, who is the head of the School of Psychiatry and is a perinatal psychiatrist who works in that field extensively, being only one of three in the country. He stated that it is true that abortion is not a treatment for suicide but he added that counselling and anti-antidepressants are not treatments either and that there is no treatment for suicide. He argued that we have to try to prevent suicide by looking at the reasons for suicide. I put it to the witnesses that we all advocate that abortion is not a treatment for suicide, but it is the choice of the woman and it is the doctors who certify the woman to be suicidal. These are trained medical psychiatrists who, day in, day out and week in, week out deal with risk and put people on suicide watch. Are we now to believe that they are incapable

of ascertaining whether a woman is suicidal? We all agree that abortion is not a treatment for suicide. It is the woman's right to choose.

Chairman:

I call on Ms McDonagh to start and we will give you five minutes each to reply. Six other members have indicated to speak.

Ms Sunniva McDonagh:

I am not a medical doctor but, to take the last point first, I am dealing with the legal position in respect of the protection of the unborn and the right of the mother to every medical procedure that will save her life. I am not here to advocate a policy, such as a woman's right to choose, but I am addressing the psychiatric evidence which is available. One wonders why the entire matter has been medicalised if, in fact, the idea behind the Bill is a policy consideration that women should have the right to choose. It is not that I have a problem with anything to do with appropriate legislation, I am merely drawing the attention of the committee to what the consequences could be. I am here as a lawyer not as an advocate. I am merely pointing out that the HSE under the Health Act can enter into an arrangement with any provider provided, it seems to me, it is co-located with maternity services, etc. I am only pointing out that one could have a situation where one could have, in the grounds of a hospital, a private provider. One wonders was that what was intended, if there is to be oversight.

Deputy Seamus Healy:

That could be amended.

Chairman:

I will bring you back again.

Ms Sunniva McDonagh:

Absolutely, of course it could be amended. All of these things can be amended or changed. One presumes that is why we have all been called to give our view.

Deputy Kelleher raised a question about abortion being a treatment for suicide. In response, in the penultimate paragraph in the explanatory memorandum to head 4 the framers state, "In circumstances where the unborn may be potentially viable outside the womb, doctors must make all efforts to sustain its life after delivery." However, it is not so much a matter of where in the Bill one finds that the unborn is going to be targeted. The question is where does one find in the heads of the Bill protection given to a foetus who is potentially viable outside the womb. By extension, I would say that one also has a difficulty in principle once it is acknowledged that there is a right to life once a foetus is viable. Where does one draw the line? Where does one draw the line if it is 20 weeks and some form of protective treatment can be put in place for four weeks? It is very difficult once the viability argument is conceded to see if there is not a principled argument throughout. Anyway, I do not see here any explicit protection for the unborn up until viability. Let us not forget the other related point that came up in respect of the definition of "unborn". One is unborn until one has proceeded fully from

the womb, according to the explanatory section. That does not give any comfort if, in fact, the life of the unborn can be terminated.

Dr. Ruth Fletcher:

I wish to respond to Deputy Ó Caoláin's question about whether the recommendation is equivalent to the merging of heads 2 to 4. In short, the answer is "Yes". Having extra procedures and extra personnel required in the case of suicide risk is effectively discriminatory against people who threaten suicide.

The effect of my recommendation is to remove that kind of discriminatory provision within the heads. The effect could be achieved through having the same test and, effectively, merging heads 2 to 4. Therefore, I would support that.

I will respond to Deputy Healy's question on the definition of the unborn and the possibility for having that definition exclude foetuses with lethal abnormalities. The main argument I was making in terms of having a brief to talk about the ethical arguments today, was that the future potential personhood of those foetuses unfortunately is not going to be achieved. In ethical terms, one is asking women to sustain pregnancies when a future independent life is not going to be achieved at the end of the day. It would be regarded as unethical in that sense in that one is imposing suffering when a good is not going to be attained out of that suffering at the end of the day.

On the legal point in D *v*. Ireland, given the ethical arguments and given the legal possibility of defining the unborn in a way that it would exclude foetuses who have these particular extreme conditions, which mean that they cannot survive birth, that would achieve the delivery of the State's argument in D *v*. Ireland which, in effect, meant that D lost her case before the European Court of Human Rights because she had not gone to a local court in Ireland. The European Court of Human Rights said that argument could have been made before a domestic court and therefore the case was thrown out. That gives the Legislature an added responsibility to act on behalf of those women given that this case was thrown out by the European Court of Human Rights on the basis of that argument because it believed in the possibility that Irish courts and the Irish Legislature could interpret Article 40.3.3° in this way. The Legislature does have a moral obligation to pick that up as well.

Dr. Ciaran Craven:

I will deal with the questions in the order in which they were put to me. I will deal with Deputy Kelleher's question first. What he said about the Medical Council guidelines on suicide is correct but the council is simply making a statement of its understanding as to the current legal position. It is doing no more than that. I certainly do not think on any reasonable reading of that particular provision that it is actually saying this is nevertheless ethical. Having said that, I recognise there is a fundamental inconsistency between a bald statement in relation to legality divorced from any consideration of the ethicality of what is actually stated. I should say that I do not hold a brief for the Medical Council and I am not here to defend its position or what it has said in this area.

Moving on Deputy Ó Caoláin's comments, he was quite right in what he said. It is fair to say that I am highly critical of the approach the Bill has taken. There is a certain philosophical inversion in terms of what is required. Rather than simply examining what the evidence is

and, therefore, what is ethically and legally mandated, it seems to decide there are certain procedures which are not defined which somehow are lawful and defensible and then it invites the professional bodies and the regulatory agencies to provide assistance in relation to the implementation of the legislation. With respect, in terms of a very significant policy issue, that strikes me as being an inversion. Whatever doctors, the regulatory bodies and the professional bodies may say about these matters, the questions of policy and the principle are not ones which, in my respectful submission, are capable of being avoided by the Oireachtas.

My comments in relation to conscientious objection have to be taken in context. If the proposed Bill is reflecting proper ethical, legal consideration, then the question of conscientious objection simply cannot arise because it accords with both the ethical imperative and the legal imperative as I tried to make out. If, on the other hand, it is doing something different, then it may well be the case that a question of conscientious objection arises. Whereas the case has been made that conscientious objection is something of a personal right and is vested in individuals, it in itself, as we know from other jurisdictions, is capable of giving rise to all kinds of issues and difficulties when one steps one position more remote from the person who is involved in the procedure. In our neighbouring jurisdiction there have been significant problems in relation to it.

In so far as the question of whether this is a right which vests in institutions is concerned, again the courts recognise that no doctor or health care professional can be obliged to do something which he or she considers to be contrary to the best interests of the patient. Institutions do not have arms and legs or eyes and ears, they can only operate through the personnel they employ or engage. Trying to make a distinction between a right to object in relation to institutions, on the one hand, and individuals, on the other, is, in my view, not sustainable.

Moving on to deal with Deputy Healy's question, I hope I have not misled him in regard to the Mental Health Act. That Act of itself is one with issues related to it. Since the question has been raised, that Act evolved and was designed with a particular policy objective in mind and it sets out the various principles which were to apply and then it sought to import those principles by way of giving effect to the policy objective. While I am certainly not holding it up as a paradigm in terms of how it might be done, the point I wish to make is that with the policy having been decided one cannot then seek to implement it without having reasonable regard to the ethical legal principles which will result in proper implementation of the policy.

Deputy Conway's question has probably already been dealt with by Ms McDonagh in her response. In so far as Dr. McCarthy is concerned, the evidence given before the committee on 8 January of this year was pretty much to the same effect. The argument is not being made that abortion is a treatment for suicidal behaviour, suicidal intent, suicidality or however one wishes to characterise it. If it was the case that the Oireachtas seeks to introduce a regime for other reasons, then that is policy debate of an entirely different order. As Ms McDonagh has already pointed out, what this Bill purports to do is to medicalise the matter. If we were to engage with it from a rights-based perspective, that would be a debate on an entirely different matter.

Chairman:

Six members have indicated they wish to speak and I call Senator Colm Burke.

Senator Colm Burke:

I ask Dr. Fletcher to expand on the issue of lethal abnormality. I understand that under Article 40.3.3° the life of the unborn is protected. If the unborn has only the prospect of surviving one second after being born, the legal position is that the pregnancy cannot be terminated. Dr. Fletcher seems to have a different view and I would like her to clarify that issue.

Ms McDonagh referred to the Mental Health Act and the structures that are in place. In terms of the heads of the Bill, is it her view that we should have a similar structure for dealing with whatever procedures have to be put in place to deal with such an application, especially under head 4, or is she suggesting that a more comprehensive structure should be put in place? Once a decision is taken in this case it is not reversible and when the procedure goes ahead it is not reversible. Ms McDonagh might clarity that matter.

Deputy Catherine Byrne:

I find it very difficult to stand up and question people who are very intelligent and knowledgeable about the law. It is difficult for me as a layperson to take in all that is being said, and I mean that with greatest of respect to the witnesses.

I had to undergo surgery a few months ago and I had to sign a consent form. I signed it in good faith believing that when I was wheeled down to the theatre the people would look after me and do their best. This Bill is very important in that we are entrusting the medical people in our country to look after people who turn up on their doorstep in a mentally distressed state and to act in good faith to protect the mother and the unborn child.

That is my definition of what this Bill is about as a non-medical person or a lawyer. It is what I believe as an individual.

I have a question which I am finding difficult to put into context but I ask the Chair to allow me read two brief extracts from statements provided, one of which is from Mrs. Justice Catherine McGuinness under "unborn". It states:

> I accept that this definition is based on the Supreme Court judgement in the Roche case [whatever that was]. However, it should be pointed out that this definition of the personhood of the unborn is not universally agreed.

I read most of Dr. Fletcher's statement but in her contribution earlier she stated: "Foetuses ... are the bearers of biological life and they will be future persons but this is not the same kind of life as that of the breathing, feeling and thinking woman". I find it difficult to formulate my question but would Dr. Fletcher say that the unborn foetus was the same as a living person who has been tragically maimed in a very serious accident where people are brought into a room and told that this person who was living and feeling is now on a life support machine and has been pronounced brain dead? I may have formulated that question wrongly but I am trying to ascertain if there is a difference between the unborn person and that person lying in a bed in intensive care whose family are being told there is no prospect of life and therefore, not wishing to use the phrase, to end their life. I ask the witness to formulate a response to that question.

Senator Jim Walsh:

First, in regard to the children's referendum-----

Chairman:

That is not part of the heads of the Bill.

Senator Jim Walsh:

This relates to the heads of the Bill if the Chairman would allow me finish without interrupting me. In the witnesses' opinion is the ability of the State to enforce an abortion against the will of the family covered in the heads of the Bill, and would that be an ethical process?

Second, what limitations, if any, should be placed on a physician's choice of method or technique for abortions either before or after viability? Where the child is not viable, may the physician use a procedure, for example, which would directly end the life of the unborn? I do not want to go into the gruesome details that entails but issues arise such as suction aspiration and dilation and evacuation, D and E, where the child is partially evacuated. Post-viability, even though there are serious risks attached to the health of the child, what is the position with regard to the person performing that abortion, having regard to perhaps a safer method of abortion which would involve the death of the baby as against another method such as induction which might save the life of the baby? Is the Bill clear on that and the ethics attached to it? Third, is there an obligation on us, as legislators, to enact laws that are just?

Chairman:

For the record, Senator, the Chair intervenes; it does not interrupt.

Senator Ivana Bacik:

I will note the Chairman's distinction in that regard. My first question is to Dr. Craven. I am at a loss to understand his submission - I have read his submission as well as listening to his contribution - and the basis for his opposition to the heads of the Bill. His view is that it changes the current two patient duty, as he put it, but in my reading, and according to the experts we heard earlier, the heads of the Bill do nothing to change the current duty under Article 40.3.3o, which is a duty both to preserve the right to life of the unborn as far as practicable and to preserve the right to life of the pregnant woman. Head 1 of the Bill, which sets out the definition of "reasonable opinion", and head 19 specifically cover that requirement as well as the duty that others have referred to of any practitioner operating within the Bill to observe the terms of Article 40.3.3o, which remains in place. I cannot accept the basis for that submission.

Dr. Fletcher made some very thoughtful points in her submission about the issue of life. I ask her about heads 1 and 19 in particular. On head 1 she points out the difficulty with the definition of "unborn". My reading of the current definition is that it covers cases where, tragically, there is no longer foetal life, in other words, a foetus which is no longer alive. The witnesses from the Institute of Obstetricians and Gynaecologists told us that they would not regard that as an unborn and that they would regard it as miscarriage but my reading of the definition is that it is not sufficiently focused to exclude that, and that it would lead to the difficult and traumatic situation of a pregnant woman being forced to carry to term a foetus

which she knows to be no longer alive. That is a traumatic thing to require any woman to do. Dr. Craven helpfully reminds us that section 58 of the Civil Liability Act 1961 refers to unborn, specifically stating "provided the child is subsequently born alive". That bears out the argument the witness is making. Clearly, there is litigation waiting to happen along the lines of the D case in an Irish court where a woman with a fatal foetal abnormality challenges the State for failing to provide her with the right to a termination.

On head 19, Dr. Fletcher made a very strong argument about the need not to criminalise the woman, or indeed the young girl, who attempts or carries out an abortion on herself, which is a real practical point because so many young women are importing abortion pills for use in this jurisdiction. I take her point, which was helpful of her to make.

Deputy Denis Naughten:

Following on from Senator Bacik's question to Dr. McDonagh, I ask her to elaborate on that because my understanding of head 19 is that it specifically prohibits the intentional destruction of the unborn. I ask her to clarify that for me.

I read with interest Dr. Fletcher's contribution and thank her for appearing before the committee because it opens up an issue that needs to be debated. She referenced the College of Obstetricians and Gynaecologists in her paper and the threshold of the 24 weeks gestation. As she is aware, there was a case in the United States in which Amelia Taylor was born just short of 22 weeks gestation. In those extreme circumstances would that neonate have less legal protection if we introduce a definition along the lines she is talking about?

In that regard, at the other end of the scale and following on from the question Deputy Catherine Byrne asked, which is a valid question, Dr. Fletcher made the point that a person's ability to reflect on life over time and make their own moral choices. We all accept that but someone with Alzheimer's disease, for example, would fall into that category where they cannot reflect on their own life or make their own moral choices. How do we deal with the ethical issues that raises?

Ms Sunniva McDonagh:

I hope I have got all the questions. The first question was on the Mental Health Act. I do not hold a view as to precisely what should happen but I would like to point out that there are other safeguards in the Mental Health Act other than the ones I have mentioned. The Mental Health Commission is an independent statutory body and it advertises and recruits independent lawyers, lay people and psychiatrists to sit on its tribunals. It is also mandated to act in the best interests of the patient. Interestingly, there is a five year review clause for the mental health legislation also. Looking at this proposed legislation, when we come to the review panel, it is the Health Service Executive that licenses the hospital, yet the HSE is also the body tasked with setting up the review panel and a HSE employee acts as convenor of the panel and chooses the panel. It was the framers of the legislation who were looking to the mental health legislation as a template and if it is to be seen as a template, it might be an idea to take some of these further safeguards from the mental health legislation.

I agree with Deputy Byrne. I do not believe that this is a very complicated issue. One would hate to think that the intervention of lawyers and doctors was over-complicating what is essentially a very simple issue in which everybody in the State and the people who enacted

the Constitution have a stake and a right to have a view on. It is finding the right balance between two competing constitutional rights and one would hate to think lawyers were trying to be obtuse when, ultimately, it comes down to simple value questions.

With regard to the section 19 offence, the terminology in the draft is very unclear because it mentions the intention of ending unborn life. Throughout the Bill there is an interchangeable use of the phrases "termination of pregnancy" and "medical procedures". There is a very important principle distinction between the two but they seem to be used interchangeably throughout the Bill as if they were the same thing. Many medical procedures, such as oncology and cardiac procedures, which are performed on a woman whose life is at risk, happily do not end up with the baby dying. The intention of these procedures is to save the mother and if the baby dies it is a regrettable consequence of the necessary treatment, but sometimes the baby does not die. Interestingly the Bill mentions having procedures in place to bring to the attention of the Minister the statistics on this area. It might be a good idea not only to collate statistics on terminations at risk of suicide, but also necessary medical treatment which did not end the life of the baby.

It is a little problematic because it seems clear when a woman states she is suicidal, the reason she is suicidal is apparently the existence of the pregnancy, and this is the proposed basis for intervention. Not to minimise the terrible distress of a woman who feels she cannot possibly bring a baby to term because it has a disability or because she suffers from serious social stressors and she feels she will kill herself, surely then let us not confuse terminology. When psychiatrists certify without perhaps having examined the patient, an obstetrician will be faced with the certificates and will see in front of him or her a woman who is physically all right and baby which is physically all right. The obstetrician will then be supposed to intervene to avert the risk, which he or she must do apparently by directly targeting the unborn. I cannot see how this could be described as other than a direct termination of pregnancy. It is suggested and proposed that if the ground is enacted it will certainly be the case that this will not be a criminal offence. This is true. This is the reality and the distinction which one must emphasise between treating the mother and the baby dying unfortunately, and intervening in this direct way.

Dr. Ruth Fletcher:

Many rich questions were asked and I thank committee members for them. I will address the points on the definition of the unborn. The question was asked as to how the proposed definition of "unborn" would deal with the idea that it applied to those foetuses which are born and survive for one second. Another issue was whether it includes dead embryos or foetuses in the womb.

At present we do not have legal precedents on the definition of the unborn where a lethal abnormality exists. We do not have a direct legal precedent on this particular issue. Because we do not have this direct legal precedent the Legislature has the ability to define "unborn" in a way which would address these problems which have arisen through acknowledging the suffering of women and couples who have had to travel, even though the pregnancies will not survive. The view has been put forward that "unborn" could apply to foetuses which have survived even for one day, but I advocate we do not accept this view and that we define the unborn in a way which excludes foetuses which do not have the capacity to survive. This is not to say these foetuses have no value; I do not argue this at all. I am just arguing no good will be achieved by forcing a woman to continue a pregnancy when the child will not survive.

With regard to the point on the current definition of the unborn being overly broad and not excluding even dead embryos or foetuses, it is interesting that the institute raised this issue. Obviously as a medical matter it is seen as excluded and comes under the category of miscarriage. This is what is happening in medical guidelines and practice at present. We need a tighter definition of the unborn to exclude this possibility. We also have an opportunity to have a definition of the unborn which deals with foetuses which would survive through pregnancy but would not survive for long after birth.

The second interesting set of questions raised were to do with arguments around full personhood and how we distinguish between the foetus as sentient life and the born patient stripped of consciousness because he or she was in a crash or is a patient with Alzheimer's disease. We are not stating that full personhood is all that counts; we are saying there are three different forms of human life which all impose values and status. I distinguish between the example of a person with Alzheimer's disease or the person in a crash and sentient foetal life in the womb because a person with Alzheimer's disease or a person who has been stripped of consciousness through an injury had been sentient with a conscience and a will but through accident or disease this capacity has been lost. Because such people had this full personhood status it is possible to distinguish them from an earlier foetus which has not yet attained these capacities. Its ability to attain these capacities is dependent on a pregnant woman getting it to the point of attaining them. There are ethical ways in which we can distinguish these cases. The ways in which they are similar are obviously that in all cases families and loved ones are concerned about the value of these forms of life. If they are sentient forms of life they are similar in this way and this can impose duties on us. I am just saying they are not the same order of duties as full personhood would impose.

The final point raised had to do with criminalisation. One of the big risks of criminalisation, or why we should not act disproportionately and punitively in implementing Article 40.3.3°, is because it will affect the most vulnerable. Young women who are avoiding using health care practice by ordering medical terminations over the Internet are a classic example. We would be effectively criminalising this behaviour and making the situation worse. This is not a good use of our law when we have the opportunity to do something more positive and progressive.

Dr. Ciaran Craven:

The questions asked by Senators Reilly, Byrne and Bacik relate to foetal abnormality and what the unborn is. I listened with interest to what Dr. Fletcher stated and it strikes me as quite a novel proposition that we can characterise life as having three different forms. Be this as it may, I am concerned about Senator Bacik's characterisation, and I am subject to correction on this, when she discussed the question of lethal foetal abnormality and whether it is something which ought to be protected. We must be very careful to note the mere fact a baby happens to have a lethal abnormality does not of itself mean it is wholly inconsistent with life. Generally it means it is inconsistent with prolonged life. It may well be a matter of minutes, hours, days or even months.

The committee should be careful not to consider lethal foetal abnormality as something that is incompatible with life outside the womb in the sense in which that is ordinarily understood.

There has been some discussion of what "unborn" means, as if it is an abstract verbal noun. Committee members will be aware that, when this is dealt with in Article 40.3.3° of the

Constitution, the Irish expression is "beo gan breith", which literally means living without being born. Senator Bacik rightly referred to section 58 of the Civil Liability Act 1961. With respect, however, it does not refer to the unborn, but to the unborn child. This is not limited to our domestic legislation - it is found in European directives as well, including one referenced in my paper, the medical exposures directive. Article 10.2 of that directive refers to the duty to the mother and the "unborn child" in the context of ionising radiation involving the abdomen and the pelvis of a woman who is or may be pregnant. We must remind ourselves that we are discussing an unborn child, not an abstract verbal noun.

Deputy Catherine Byrne was right, in that one signs a consent form in good faith and expects doctors to act in good faith as well. We are entitled to rely on that expectation. My point, which I might be making somewhat inelegantly, is that good faith, while necessary, is not sufficient. I can treat someone in good faith and make a complete mess because I breach all appropriate standards of care and misunderstand what is wrong with the patient and how he or she should be treated. Good faith and proper professional practice are not interchangeable.

Reverting to Deputy Ó Caoláin's comments, my philosophical difficulty with this is that it adopts the good faith model, which is old-fashioned, regressive and potentially dangerous. Relying on the good faith of doctors in this day and age is no longer sufficient. Neither the Medical Council nor the courts believe it is sufficient.

I disagree with Senator Bacik's characterisation of the proposed legislation as something that does not change anything about the duty owed to the mother and her unborn baby. It does not recast the duty of care, but the appropriate standard. It regresses to an old-fashioned standard, one that was fashionable in the courts 30 to 60 years ago. From a patient safety point of view, it is no longer sustainable.

The point on review panels has been addressed by Ms McDonagh. That the Oireachtas vests so much trust in doctors to get it right all of the time when the natural history of health care in this jurisdiction indicates - not globally, but in certain high-profile instances - the contrary is perplexing. Doctors are good people, but they are not necessarily the ones who should have the final say in this regard. It is these questions of policy and the underlying principle that I commend to the committee.

Deputy Robert Dowds:

I have a question for Dr. Fletcher and Dr. Craven, although I thank everyone for attending. Do they believe in criminalising a woman who attempts an abortion on herself? If so, how far should it be pushed? In the case of an unstable pregnancy, a woman could end it simply by doing housework.

Senator Imelda Henry:

I am incensed by Dr. Craven's comments about the medical profession. It is not always possible to save a mother and her baby, but both my baby and I were saved. I would like Dr. Craven to withdraw his remarks about the medical profession. We trust our doctors. I am really unhappy with Dr. Craven's comments.

Deputy Catherine Byrne:

I wish to raise two issues.

Chairman:

Very briefly.

Deputy Catherine Byrne:

I am always brief. Dr. Craven referred to good faith. It may be a lay term and it may be old-fashioned, but I have relied on it for all my life, as have many ordinary people. It is in good faith that we trust daily - when we take a bus to work, when we cycle or when we put our names on lists for operations.

I thank Dr. Fletcher for her answer. I raised my point because my understanding was that a brain dead person's life ended when the life support machine was turned off. There is a difference between this and the case of someone with Alzheimer's disease or dementia, for example, my mother. She lived, walked around, breathed, ate and was able to wash without needing a life support machine. My impression, regardless of whether it is right, is that the machine is the mother's womb. Does Dr. Fletcher understand what I mean? This is the lay person's vision of the situation. These hearings are about understanding the situation in lay terms. I do not have the ethics, surgical knowledge or so on, but I have a lay person's thoughts on the matter. When people attend my office, I must reply to them in lay terms.

Chairman:

I assure the Deputy that she has the ethics.

Deputy Catherine Byrne:

I did not mean to say "ethics". I was looking for "expertise".

Chairman:

I invite Dr. Fletcher and Dr. Craven to reply to the questions from Deputies Dowds and Catherine Byrne. Senator Henry's question was directed to Dr. Craven.

Ms Sunniva McDonagh:

I do not believe any of those questions was directed to me.

Dr. Ruth Fletcher:

I agree that, in terms of the criminalisation of attempts, the category is too broad. This is a problem. I am against the criminalisation of attempts, as it would bring the law into dispute if behaviour intended to result in the destruction of unborn life was unsuccessful. It would be contradictory in its objectives. I hope that I have understood the Deputy's point correctly.

I may have cited two different examples together in a desire to answer several questions. In response to the point that Deputy Catherine Byrne is raising now regarding forms of life,

brain dead life is a biological form of life sustained by a machine. There is value in the example in that sense.

Dr. Ciaran Craven:

Regarding Deputy Dowds's question, criminalising attempts raises serious practical issues in these circumstances. It is a policy matter as to whether it is in the public interest to pursue the issue. I do not differ particularly from Dr. Fletcher.

Regarding Senator Henry's point, I fear that I have been misunderstood. I was making a simple point that I may have put somewhat inelegantly. There are ethical imperatives in professional practice. There are legal imperatives that dovetail with them. There are objective standards. They are not questions of good faith. There have been episodes in which excessive reliance was placed on good faith and undue deference may have been paid to the profession. The point that I wished to make was a simple one and was from the perspective of 2013. The degree of deference one should have to the medical profession, I respectfully submit, should be tinged with a certain caution. This is why we have external regulatory bodies and oversight. Ms McDonagh has alluded to this issue in terms of the appointment of the psychiatrist, the convening authority, composition and funding of the committee and so on. Some kind of external oversight is necessary.

In so far as our hospitals are concerned, this is a generic point, as the standards are set externally by the Health Information and Quality Authority, HIQA. The standards promulgated by the professional bodies are evidence based, in so far as that is possible. The protection of the public safety, which is a question of assuring quality of care and ensuring that care is delivered safely, requires external oversight.

It seems to me this Bill does not necessarily give such oversight. That is the limit of the point I was seeking to make.

Chairman:

Does Senator Burke wish to speak? Very quickly, please.

Senator Colm Burke:

I refer to maternity care. It must be acknowledged we have one of the lowest perinatal mortality rates in Europe, which is a tribute to the medical profession. I would not like the wrong impression to be given out today.

Senator Ivana Bacik:

I wish to clarify-----

Chairman:

One sentence.

Senator Ivana Bacik:

Dr. Craven misunderstood the question I asked, namely, whether the definition of unborn, as currently constituted in head 1, included even the very sad situation where the foetus is no longer alive. I believe it does, which means that it would require women, even where they do not wish to do so, to carry to term a foetus that is not alive. That is my concern, and also that in head 19 we are criminalising those women and girls.

Chairman:

We will move to the non-members' time for which we have a total of 30 minutes. Seven Members have indicated. To explain, because there appears to be some confusion, in deciding the allocation of time the committee allocated a certain proportionality. I will take Senators Rónán Mullen, Fidelma Healy Eames and Paul Bradford, in that order.

Senator Rónán Mullen:

I have a couple of questions. Again, we have heard some very differing opinions about certain ethical and legal realities. In regard to the question of fatal foetal abnormality and those very tragic situations, I wonder whether that debate is not more appropriately categorised as part of a euthanasia debate. Defining the unborn by reference to any future personhood or life that he or she might have seems to miss the point of what the eighth amendment was about, namely, to recognise the right the unborn has in the present. It would seem to me immaterial what the future life of that child should be. It also seems that a dangerous approach is being advocated because there is such uncertainty here. When we talk about foetal abnormality, as Dr. Craven noted-----

Chairman:

Can we respect the speaker, please?

Senator Rónán Mullen:

How long a child with a so-called fatal foetal abnormality might survive after birth is unknown, in the extreme, if one thinks of conditions such as Edwards syndrome and others. As to whether there is an obligation to maintain a pregnancy where a child has actually died, frankly I find that very surprising and such would not be my understanding of the law. Perhaps others would care to comment.

Ms McDonagh spoke about medicalising a decision that is not medical. Is that a fundamental problem with the proposed legislation? Is it almost ethical bad faith? We are not talking about cases of mental health where I believe it has been well established to everybody's satisfaction that abortion is not a treatment for suicidal ideation. That would imply it is not a treatment for suicidal ideation that arises in a mental health difficulty. Is it Ms McDonagh's position, therefore, that psychiatrists are being drawn into a role that is not really a role for a doctor and that there is thereby a kind of ethical unsoundness at the heart of what this Bill presents?

Do any of the witnesses have a view on whether it is legally necessary to go this route in order to satisfy our obligations under the decision of the European Court of Human Rights in Strasbourg? Is there an alternative path? Part of the rhetoric around the Government's proposal has been that this action is necessary but we heard that disputed in earlier sessions today.

What is the view of the witnesses as to whether there should be a review? Is there a disproportionality about the fact that the refusal to certify a termination under head 4 is susceptible to a review at the request of the mother, while there appears to be no legitimate contradictor or possibility that somebody else might invoke a review, given the final and fatal consequences for the unborn in that case?

Senator Fidelma Healy Eames:

I believe I heard Dr. Craven correctly. He stated that a conscientious objection does not arise when there is evidence-based practice and a duty to both patients. What about the Supreme Court judgment in the X case which was not based on medical evidence or best practice? In Dr. Craven's view is this judgment ethical?

I agree with Dr. Fletcher that we have an ethical obligation to value women's lives. Is there an equal ethical obligation to value the life of the unborn? I am somewhat uncomfortable with Dr. Fletcher's recommendation No. 1, about the definition of the unborn. She said this should be defined in order to exclude those foetuses which have lethal abnormalities. Medical error is not uncommon and doctors frequently get things wrong. I met a mother recently who gave birth to twins. In the UK she had been advised to have a termination on the basis there was a strong likelihood the babies would be Siamese twins. They are now healthy eight year olds. In formulating her view, I wonder what research Dr. Fletcher has done and whether she has asked mothers and women who have carried babies that had lethal abnormalities what status they would have put on the unborn. I know many women are delighted to be pregnant, even though they may not give birth to a live baby, or a "take home" baby, as it is sometimes called.

My final question is for Ms McDonagh. Earlier I asked Mrs. Justice McGuinness about the introduction of time limits and she said we should have a go, in spite of the fact that it might be deemed unconstitutional. Would that be Ms McDonagh's view? Yesterday, for example, Dr. Peadar O'Grady, representing Doctors for Choice, suggested a limit of eight to nine weeks. If time limits are introduced would it follow that under head 4, after a prescribed time limit all unborn babies would be safe?

I beg the Chairman's indulgence for a final question to Ms McDonagh, to hear her legal wisdom. In the event of premature induced delivery, post viability, where the baby may be severely disabled, could the State be deemed liable, given it would be working against best practice under head 4?

Deputy Terence Flanagan:

I have a question for Dr. Fletcher. In regard to head 1, when does she believe a life becomes human and when does it acquire human rights? What rights does life acquire?

I refer to the panel and medical ethics. There are many genuine concerns in this Chamber and in the Oireachtas as we look around at other jurisdictions and as we see what has happened in the United Kingdom, where medical practitioners have flouted the law with some regularity by providing pre-signed abortion consent forms. From a medical ethics point of view should the proposed law be cognisant of the very real possibility that abortion safeguards will be flouted, especially by those who consider that such safeguards unfairly limit the expression of abortion rights?

I refer to head 12 which deals with the rights of conscience and conscientious objection. There was mention of the patient, and of doctors and midwives having a conscientious objection. Do institutions have a right to a conscientious objection, as endorsed by the Council of Europe? Is it the witnesses' opinion that point 3 in head 12 should be removed from the Bill or should it stay?

Deputy Liam Twomey:

I address this question to Dr. Craven. During the course of the past 40 years the legislative and ethical issues dealing with women's reproductive concerns have had a fairly messy history in this country, to put it mildly. We have struggled with issues such as who should be given the contraceptive pill and, in legislating for the morning-after pill, what the definition is of the unborn. We had the same concerns about when human life supposedly begins when legislating for the implantation of the Mirena coil. We still live in a country where there is no legislation governing either *in vitro* fertilisation or stem cell research. As Dr. Craven noted, we can order RU486, an abortifacient tablet, over the Internet, with no legislation intervening. The individuals who would be ordering such medications are the most vulnerable people of the cohort of women we are discussing. At very best, they see doctors and the wider administration of the Government, the churches, or whatever as adversarial, at worst they believe we are trying to criminalise them. As a member of the legal profession, does Dr. Craven agree that perhaps we should not have punitive legislation that would set down how many years a person should be imprisoned for if, for one reason or another, she was using this medication? That question is also addressed to Dr. Fletcher.

That question could also be addressed to Dr. Fletcher. There is a need to separate heads 2 and 4 because physical illness is much more subjective than mental concerns. I am a doctor and I understand the concerns about the enforcement of the Mental Health Act and its use as it stands.

In the course of these hearings I have had a fair idea of where everybody stood ideologically and if they were pro-choice or pro-life. I am a bit in the dark when it comes to the current witnesses, and none has been a member of an organisation that could be described as strongly pro-life or pro-choice. Is that correct?

Chairman:

We can come back to that. I apologise to Senator Bradford as I inadvertently missed him.

Senator Paul Bradford:

If this was a sitting of a medicines licensing board and if the witnesses before us with an ethics background were debating the registering of a particular drug for use and transmission to the general public, we would want to satisfy ourselves that it is safe, appropriate and useful. If we reviewed the drug on a trial basis over ten, 15 or 20 years - in a sense, like the X case - and it was the view not just of most people but of everybody that it was not suitable, I believe it would not be licensed.

With reference to head 4 - the rest of the legislation could be passed in a half day in the Oireachtas - there is the proposal of the concept that abortion is a suitable treatment for suicide, notwithstanding the fact that every presenter this week, last January and over the

course of the debate has said the opposite. What is the response of witnesses to that? Is it ethical to put into law a treatment we know is not a treatment at all?

I thank Dr. Fletcher for the contribution and I very much appreciate where she is coming from philosophically on the topic. She mentioned what was described as a troubling mistrust of women with suicidal ideation. We have been asked by the Chairman not to use emotive language and I do not believe the problem to be the mistrust of women with suicidal ideation; we are proposing the possible mistreatment of women with suicidal ideation. Will the witness comment on that?

I concur with Senator Fidelma Healy Eames on the proposed new definitions of "personhood", the "unborn" and difficulties which may flow from that. It is somewhat cold to state people do not have a future as persons. It almost sounds Orwellian and it is frightening language. That is why some of us are so fearful of this legislation, as we are afraid of the scary thoughts it may bring us. That is why we must be careful.

I thank all the witnesses as they gave very interesting and worthwhile presentations. We can agree to disagree on some issues.

Deputy Billy Timmins:

I agree with the points mentioned about Ireland being a safe place for women based on mortality rates, as we allowed a different message to go out earlier in the year. I have a point that may have been covered earlier and one speaker can respond to it. If there is physical or mental incapacity, is there any role in the Bill for next of kin, such as parents, father, sister or brother if there is a requirement to act or not act? Is there a role for next of kin in the legislation?

Chairman:

I would appreciate if the next speaker, Deputy Mathews, could ask a question.

Deputy Peter Mathews:

My question will be a little different. I ask the witnesses and everybody else here when they decided to come into this world.

Chairman:

We are discussing the heads of the Bill.

Deputy Peter Mathews:

It is a point. The Chairman is really too quick off the mark. When did they first decide to become unborn? These are philosophical questions as this is a matter of texture, depth and profoundness. We are here specifically to try to determine clarity in the law and the Constitution with regard to two lives. With the new life, the question is when the life begins, and there is also the question of the host life, or that of the mother. We can argue for days, weeks and months and go into law in different jurisdictions. We have always gone to the English-speaking world but in France in 1975, tight legislation was introduced in this area.

We mentioned earlier that in France girls, even those under 16 years old, can go to a general practitioner and have an abortion without the knowledge of parents. That is the reality. We must face up to the question.

The issue highlighted is head 4. The evidence from experts in psychiatry, obstetrics and gynaecology, ethics and law is that where there is no other treatment available for the threat or intent of suicide, there is a legal justification in the proposed Bill that the termination of the life of the unborn is legally allowable. That means the mother would have to have in her intentions the termination of that life. We would be accessories to the termination of a life in order that the host life can be saved when it is not the only possible treatment for that life.

Ms Sunniva McDonagh:

I thank the committee for inviting me to give some of my observations and I will briefly address some of the questions raised. Under the A, B and C *v*. Ireland case we must ensure our law is clear and accessible, and we are given a margin of appreciation. Ireland is one of the only countries I know with an explicit right in the Constitution giving a right to the unborn. Comparing us with other jurisdictions is not particularly helpful in that regard. We are entitled to ensure our law is clear and if this is about clarity, the suggestion that we should have a go at putting in certain time limits in our legislation must be the antithesis of clarity.

The question has arisen of the necessity to legislate now because there have been many years since the X case and we have maintained our excellent medical service. No other girl has come to court except for the girl in the C case, who I now understand regrets the course of action that her case took. It seems to be working well at the moment. With regard to the Supreme Court and the X case, the test now being proposed is supposedly a medical test but there is no evidence in the Supreme Court test and when it considered the issue, there was no idea of averting the right to suicide. We know it is a principle of Irish law that a point not argued is a point not decided but one needs to only look at how the Supreme Court has approached, for example, cases of historical sexual abuse, where insights gained from psychiatry and psychology as to why people do not come forward sooner, the nature of disclosure and the effects of abuse on complainants. In the case of SH *v*. Director of Public Prosecutions, there was acknowledgement of the insights brought to bear on the Court's thinking on advances in psychiatry and psychology.

Dr. Ruth Fletcher:

There were many issues raised so forgive me if I do not get to all the points.

In response to the question whether this legal definition of "unborn" accommodates the experiences of women who would like to continue their pregnancies, if we define the unborn in this way so as to exclude foetuses with lethal abnormalities, that in no way forces women who do not want to avail of a termination to have one. All we are doing would be to enable women with pregnancies that have lethal abnormalities to end those pregnancies. That has no consequence for women who do not want to take that route. I do not accept that there is a problem on that point.

I want to comment on the idea one of the Deputies raised that mental health is subjective. We have heard so much testimony on the way mental health is clinically assessed and how it is an objective condition that people live with. However, to describe mental ill health as something

that is purely subjective completely fails to acknowledge the significance of it. It is also an objective condition. Physical conditions are subjective in the sense that people interpret those physical conditions; they mean different things to different patients. Both sets of illnesses have subjective and objective elements. Patients are able to express a view about that and their medical practitioners are able to help them in assessing it. I would not want to see us going down a route of devaluing either of those sets of experiences.

Dr. Ciaran Craven:

I thank the committee and the House for inviting me here today. It might be easier if I deal with the questions which have arisen in an omnibus manner. Ms McDonagh has already dealt with the question whether legislation is necessary. The State is allowed a fair margin of appreciation in terms of how it approaches this matter. It ought not to consider that it is wedded to legislation and that this is the only manner in which one may proceed. There are other legitimate options about which we may disagree.

Regarding the question of the X case and whether a conscientious objection might arise in those particular circumstances, even at the time of the X case it struck me that this was bad medicine. If it was not bad medicine then, it is bad medicine now. For one to feel oneself constrained in any sense or be put in a position where one would have to comply with that kind of situation now seems to me to be fundamentally untenable from an ethical perspective.

On the question of flouting of possible safeguards, the members do not need to hear from experts in ethics or law on that. They can engage in their own sociological review on that and that speaks for itself. The question on a licensing board, reviewing whether a certain drug treatment were appropriate in the circumstances, is a point well made and underscores what I have been attempting to say, which is that one should proceed only if one has decent evidence which makes it safe to proceed. That is why I characterise the approach that is being promoted by the Bill as not alone regressive but also potentially dangerous.

Deputy Timmins raised the question on whether there might be any lawful proxy decision makers in respect of issues which might arise. The Bill is silent on it, but that is not a criticism of this particular Bill but a criticism which one might apply across our legal order where there are gross deficiencies regarding the role of proxy decision makers and what one does when one has individuals who are incapacitated.

Senator Fidelma Healy Eames:

I would be grateful if Ms McDonagh might answer my second question, whether in the event of premature induced delivery which could lead to severe disablement of a child the State could be liable, given that under head 4 it was acting against best medical practice?

Deputy Liam Twomey:

I asked the question about disclosure. I am surprised nobody answered a "Yes" or "No" on it.

Ms Sunniva McDonagh:

I would have to think about that but I thought it would be a question more for the medical practitioners involved. They would be attached to a HSE hospital but it would be a medical

procedure that may or may not be warranted. I would have to give some thought as to what would happen if one had a whole series of children who are delivered but unwanted by their mothers. It would be a very difficult decision. I would hope it would not happen.

Deputy Liam Twomey:

Is Ms McDonagh, or has she been, a member of any organisation-----

Ms Sunniva McDonagh:

No. I am in a tennis club-----

Chairman:

That is all right, that is good.

Deputy Liam Twomey:

I made it quite clear that I was not asking about Ms McDonagh's tennis club affiliations.

Chairman:

I am surprised Senator Mullen did not ask the question. He has been asking it all day.

Dr. Ruth Fletcher:

I am here on the basis of my research expertise and there have been moments when I have done some support work as an expert for Doctors for Choice, for example as a consultant regarding submissions to the European Court of Human Rights on the case of A, B and C *v.* Ireland. Those are normal. I have been involved.

Dr. Ciaran Craven:

The short answer to Senator Healy Eames's question on potential liability is "Yes", but the extent and limit of that liability remains to be seen. On disclosure, it is a matter of public record that for a period of time I was a member of the Pro Life Campaign. That association finished in 2002. It is also a matter of record that I appeared before the all-party Oireachtas committee on the Constitution in 2002 representing the Irish Episcopal Conference.

Chairman:

I thank Ms Sunniva McDonagh, Dr. Ruth Fletcher and Dr. Ciaran Craven for attending and giving of their valuable time and expertise today.

Sitting suspended at 5.25 p.m. and resumed at 6 p.m.

Members' Time and Closing Statements

Chairman:

This is the 12th session in our series of meetings on the heads of the protection of life during pregnancy Bill 2013. I remind everyone to switch off their mobile telephones. I will call the Minister of State at the Department of Health, Deputy Alex White, to be followed by contributions from Members, Senator Rónán Mullan on behalf of the non-Members of the committee and the Minister of State will close the session. Is that agreed? Agreed.

Minister of State at the Department of Health (Deputy Alex White):

I am pleased to be here today at the closing session of these public hearings on the general scheme of the protection of life during pregnancy Bill 2013.

First, I wish to commend the Chairman, Deputy Jerry Buttimer, all the members of the committee, those Members of the Oireachtas who participated in these hearings, and all the invited guests for the balanced and respectful approach that we have witnessed over the past three days. Second, I have been following the hearings as closely as I could manage, and have noted that there is a high level of consensus on most of the provisions contained in the General Scheme. There are also, of course, diverging opinions on some of the provisions - both within and between the legal and medical professions represented before the committee.

I assure you Chairman, and the members of the members of the committee, that we will examine these issues from a policy and legal perspective with a view, where possible, to improving the operation of the Bill. I am confident that all of the submissions, and the report that this committee will produce on your deliberations will greatly assist me, the Minister for Health, and officials in examining and refining the issues involved in the drafting of this Bill.

The aim of the Bill is to regulate access to lawful termination of pregnancy in accordance with the Supreme Court judgement in the X case and the A, B and C *v.* Ireland judgment of the European Court of Human Rights. The purpose of the legislation is to clarify in statute what is currently already lawful as a consequence of the judgement in the X case, and to set out clearly defined and specific circumstances in which this treatment may lawfully be provided.

I would like to address some of the issues that have been raised by contributors during the debate, to allay, if possible, some of the concerns involved. I am aware, for example, that there has been considerable debate about head 4 and the inclusion in the legislation of the risk of loss of life by way of suicide. The Supreme Court in the X case specifically recognised a risk to life arising from suicidal intent, which it referred to as a risk of self-destruction, as a legitimate basis for permitting termination of pregnancy - but only in circumstances where there was a real and substantial risk to the life of the mother; and where this risk could only be averted by the termination of her pregnancy.

Ireland, as a signatory to the European Convention on Human Rights, is under a legal obligation to implement the judgment of the European Court of Human Rights in A, B and C *v.* Ireland, and must put in place a legislative or regulatory regime providing effective and accessible procedures whereby pregnant women can establish whether or not they are entitled to a lawful abortion in accordance with Article 40.3.3° of the Constitution as interpreted by the Supreme Court in the X case. The Bill has taken account of the fact that assessment of self-destruction is more subjective and, therefore, requires more safeguards to be put in place. It specifies that three doctors are required to form an opinion and jointly certify that a termination of pregnancy may take place if it is necessary to save the woman's life. This

provision is made in the Bill in recognition of the clinical challenges associated with accurately assessing suicidal intent, and the absence of objective clinical markers. The legislation specifies that one of the doctors involved must be an obstetrician-gynaecologist and the other two must be psychiatrists. It also allows that it may be appropriate that the pregnant woman's GP is consulted during the process of assessment, where practicable.

I am also aware that the lack of a gestational time limit in the Bill has been raised, and that concerns have been expressed in respect of where a termination of pregnancy is deemed necessary, and the pregnancy has reached a stage of gestation at which the foetus is or may be viable. In such situations, it must be stressed that the wording of Article 40.3.3° and the judgment in the X case make it crystal clear that the life of the unborn must be protected and vindicated where practicable. This means that where a woman has a pregnancy that places her life at risk, and her foetus is or may be viable, she may have a right to have the pregnancy brought to an end but not a right to insist that the life of the foetus be deliberately ended.

In circumstances where the unborn may potentially be viable outside the womb, doctors must make all efforts to sustain its life after delivery in accordance with existing medical practice with early deliveries. In this regard, I note that this aspect was referred to at some length by a number of the obstetrics experts who appeared before the committee.

It should be noted, however, that this requirement does not go so far as to oblige a medical practitioner to disregard a real and substantial risk to the life of the woman on the basis that it will result in the death of the unborn. Essentially, the decision to be reached is not so much a balancing of the competing rights, rather it is a clinical assessment as to whether the mother's life, as distinct from her health, is threatened by a real and substantial risk that can only be averted by a termination of pregnancy.

Concerns were raised about ensuring that the monitoring systems provided for under head 11 would incorporate appropriate requirements to preserve the confidentiality of the patient and the certifying practitioners. The provisions with respect to monitoring have been included in the Bill because there is a need to keep records on the terminations carried out, and the medical reasons that gave rise to same. Information is also required to inform policy, as well as to ensure that the various statutory principles and requirements are being upheld. However, although the Bill provides for the collection of this data, it is not the intention that personal or identifying information will be published. I think it is clear in the explanatory notes to the Bill that it is not proposed that the Freedom of Information Act 1997 will apply to the records collected as part of the monitoring systems.

In closing, the main objective of the legislation, if I may reiterate again, is to clarify what is lawfully permissible in cases where there is a real and substantial threat to the life of a pregnant woman, and to set out clearly defined and specific circumstances in which a termination may lawfully be carried out. As the committee will be aware, a very significant amount of work was involved in producing the heads of this legislation. More than 50 drafts were composed as we moved to produce what we believe to be balanced proposals that meet our obligations. Of course, as the committee is fully aware, the next phase is the drafting and publication of the Bill. Following publication the Bill will go through the Houses of the Oireachtas, where there will be further opportunity for parliamentary engagement and input. I look forward to working closely with colleagues in both Chambers as we consider the Bill.

I thank the Chairman, his officials and all of those who have participated in any way in these

public hearings for the invaluable contribution they have made to this issue both now and at the public hearings in January, and for the assistance they have provided to me, the Minister for Health, and our officials in this work.

Deputy Billy Kelleher:

I welcome the Minister of State. We had the three days of hearings and preliminary discussions about legislation in January and there is no doubt they were beneficial in terms of Members being able to ask questions of experts. The Minister of State said he was following the debate closely and noted a high level of consensus. I can assure the Minister of State there was a high level of consensus in the areas where Members agree and where experts agree but there was a high level of non-consensual discussion as well in the sensitive area of head 4.

There is no point in discussing the broad issues without focusing on the fact that head 4 has proved contentious for this committee hearing. The Minister of State referred to it in his speech. The witnesses who presented also held varying views. There is no doubt that there is an obligation on us, as legislators, to deal with this particular issue. That is also my personal view and my party will discuss the matter when we read the final text of the Bill.

It has been propagated, to a certain extent, that there is never a risk to a woman on the issue of suicide. It was clearly stated by experts that there is and that it is a real risk at times. When we speak, we should be very conscious that we do not dismiss the real and substantial risk to the life of a woman in very rare and limited circumstances. It is still a risk and there is an onus on us to deal with the issue.

The Chairman has received praise from all around on his handling of the committee. The next phase is parliamentary input, and discussions will be held in the Houses of the Oireachtas as the legislation wends its way forward. One would need the wisdom of Solomon to address the entire matter. I hope that the Chairman will take on board the flavour that exists. People hold opposing views on the matter. I believe that many people are in the middle ground and want us to deal with the matter. We must find the consensus, wherever we can, to bring as many people as possible to the centre ground. Extreme and inflammatory language has been used by both sides but that does not encourage a broad debate.

The Chairman has pointed out that we are obligated to work within the parameters of Article 40.3.3° and the X case judgment. Regardless of whether people think that is restrictive, people should be mindful of the fact that we are obligated to deal with the issue within those parameters when we debate the final legislation.

I thank all the members for the discussion. As the Chairman said, the hearing has proved that divisive issues can be discussed when temperate language is used and there is understanding given to the views of others. One can have a calm, rational debate and tease out strong views while displaying respect and dignity. The debate also helped and highlighted that head 4 is an issue that is deeply rooted in people's view, either ethically, religiously, morally or otherwise. The Government should be conscious of that in the context of these hearings. I thank the Chairman and members for their company over the past three days.

Deputy Caoimhghín Ó Caoláin:

Go raibh maith agat. I thank all who participated over the past three days of hearings. I do not exaggerate when I say that this has been an intense and sometimes gruelling engagement. In particular, I commend the Chairman and members of the Oireachtas joint committee who very responsibly faced the task that was set. The process has been and will continue to be challenging for many of us. It has been a necessary engagement and, as described by one of the participants, an exercise in democracy.

The hearings have helped to tease out and clarify a number of issues related to the heads of the Bill. This has not been about trying to get some Members of the Oireachtas across the line, as portrayed by some sections of the media. The media's focus, and I mean no disrespect to any of them, on Oireachtas voices who hold strong rejectionist views of the Bill, many of whom are not members of the committee, has overshadowed the hard work and dedication of committee members from all parties. Real questions and deep concerns have been addressed here, and that is positive. No one should be surprised that consensus has not emerged among all of the medical and legal voices. Among them, as much as any section of society, there are diverse views on the question of abortion.

That said, I believe there is now a very widely held view, and I would say it is a majority view, in society that legislation along the lines set out in the heads of the Bill is not only necessary but long overdue. Implementation of the X case judgment and legislation in compliance with the A, B and C case judgement are required as soon as possible. We must safeguard the lives of women. We must provide legal clarity. We must ensure there are clear guidelines for clinicians. Some have argued that these conditions already exist. I would argue, and Sinn Féin has long argued, that is not the case and, hence, we need the legislation.

Much of the focus of these hearings, and public discussion generally, has been on the inclusion in the heads of the Bill of the threat to the woman's life through suicide. That is understandable. All aspects of that question have been thoroughly explored. Varying views have been given but the time for decision is approaching. While the anticipated incidence of its employment is thankfully very low, it is our view that it must remain in the Bill. It is a pity the suicide aspect has dominated discussion. It has tended to obscure the other vital and important elements of the Bill and other much more prevalent, commonplace and likely threats to the lives of women in pregnancy. Do the heads of the Bill go far enough to protect women in that regard? That is a question we must all, individually and collectively, address.

We must move on. The Government needs to publish the Bill. It needs to be progressed through the Oireachtas. Sinn Féin will assess the published Bill in light of its party policy and the questions, answers and issues raised during the hearings and in the wider debate. We will engage on each Stage of the Bill's passage. We are committed to ensuring the strongest possible protections are in place.

Deputy Seamus Healy:

I welcome the Minister of State, Deputy White, to the final session and thank Deputy Buttimer for chairing the committee. I thank all the various witnesses who presented over the past three days. I thank each and every member of the committee and other Members of the Oireachtas who contributed. I also thank the committee secretariat for their excellent work.

The process has been ongoing for quite some time. We have had debated the issue on three occasions in the Dáil Chamber, two to discuss the Bills published by Deputy Clare Daly and

one to discuss the Sinn Féin Private Members' motion. The committee held a hearing that lasted three days in January and we have had another three days now. With so much discussion and all of the presentations, it can be difficult to see the wood for the trees, to some extent. Therefore, it is important to restate the parameters within which the legislation is being brought forward. They are restrictive. Article 40.3.3° of the Constitution protects the life of the woman and the unborn. The X case concerns a real and substantial threat to the life as distinct from the health of the mother. In a situation where the threat to a woman's life can only be averted by termination, the woman will have the final say.

The past three days have been very helpful and necessary. We have heard varying degrees of views right across the spectrum, which are sincerely held views that were well thought out and put forward. The Minister and his Department will have to examine, give further consideration to and allow discussion on the many areas that have been highlighted, such as an appropriate location, the very significant criminal sanction in the Bill, the timeframe for review, consent regarding people who are under age, particularly children, monitoring of the Bill and various other areas that were highlighted over the course of the hearings.

These three days were helpful and necessary. I look forward to the completion of the committee's report and the presentation of that report to the Department, as the Chairman stated, by the 30th of this month, and the Minister publishing the Bill at an early date.

Deputy Ciara Conway:

I thank the Chairman for his chairing of the past couple of days and his direction on breathing exercises, which have been most useful for some Members from time to time. I thank the clerk to the committee and his team for their support in preparing the past couple of days.

Following on from what Deputy Seamus Healy spoke about, that there have been three Private Members' Bills on this issue and the committee held three days of hearings in January. I would go further and say there have been six successive Governments which have spoken about this and which have done nothing. I, for one, am glad to be a member of the Government that has decided to legislate for this issue and it is incumbent upon us to ensure that happens now because we have talked and talked about it. We now need to see the Bill published on this important issue for so many women and to see it pass through both Houses of the Oireachtas.

There is only one issue which I want to bring to the attention of the Minister of State, namely, head 19 on the criminalisation of women. We have heard, most interestingly, from psychiatrists on both sides of the argument who agree that this is a difficult area, that they do not want to see criminalised women who may purport to take medication that would be, in essence, a medical abortion. The head is drafted broadly. Today Mr. Callanan even spoke about the fact that it is drafted so broadly that it could be interpreted that somebody who is advocating for a pro-choice regime could be liable to criminal sanctions. That is something that should not be part of the heads of the Bill. I would ask the Minister of State to bring that back to the Department and the drafters and that we would refocus our energies around head 19, taking reference and looking at the Criminal Law (Suicide) Act 1993 which similarly imposes a penalty of 14 years but does not criminalise the person who attempts suicide. We could use this as a basis for us having similar sanctions for those in relation to abortion.

I thank everybody. I thank my colleagues and fellow members of the committee for their contributions over the past number of days. As they say, it has been emotional.

Senator Jillian van Turnhout:

The 2002 referendum was my first referendum vote. I worked in the private sector for 15 years and then headed up different children and youth NGOs, both in a voluntary and professional capacity. In these roles, I have always listened to the debate but I have never had to actively formulate a position. I am a little nervous now because this is the first time I am publicly stating how I feel on this issue.

The hearings we held, both in January and over the past three days, have given me an opportunity to form a definitive position. I want to begin by thanking all of the experts, both in January and over the past three days, for their informative and sometimes contradictory testimonies. All has been extremely useful. I thank my colleagues, the secretariat and, in particular, the Chairman, Deputy Buttimer.

I can now say in confidence that I support the Government's decision to legislate. These heads of the Bill only deal with difficult, rare and complex circumstances.

Of course, I would add some caveats. I am concerned about us separating out physical and mental health. In the wider public debate, it will be a step back for us. Therefore, I believe that heads 2 and 4 should be merged. I have not heard legal reasoning - obviously, I have heard contradictory reasoning - but from what I have taken, I do not believe that they should be distinguished. As noted by the expert group, differentiated treatment does not appear to be required for medical or practical reasons. Dr. McCarthy stated that suicide in pregnancy is a real risk; it does happen. There is no distinction in Article 40.3.3° and, therefore, to exclude it in these heads of the Bill would be to change the law. I do not believe that we should have any differentiated treatments.

I am concerned about the scope of head 19. It is extremely broad, in fact, too broad. It covers a wide range of activities, including and beyond those previously covered by sections 58 and 59 of the Offences Against the Person Act 1861. Some of the scope is unclear about what exactly is covered and the penalties are disproportionate.

I have concerns over the appeals process timelines and conscientious objection. We need a further discussion exploring this issue.

I am concerned about the silence in relation to children, specifically young girls. I believe we need specific legislation to address many of the issues raised over the past few days. I am troubled that we will compound the situation of voiceless children who are in the care of the State in this legislation. The hearings have also highlighted the importance of the assisted decision-making (capacity) Bill, which is urgently needed.

I found any association, actual or implied, between abortion in Europe and the Holocaust to be distasteful in the extreme. Besmirching the memory of millions of murdered Jews by turning them into a pawn in the abortion debate displays a woeful ignorance of the Holocaust and a woeful disrespect to the memory of the victims. Whatever one's opinion on the abortion issue and the debate between well-intentioned persons on both sides of the argument, there are no two sides of the Holocaust. I would respectfully encourage my colleagues to desist

from making this highly offensive connection during the continuing debate. We must not allow the 6 million victims of a diabolical pre-meditated attempt to eradicate an entire people to be dragged into this abortion debate.

I was appointed by the Taoiseach, particularly in recognition of my work on children's rights. Advocacy on children's rights has not been an easy road to travel. Therefore, on this decision and in talking about child protection, I had to consider my position, but I stand here in confidence and I will continue to constructively engage with care, conviction and compassion.

Deputy Catherine Byrne:

I thank the Minister of State for making it clear this evening in his closing statement what these heads of Bill are about.

The time is right for this Bill. We have seen it over the past three days. It has been a privilege to be here. I have been proud to be in the Chamber with Members, those on the committee and those who are not.

I have been moved and touched by many statements that have been made. Most of all, I want to express how proud I am of the experts who have been here from all walks of life, whether doctors, medical experts, lawyers or whoever. It shows the considerable expertise in this country and the pride we should have in our systems, whether medical or legal.

Our role of the past three days was to listen and learn - that was my role anyway and I am sure it was that of the members of the committee as well - because we can only learn if we listen to each other. We learn wisdom, we learn understanding and, above all, we learn compassion.

As I stated, the heads of the Bill are about having compassion for those who find themselves in a very difficult place. Whether in the Dáil, in the community or at home, now and again, we all must have a bit of compassion.

My focus over the past few days was on saving women's lives as well as the life of the unborn. It was made very clear by doctors here that their job is to save lives, whether it is the mother or the unborn. That came across clearly to me.

On whether the heads of the Bill go too far or go far enough, one aspect that stood out which is not in the heads of the Bill was that foetal abnormality was raised on a number of occasions by many in the Chamber. Many of the calls I received have been about that issue. As to whether it deserves consideration at this time, I am not too sure.

The role of GPs, which was referred to by many Members here, is most important. The GP, for anybody, whether a mother, a father or a child, is the first port of call. We need to rely on the expertise of the GPs. In my view, that is honest and open.

I still believe in good faith. It is important in everyone's life to believe that when one puts one's life in the hands of someone else, they will look after one and do the best they can. That is what we do as committee members, as Members of the Dáil and as legislators; we do our

best. We may not always be right but we do our best and, consequently, the people decide to elect us on good faith.

I found the arguments on both sides to be at times interesting, at times offensive but above all, genuine. I mean this with the greatest of respect. No one in this room, regardless of what side of the fence he or she is on, wishes to see people losing their children at any state or time and there is general concern about the mother and the child. One must consider all these viewpoints because I know I have. As I stated, members have listened to the experts, including the masters of the maternity hospitals, and others. I believe that on a daily basis, they will be the people who will make the decisions. It will not be those who are sitting in this Chamber and nor will it be a piece of paper. However, it will be what actually is done when someone arrives into their accident and emergency units.

I was filled with great pride to see people appear before the joint commitment but above all, by Mrs. Justice Catherine McGuinness. She is a woman of wisdom and great presence who has done this country a huge service even through her presence here, which I greatly appreciate. I will finish by thanking the Chair. While it is difficult to chair any kind of meeting, it is especially difficult when there are widely differing views. However, I believe he handled this task with care. I also thank the Oireachtas staff and my other colleagues on the joint committee, as well as those who were not on the joint committee and those who have just arrived on the committee. They have all done a wonderful job, even though they sometimes took over my time. I also thank the witnesses, the people in the Gallery, all the former Members of the Oireachtas who attended and especially, the people at home.

Senator Jim Walsh:

I will start by thanking the Chairman for accommodating me as a substitute member of the joint committee, for his engagement prior to the hearings with regard to people coming in and for his subsequent chairing of the joint committee, which was good. That said, the process was very rushed. While that was not the Chairman's fault, it was rushed both for members and for those presenting, as some of the latter have noted subsequently. Despite this, however, it has been quite productive.

The question all members will ask themselves is what they have learned from these hearings. Before the proceedings began, for example, members knew the A, B and C *v*. Ireland case in the European Court of Human Rights did not involve suicide. They learned that the circumstances of the C case were covered adequately by current medical practice on the treatment of cancer patients and this point was stated here emphatically. They also learned, which they probably knew, that the European Court of Human Rights required not legislation but clarity surrounding the treatment to which Miss C was entitled. They learned an interesting point today in respect of the X case, which is that where an argument in the Supreme Court or any court is conceded, it loses its evidential value and therefore, it only binds the parties in that particular case. This was the incontrovertible evidence presented to members today.

A number of those who presented today stated we are not required to legislate in this instance. I took particular note of the comments of the eminent former Supreme Court judge, Mrs. Justice McGuinness, who stated that over the past 21 years, Governments did not act unconstitutionally by not legislating. Members also learned, although they probably knew it from the previous hearings, that it is not possible to predict suicide. A British study

demonstrated that it is only correct in 3% of cases, with 97% being false positives. Emphatically, members learned from all psychiatrists appearing before the joint committee, be they pro-choice or pro-life, that abortion is not a treatment for suicide. I believe that was a unanimous view.

Members did learn something that presents a challenge to the Government, namely, that where a woman presents with a crisis pregnancy and in distress seeking an abortion and is not mentally ill, she is entitled to refuse other treatments such as psychotherapy or home visits that might be offered to her. If she still refuses, she then will be entitled to a certification to allow her to have an abortion. Because of her distress, she will perceive her only solution to be a termination of the life of the baby. This presents a significant challenge and from what I have heard in recent days, I believe that what the Bill is most likely to deal with under head 4 are cases of suicidal intent not associated with mental illness. I believe, as stated by a number of witnesses, that both in law and in practice, this is a highly significant change from the current position.

Members also learned, which certainly has concerned me and I expect most members of the joint committee, the psychiatric profession is divided and more or less polarised on the issue. If, as has been suggested, pro-life psychiatrists do not participate or the selection process is skewed or both, my honest opinion is that Ireland will have a liberal abortion regime within a short period. As the debate progresses, I genuinely hope the Government will pay attention to and act on the evidence presented generously to the joint committee over the past three days by those who appeared before it. This did not happen on foot of the hearings last January and in this instance, I appeal to the Government to pay close attention to the points made, which summarise much of the evidence that came before members.

Deputy Mary Mitchell O'Connor:

I thank the Chair for the very good job he did over the past few days. I also say well done to his staff at the top table. The Chairman kept everyone under control and a very good exercise was conducted. I actually learned a lot over the past three days.

In his statement to the joint committee, the Minister of State stated, for the benefit of the public, "Of course as the committee is fully aware the next phase is the drafting and publication of the Bill". Can he provide a timescale of when that publication will take place? From the first page of his statement, I understand he intends to take into account the submissions that have been made during the past three days. Again, he should elaborate a little in order that people, including me, are assured these submissions will be taken into account.

Three areas really stood out for me. The first was the area in respect of children highlighted by Senator Jillian van Turnhout. Many questions have been asked about young girls in care in particular and on how precisely that cohort of people will be dealt with. I am sorry to bring it up but I have concerns in respect of head 19 and the reference to 14-year sentences. One thing I learned in the course of these meetings is that women are importing abortifacient drugs to have abortions. Were a girl or young minor to import some kind of drug, would such a person face criminal charges associated with that provision? I do not believe the issue of people importing such abortifacient drugs was really discussed.

The final issue pertains to the issue of conscientious objection, which was brought up today. I seek assurance that there will be a balance between what will be the law of the land and the conscientious objections of the medics. While I understand it fully, I also wish to ensure that a woman who enters the hospital will be assured of the best treatment. Dr. Simon Mills today brought up the provision that no institution, organisation or third party shall refuse to provide a lawful termination of pregnancy to a woman on grounds of conscientious objection. However, if, in respect of a board of management or whoever runs a hospital, this is not the case, how shall one ensure that this woman will get the treatment she expects?

Senator Ivana Bacik:

I thank the Chair for the impeccable way in which he has run the proceedings over the past three days. I also thank the clerk and the secretariat for running the proceedings so well. I feel privileged to have taken part and to have been enabled to take part as a substitute member, that is, as someone who has just come to the committee.

I welcome the Minister of State and thank him for his clarity in addressing some of the issues that have arisen over the past three days. All members are mindful of his comments that they are scrutinising the heads of the Bill to ascertain in what way they can improve the operation of the Bill, bearing in mind their obligation as legislators to ensure an effective and accessible procedure is available for women who seek to access the lawful abortions to which they are entitled where their right to life is threatened by the continuance of a pregnancy.

Like Deputy Conway, I am very proud to a Labour Party Senator and to be part of a Government that is at last facing up to its responsibilities as legislators in this regard. There has been a compelling need to legislate for the past 21 years, made more stark by the A, B and C judgment in December 2010.

I have a fundamental objection to the wording of Article 40.3.3°, the eighth amendment. Like Mrs. Justice McGuinness, I believe it would be preferable if abortion could be dealt with outside of the constitutional framework altogether, through legislation, but I accept that Article 40.3.3° is the law of the land, as interpreted by the Supreme Court and as upheld by the people in 1992 and 2002. Within that framework the Bill represents a reasonable if conservative attempt to ensure we have an accessible and effective procedure in place for women to access their constitutional rights.

In engaging constructively with the Bill, it has been very useful to hear the comments of the legal and medical experts we have heard in the past three days who have identified specific issues, to which other members have referred, where the operation of the Bill could be improved. I refer in particular to the definition of "appropriate location", which should be reviewed to cover generally approved hospitals. The definition of "unborn" in head 1 was also raised. The merging of heads 2 and 4 was raised by many of the professional bodies. The requirement that psychiatrists have to be attached to particular institutions in head 4(1)(b) was a concern, in particular of the psychiatrists in the College of Psychiatrists of Ireland, on the basis that it was unduly restrictive and that too few psychiatrists would be able to fulfil the condition. Others pointed out in heads 6, 7 and 8 that the timeframe is too long and it should be shorter, for example, 72 hours for each stage of the review procedure to ensure it is accessible. In head 12 there is a need to ensure a woman has access in a timely manner to another doctor where a doctor exercises his or her right to conscientious objection.

Other speakers referred to head 19. Three specific problems arise with the head as currently drafted. First, the language is too broad. The framing of the offence is too broad. Second, the penalty is too onerous and, third, we must look carefully at whether we need to criminalise the woman - or in most cases the young girl - who might be at risk of prosecution under the provision. Dr. Ruth Fletcher's submission was particularly useful in that regard.

Senator Colm Burke:

Thank you, Chairman, for the way you have managed the public hearings. They have been extremely well organised and conducted. I thank you and the staff for the work done. I welcome the Minister of State, Deputy Alex White, and thank him for his contribution this evening.

I came to the hearings with reservations concerning two issues. I felt we had not done all of our homework on the heads of the Bill. The same two issues emerged as being of general concern. The first was head 4 and how the decision is arrived at by the two psychiatrists and the obstetrician making the decision. The proposals from the Medical Council and the College of Psychiatrists of Ireland should be taken on board. It is interesting to see that they are both coming out with the same view. The heads of the Bill do not adequately deal with cases where an expectant mother is under 18 years of age. The issue must be examined carefully.

It is interesting that it is our role to be legislators and that it is not the role of the courts. It is important to remind ourselves again of the words used by Mr. Justice McCarthy on page 82 of the judgment in the X case: "The failure by the Legislature to enact the appropriate legislation is no longer just unfortunate; it is inexcusable." That comment was made on 5 March 1992, more than 21 years ago, yet nothing has changed in the intervening period. We have a role to play as legislators and that is what we have done over the past three days. We have examined all of the angles on the preparation of the legislation we so urgently need to deal with the issue, and also to provide clarity to those who work in the medical profession.

I pay tribute to all of the experts who came before the committee, who gave of their time and who also put a lot of work into preparing the submissions. No one came before us without having carried out a detailed examination of what they had to say. They spent a long period putting their submissions together. No matter what angle they took – even if I disagreed with their views – everyone who came before the committee was extremely constructive.

On the completion of the hearings it is important to say to those in the medical profession that we are fortunate to have the lowest perinatal mortality rate in Europe. We should never forget that. It is the reason we must put supporting legislation in place to give clarity to those who provide the service on a daily basis, regardless of the time of the day or night they are required to provide the service. I thank the leaders of all of the groups for their constructive contributions throughout the three days.

Senator John Crown:

I welcome the Minister of State, Deputy Alex White. I also pay tribute to your job, Chairman. There is a phrase in academic medicine that sometimes trying to chair meetings of academic doctors is like herding cats. The hearings were a bit like trying to herd cats when they had been taking crystal meth and possibly had rabies.

Chairman:

We should be temperate with our language.

Senator John Crown:

I am very sorry. I regret any offence to the cat community for the latter remark of drawing an analogy between them and Irish parliamentarians.

There can truly be few situations where the will of the people and the voice of the Constitution have spoken as clearly as they have on the narrowly defined necessity for abortion in very narrow circumstances, ones which entirely relate to the life of the mother, the termination of which life would also by necessity result in the termination of the life of the child. People who are pro-life need to understand what the Bill is about. It is about saving life; it is not about ending life. Those who allege that they have a superior pro-life position to others in that the position of those who support the Bill is somehow less purely pro-life than theirs are working on an assumption which has been tacit, and in some cases explicit in recent days, that a large number of citizens are plotting in advance to game the law, to cheat, to lie and to collude in the death of an unborn child for some secondary gain other than their own health. There is no other way to cut this up. That is the only interpretation that can be put on the suggestion by some that somehow the Bill will give wide access to abortion. I just do not think it is true. We must follow the Constitution.

We all have positions on abortion. It will surprise many of those present to know that I was the recipient of a scathing editorial by Doctors for Choice Ireland who pointed out that I was an anti-choice person. I have to say I am; if choice means having the right to choose to kill someone else, I am anti-choice. I do not support that right. I have a very nuanced position on abortion, which is one that would not make people on either side of this House particularly happy, but it is irrelevant today, as are the considerations of evidence-based psychiatry. We are here to defend the Constitution and in this regard let me remind the committee of the Garda oath:

> I will faithfully discharge the duties of a member of the Garda Síochána with fairness, integrity, regard for human rights, diligence and impartiality, upholding the Constitution and the laws and according equal respect to all people.

We have the privilege of sitting in these Chambers without having to swear such an oath and not having to declare our loyalty to the Constitution, something which I hope will be fixed. That is all we are doing today; one Supreme Court verdict, Article 34.4.6° – the decision of the Supreme Court shall in all cases be final and definitive. It is not a case of ignoring it if we do not like it or think it is flawed. There is stuff in the Constitution I do not like but I will live by it and if I want to agitate to change it within the law, I will do it.

It is regrettable that the Minister, the CEO and the-----

Chairman:

Senator Crown's time is up.

Senator John Crown:

I am very sorry. I will finish on this point. It is regrettable that the Minister, the CEO and the chief medical officer have not been able to be present for the three days of hearings. They were present for the first session. The Minister left and we were under the impression that the CEO and the CMO of the Department of Health would be present, but they were not. I cancelled an international cancer meeting – not just my attendance but the meeting itself – of international speakers coming to this country. I cancelled clinics and got colleagues to cover ward rounds. It is regrettable we did not have a higher level ministerial presence.

Chairman:

I thank Senator Crown. He is way over time. He will find that Members of the Houses of the Oireachtas cancelled clinics as well. I call Senator Healy Eames to speak on behalf of the non-members of the committee and then I will take the final two speakers. In fairness, she has been present since the commencement of proceedings. She has four minutes.

Senator Fidelma Healy Eames:

This has been a most insightful opportunity to listen and to learn.

I start by thanking the Chairman and staff of the House, and especially the expert witnesses that came before us. We can stand proud in this country to have such fine people serving the people and our patients.

It is important we say that but my key remarks will be addressed to the Minister of State. I represent non-members; we are a disparate group from all parties and both genders. We want to see the key learnings and findings from these three days taken on board and integrated into the drafting of the legislation. Regrettably, we did not see the key learnings from January built into the heads of the Bill - that would be acknowledged by some of the members of the committee - even though they were recommended.

We are linked by our underpinning concern, namely, compassion for both the pregnant woman and the children. We are coming from the two-patient principle. We believe if the Government does one thing, if it acts on the best medical practice available, it will achieve the right outcome for both. If I have learned one thing in the last few days, it is that not acting on best medical practice will lead to serious problems and will be unsafe. We have learned today that it will lead to ethical considerations that the Supreme Court judgment has been deemed not ethical and can leave the State open to liability, as was confirmed today by Dr. Craven. This is a serious issue. We also learned that we are not obliged, although it is the wish of the Government, to legislate for the X case since it is not based on best medical practice and that is our duty as legislators. I am making a call, therefore, to the Government and the Taoiseach to seriously reconsider meeting the clarity required by the European Court of Human Rights while not legislating for X.

We are also concerned about term limits and I share the concerns of many about the criminalisation of women who have been in a dark and vulnerable place. It is too stringent.

Finally, I acknowledge those women who have had abortions, the women who have been hurt by abortion in particular, who did their best to come before the committee. In their absence, I acknowledge them.

Senator Imelda Henry:

I welcome the Minister of State to the House and thank the Chairman for the way he has chaired the hearings in such a calm and fair manner. I also thank all the witnesses that came before the committee, members, non-members and the staff.

We heard many expert witnesses in their professional capacities, with conflicting views, and at times personal views. The debate became intense at times and I have the utmost respect for people and their views. For me this debate is about women, pregnant women. The reality is no one knows more about pregnancy than women themselves. I do not want to insult any of my male colleagues and I know men play their part but they do not become pregnant. I agree with Deputy Catherine Byrne that there were times I found the debate here offensive.

As a woman, a mother and the mother of a teenager, I support this legislation for the X case. I know personally it is not always possible to save both mother and baby. I believe we must protect our doctors in the rare event that the mother's life is at risk and a termination is required. Where a woman with serious heart disease is pregnant and needs a termination to save her life, I would like to think she could have the termination in this country and would be able to avoid the distress of travelling.

As I asked in January, what about the parents who have a 14 year old daughter who was raped and made pregnant and may be suicidal? Parents along with that daughter must make a decision. I know not all but most parents would do one thing. I have concerns for children in care who are in that position and that position must be clarified.

There must be some changes to the Bill and I look forward to further debate as the Bill goes through the Houses. I am proud to be part of the Fine Gael parliamentary party and I am proud of the Taoiseach, the Minister for Health and the Government for bringing forward this Bill to protect women in the future during pregnancy and for saving lives, not killing babies, saving women's lives.

Deputy Regina Doherty:

I thank the Chairman for his professionalism during the last three days and the entire team for the way the hearings have been carried out. It has been a pleasure to be here. To have had access to the level of expertise we have had for the last three days has been humbling for someone like me. To hear their opinions, expert and personal, has been hugely informative and I have been struck by the things I have learned in the last three days that I have not considered before.

I never thought I would be an expert in anything but I have decided I am an expert, I am expert on me. I am a woman who has been pregnant five times and I have four truly great children. I do not want there to be any legal doubt whatsoever for any of the doctors who made a presentation before us, or any of the wonderful people who deliver babies in this country and provide medical treatment to women, or any legal doubt, pause or cause for concern in how they would offer treatment because of a lack of clarity in the law. On that basis, I am very pleased we will bring clarity to the law.

On the suicidality element of the legislation, I have thought about this long and hard, particularly thinking of my own children, and such an awful thing happening to anyone I care

about deeply as happened to the young girl in the X case. I have come full circle and decided I would want clarity not just in the assessment of eligibility but in the speed and swiftness of the action if anything like that ever happened to someone I love.

I am glad that the last three days have provided clarity for many people, not just in these Houses, but in the wider population. I am proud to have been part of this process and I urge speed in enacting this legislation before the summer recess.

Deputy Denis Naughten:

What has been learned in the last three days must be incorporated into the Bill when it is published. Many issues have been raised on elements of the Bill and it is clear there are many areas where it must be strengthened.

There is no doubt that the one contentious issues is that of head 4 and suicide. Over the last three days of hearings, we have spoken in abstract on the issue of suicide and mental health but the reality is that suicide occurs in this society on a daily basis. The real issue of mental health and suicide should be a focus, with the necessary resources made available.

All of the expert witnesses who appeared before the joint committee on Friday and Monday referred to the need to provide adequate resources for maternity services. Investment is needed both in this area and in the provision of perinatal and psychiatric support for women who are pregnant. The concerns that have been raised in these hearings need to be addressed in the legislation. I hope that the one outcome of these proceedings will be that the Department of Health and Oireachtas address the need to provide adequate resources to support women in pregnancy, irrespective of the decisions they or their clinicians must make.

Deputy Alex White:

I thank all Members for their contributions in the past three days, specifically during the closing session of this extremely important process of pre-legislative scrutiny of the heads of the Bill, for which I have the privilege of being present. I thank the main speakers of the main Opposition parties for their initial contributions, in particular Deputy Billy Kelleher for his extremely helpful insights.

When I stated my belief that there was a large measure of agreement throughout the three days of hearings, I was not oblivious to the considerable discussion that had taken place on head 4. I was simply pointing out that I believed there was a reasonable measure of agreement, a conclusion I reached primarily on the basis of the relative silence on many aspects of the heads of the Bill.

While I accept that Senator Walsh would have preferred the debate to have lasted longer, three days of discussion would be considered reasonably lengthy in anybody's book. I am sure all the concerns people have about aspects of the heads of the Bill were given some airing during the course of the hearings. From my observation of the deliberations, I share Deputy Kelleher's view that head 4 is the area of greatest concern. This was evident in the discussion.

Deputy Ó Caoláin is correct that the hearings were a very useful exercise in democracy. I was a Member of the Seanad, the House which normally sits in this Chamber, before my election

to the Dáil and appointment as Minister of State. Parliamentarians on all sides may sometimes wish to have an opportunity for greater scrutiny of legislation. The scrutiny of the legislation before us has provided important insights which will be extremely helpful to the Government. Irrespective of which side of the argument one is on, all of us will agree that this has been an extremely positive exercise from the point of view of public elucidation, elaboration and questioning of issues.

Deputy Catherine Byrne stated she was proud to have been involved in this process and noted the level of expertise that was made available to the committee. Her point is well made. We should be thankful that such a high level of expertise is available to us and independent experts are willing to come before the committee, give evidence and subject themselves to what is essentially a cross-examination by Members.

I thank Deputy Seamus Healy for his contribution. The Deputy commented on a number of specific aspects of the heads of the Bill that he and others wish to have addressed in the period ahead. He referred, for example, to the definition of the term "appropriate location" and alluded to the stringency and extent of the criminal sanction provided, the periods to be allowed for review and the issues of consent and monitoring. I emphasise that all issues raised by Deputies and Senators in the course of the debates will be considered. I want to give people the comfort, respect, courtesy and assurance that everything that has been raised here will be considered and addressed in the preparation and publication of the Bill.

Deputy Ciara Conway made a fair point that, at least on one view, society, the country and Parliament are somewhat overdue in addressing this issue. Those of us who argued in the past that it was taking too long to address this issue can now cease doing so. Let us get on with the process that is required. While I agree with the tenor of the Deputy's remarks, I am glad, as she is, to be part of a deliberative process that is finally bringing forward legislation. I also accept the point made by Deputy Conway, Senator Bacik and others in respect of head 19 that the offence or restated offences has been cast, at least in one view, in relatively broad terms. We will consider this matter. The chief medical officer, Dr. Holohan, also made this point on the first day of the committee's hearings.

I thank Senator van Turnhout for her most insightful contribution. She and others raised a concern about the differential treatment of a risk to life based on physical risk as opposed to a risk to life from suicide. As colleagues will be aware, the expert group addressed this issue. The language that has been used and is reflected in the Bill comes at least to some extent from the expert group report, which stated the following:

> Finally, the role of the psychiatrist is key where a termination of pregnancy is prescribed as appropriate treatment in case of suicidal ideation/intent. There are recognised clinical challenges in correctly diagnosing expressed suicide intent, for instance, the absence of recognised clinical markers.

The issue was, therefore, addressed by the expert group. I thank the members of the expert group, including Mr. Justice Ryan. While I accept there has been some debate about the group, on any reading, its report is a rigorous treatment of the issue which provides an extremely helpful background and foundation for the work we are doing.

I listened to the comments of Senator van Turnhout and others on penalties, sanctions and appeal times. On the two periods of seven days provided for in the heads, it is important to

emphasise that these periods are maxima as opposed to prescribed periods. If the persons who are to consider the review have been empanelled within two or three days, the clock stops and the second seven days within which they must make their determination begins. The periods are maxima which arise from genuine concern in respect of the practicality and pragmatic requirements of bringing together professionals in the field in one place to do this work. The periods were set down as a result of a practical consideration and have certainly not been born of any other motivation.

I appreciated Deputy Catherine Byrne's comment that the time was right for the Bill. She and other speakers also raised the issue of foetal abnormalities. I believe it would be fair to describe her view as one of regret that it has not been possible to address this issue in the legislation. It is regrettable that this is the case. The issue may be revisited either by the Houses or the people at some future time. If I may express a view, I would support such a course of action although it is not something that can be addressed in the context of this legislation.

Senator Jim Walsh makes a reasonable point, albeit one with which I do not agree, in asking what was the requirement of the European Court of Human Rights. The decision in the A, B and C *v*. Ireland case required clarity, as the Senator acknowledged. The Government decided that the best way to ensure this clarity was by means of primary legislation to be followed by regulations. The Oireachtas makes the law and it is necessary to provide clarity to medical professionals.

It seems to me, if I may say so, entirely appropriate that legal clarity should be provided in laws passed by the Houses of Parliament. That is where it should be done. It is the decision of the Government that it should be done and we will respectfully introduce legislation in these Houses in the hope of winning the support of a majority for its passage. That is what the Government has decided and intends to do.

Senator Walsh posited a scenario - I hope I am not misrepresenting him but rather, paraphrasing what he said - where a woman might present in a stressful situation, refuse treatment on offer to her and go on to seek and obtain certification for a termination, in accordance with the provisions of the Bill. This can only occur where there is a real and substantial risk to her life that can only be averted by a termination. We have to keep reminding ourselves of what is provided for here. It can only occur in circumstances where there is a real and substantial risk to her life which can only be averted by a termination. It is worth pausing and reflecting on the nature of that test, which is a very onerous one in my view.

There has been much debate between members of the medical profession, particularly the psychiatrists, echoed throughout these hearings, on the question of abortion never being a treatment for suicide or suicidality. I will not revisit this issue now except to repeat what Dr. Holohan said on Friday because his comments put the issue in the clearest terms. He said that we simply cannot say the circumstance of a real and substantial risk to a woman's life could never occur as a consequence of suicidal ideation. I agree with Dr. Holohan on this point. We simply cannot make the assertion that it would never occur, that a real and substantial risk to a woman's life could never occur as a consequence of suicidal ideation. I do not think anybody could make that statement.

Chairman:

The Deputy has spoken for 11 minutes.

Deputy Alex White:

Really? How much time was I allotted?

Chairman:

Five minutes.

Deputy Alex White:

I did not realise I was only given five minutes. I am sorry, Chairman.

(Interruptions).

Senator Rónán Mullen:

That is very unfair on the rest of us.

Chairman:

To be fair, there was no time limit.

Deputy Alex White:

I did not think there was a limit and I wanted to mention everybody who spoke.

(Interruptions).

Senator Rónán Mullen:

Had I known there was that much time available I would have insisted on having another word myself.

(Interruptions).

Deputy Billy Kelleher:

Deputy White is the most impressive witness so far.

Chairman:

He is not a witness.

Deputy Alex White:

Deputy Mitchell O'Connor urged me and the Government to make sure that all of the submissions were taken into account and I assure that they will be. All submissions will be carefully considered and taken into account. She also raised the issue of the breadth of head

19 and expressed concern about the importation of abortifacients. All of those issues and concerns will be addressed. The Deputy also raised the issue of conscientious objection. She spoke about the fact that conscientious objection can be invoked by a practitioner but not by an institution. That is very important. An institution cannot invoke the protection of conscientious objection. Only an individual can do that. There is a further provision in the draft legislation that where an individual practitioner invokes conscientious objection, steps must be taken to ensure that the care is given, nevertheless, by a colleague or someone other than the person exercising that objection.

Senator Bacik asked that we look again at a number of specific issues. She raised the "appropriate location" question and I understand her point in that regard. I also understand her point about the requirement for a psychiatrist to be attached to a particular institution. Indeed, I would make the same point to her in respect of the time limit. These are maxima but still, I take the point that she raises.

I thank Senator Burke for his contribution and his reflections on head 4, particularly his concentration on the issue of minors. He raised particular concerns in this regard in the course of these hearings, as did others, and those concerns will be addressed. I agree with Senator Crown's ringing invocation of the Constitution and the importance of the Constitution as the foundation of our laws. I absolutely agree with him in that regard.

I am sorry if the impression was given that the Minister, the chief medical officer or the Secretary General of the Department would be present throughout the course of these hearings. It was never my understanding that it would be so. There was no discourtesy intended to the committee.

Chairman:

That was not communicated to members of the committee either, to be fair.

Deputy Alex White:

I know, from speaking to the chief medical officer and the Secretary General, that serious attention is being paid to what is happening here. The proceedings are being monitored and will be considered carefully.

Senator Healy Eames asked us to take on board key learnings and best medical practice. I say again, at the risk of repetition, that everything that has been said here will be considered. I must say, however, that the Government will introduce this legislation to the Houses. The Government will do that. The Government will introduce this legislation and it will certainly be based, in large part, on what has been before this committee in recent days, namely, the heads of the Bill. There is always scope for addressing technical questions, amendments arising from technical issues that have been raised, drafting issues that have been raised and so forth. Sometimes unintended consequences emerge in the course of debates and these issues can be addressed too. That is why these deliberations were so useful because they will help us to improve the Bill as we go forward, but a Bill there will be. A Bill there will be, I must say that.

(Interruptions).

Chairman:

One speaker, please.

Deputy Alex White:

I was asked about the timing and I wish I could give the committee a precise date for the publication of the Bill but, regrettably, I cannot do so. However, it remains the clear intention of the Government that this legislation will be enacted, subject to the agreement of the Houses, by the summer recess, which is the end of July. We are getting pretty close to that in terms of parliamentary schedules and so on. If members work back from the end of July, they will see that it will be necessary to publish the Bill in the coming weeks.

Senator Henry is absolutely right and I agree that this debate is about women's lives. While public and parliamentary deliberations are not confined to one gender, the Senator is right when she says that this is about women, their rights and their lives. I agree with her on that. I thank Deputy Regina Doherty for her contribution on the necessity to bring clarity, which is what we are doing with this legislation. I understand the points made by Deputy Naughten and heard his contributions over the course the three-day hearings. He referred to head 4 and expressed concern about some of the issues that arise there.

I thank the Chairman, the committee secretariat, the members of the committee and all of the Members of the Oireachtas who took part in this debate. It is important that they did so. The Government has introduced a very useful pre-legislative scrutiny process, not just in regard to this Bill but others too. I thank everyone for their contributions and look forward to further co-operation and close work on this Bill, which will be required over the coming weeks.

Chairman:

As Chairman of the committee, I have probably spoken the least in the last few days. We have had almost 30 hours of hearings, 40 expert witnesses appeared before us and on average, between 18 and 20 Members of the Oireachtas have participated in the discussion on the heads of the protection of life during pregnancy Bill. I wish to address my remarks to two audiences, if I may. First, to the people who are watching and listening at home, whether on Twitter, *journal.ie* or the Oireachtas website, what we have been doing over the course of three days is discussing the draft heads of a Bill. This is a draft document which sets out the objectives and the main provisions of that proposed Bill. It provides a framework, but not the detail. It is not the final Bill, as the Minister of State has said. It is not the new law but rather a preliminary document which is to be used to facilitate discussion and consideration before producing the Bill. It is part of a pre-legislative consultative process. I am very heartened by the number of people who have listened and followed this debate through a variety of media and I wish to thank them for that.

In reforming the Houses of the Oireachtas, this Government has referred heads of Bills to committee. Indeed, this is not the first time our committee has considered a Bill on this basis.

It is and can be seen to be a democratisation of the legislative process, allowing stakeholders, us as members, and other experts and outsiders to have a real input into the preparation of proposed legislation. The entire purpose of this pre-legislative consultative process has been,

I hope, to facilitate further consideration of the drafting of the Bill, which will ultimately be presented to the Oireachtas.

At the request of Government, this committee agreed to hold a series of hearings to examine the heads of the protection of life during pregnancy Bill. In carrying out this task the committee decided, as a group, to concentrate on the legal and medical issues which arise from the outline document. In doing this we have been greatly assisted by many experts who have voluntarily given of their time so that they could share their knowledge, experience and views.

Our expert witnesses have highlighted many issues, some which need further consideration, others which will require further clarification and more that are viewed as positive contributions to the law in this difficult and sensitive area. I know that all of the contributions made at our hearings and the detail obtained during questioning will be of valuable assistance when the committee is preparing its report for Government.

Our three days of hearings have been another example of how our Parliament can function. Members of the Oireachtas are capable of holding detailed hearings on sensitive social and political matters. Members of both Houses are capable of doing so in a way that is respectful and tolerant. In particular I hope that this has helped to portray the constructive way the Houses of the Oireachtas operate, especially at committee level.

I pay tribute to all Members and expert witnesses who have contributed over the past three days. The way they have conducted themselves, being considerate and respectful, has allowed the committee to do its work. This approach has allowed Members to gather information, to ask questions, and to probe on particular issues in the absence of tension or unnecessary and unhelpful rancour. I thank all those who appeared before the Committee for their time and very helpful contributions. It really is appreciated by me and all Members, and we are genuinely grateful for their assistance.

I thank my colleagues in the Oireachtas, who are not members of the Joint Committee on Health and Children, for the way they have all discussed the issues and raised their own concerns. Their contributions have been appreciated by their colleagues who are members of the committee. In particular I thank Senators Mullen and Walsh for their assistance in the lead up to the committee meetings and in helping to organise our hearings. I say that most genuinely to them.

I thank my colleagues on the Oireachtas Joint Committee on Health and Children for their dedication and commitment over the past three days. Also, I appreciate the role they have played in the lead up to these hearings. The way these hearings have been conducted reflects the professional approach which is consistently demonstrated at all of our committee meetings.

I hope we have also shown that different political parties and groups can constructively work together. I thank Deputies Kelleher, Ó Caoláin and Conway - Vice Chairman of the committee - as representatives of their respective political parties, along with my Fine Gael colleagues, and Deputy Healy and Senator van Turnhout for the Technical Group and Independent Members. I appreciate the support they have given to the Chair, not just in the past three days, but in the lead-up to the hearings.

A considerable team has helped the Oireachtas Members in preparing these hearings. They have been dedicated, working weekends, including bank-holiday weekends and working long into the night, including past midnight. I thank the clerk, Mr. Paul Kelly, and his team, Ms Paula Cowan, Ms Mary Lindsay and Mr. Colm Duffy, for their efforts and work in the past few weeks and the long days they have had to put in. We very much appreciate that. I also thank the staff from the committee secretariat of the Houses of the Oireachtas, who are not assigned directly to our committee yet gave immense support to the clerk and his team during and in advance of these hearings.

I thank the Superintendent, Captain of the Guard and their ushers for their tremendous co-operation and assistance not just to Members of the House but also to our expert witnesses. I thank the staff in the Editor of Debates office, broadcasting and communications units, our sound engineers and the staff of the Library & Research Service for their support. I also thank our consultant, Mr. Michael O' Sullivan, who has been working with us and will continue to do so next week when we go through the written submissions. I also thank the members of the parliamentary legal service for their support and members of the media, who have been here in large numbers for the past three days and have broadcast our proceedings. I thank the Seanad office, the Seanad CPP, the Cathaoirleach and the Leader for allowing us to use this august Chamber as a fitting venue for what we have been doing over the past three days. I thank all of our witnesses and Members for their exemplary conduct, and the thoughtful and respectful way they have made their contributions.

The committee will now compile a report on our hearings and the many written submissions we have received. When this report is completed it will then be presented to Government for its consideration. I hope and I trust that these hearings will provide much assistance in the final drafting the Bill which will be presented to the Oireachtas. I thank the Minister, Deputy Reilly, the Minister of State, Deputy White, and officials from the Department of Health.

I again thank everybody for their participation and their continued work in our committee.

The joint committee adjourned at 7.35 p.m. until 9.30 a.m. on Thursday, 23 May 2013.

Appendix 3

Draft Heads of Protection of Life during Pregnancy Bill 2013

GENERAL SCHEME OF THE

Protection of Life during Pregnancy Bill 2013

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Head 1 Interpretation

(1) In this Act-

"Appropriate location" means any premises which is carried on by the Executive or by a person with whom the Executive has entered into an arrangement for the provision of a health and personal social service under section 38 of the Health Act 2004 and which are, either wholly or partly, used for the care and treatment of

(a) pregnant women in relation to pregnancy, childbirth and post-partum care, and
(b) neonates.

"Executive" means the Health Service Executive;

"implantation" means implantation in the womb of woman;

"medical procedure" includes the provision of any drug or any medical treatment;

"midwife" means a person whose name is registered in the midwives division of the register of nurses and midwives established under section 46 of the Nurses Act 2011;

"Minister" means the Minister for Health;

"neonate" means a baby who is 4 weeks old or younger;

"nurse" means a person whose name is registered in the nurses division of the register of nurses and midwives established under section 46 of the Nurses Act 2011;

"obstetrician/gynaecologist" means a medical practitioner who is registered in the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007 under obstetrics/gynaecology;

"psychiatrist" means a medical practitioner who is registered in the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007 under psychiatry;

"reasonable opinion" means an opinion formed in good faith which has regard to the need to preserve unborn human life as far as practicable;

"registered medical practitioner" means a medical practitioner whose name is entered in the register of medical practitioners established under section 43(1) of the Medical Practitioners Act 2007;

"relevant specialty" means a medical specialty listed in the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007, and relevant to the threat to the life of the pregnant woman;

"review committee" means a committee established under head ~~7~~ 6;

"unborn" as it relates to human life means following implantation until such time as it has completely proceeded in a living state from the body of the woman.

"woman" means a female person of any age.

Explanatory Notes

Subhead (1) provides the necessary definitions.

"Appropriate location"
The Minister believes that the State's constitutional obligation and its responsibility to act in the common good demand that, provision of terminations of pregnancy be only allowed in health care facilities providing obstetric and mental health services and where relevant specialists are attached**,** that can be duly monitored and investigated, should the need arise.

At present the regulation of obstetric units falls under the Registration of Maternity Homes Act 1934 and the Health Act 2007. The 1934 Act provides for a system of registration for maternity homes and for the keeping of certain records, administered by the Health Service Executive (HSE). It is due to be repealed under the proposed modern licensing system for all acute hospitals. In the meantime, under Section 8 of the Act, HIQA sets standards on safety and quality in relation to services directly provided by the HSE and bodies funded by the HSE to provide services on its behalf (i.e. the public health service). It is the Minister's view that the 2007 Act offers scope for oversight of terminations of pregnancy permitted under the Bill and consistent with our obligations under Article 40.3.3.

The relevant medical treatment, therefore, may only be provided in public obstetric units except in emergencies for the following reasons:

1) HIQA can monitor their compliance with standards on safety and quality
2) HIQA can carry out investigations as to the safety, standards and quality of public obstetric units
3) The Minister can request HIQA to carry out investigations as to the safety, standards and quality of public obstetric units

There are currently 19 public obstetric units across the country. Sixteen of them are managed by the Health Service Executive, and three are voluntary maternity hospitals. The HSE has responsibility for the management and delivery of health and personal social services under the Health Act 2004. It delivers services itself and it can also, under section 38 of the Act, enter into an arrangement with other agencies to provide services on its behalf. This would include the three voluntary maternity hospitals.

The HSE and agencies providing services under section 38 on behalf of the HSE come within HIQA's remit and the remit of the Mental Health Commission.

"Implantation" means implantation in the womb of a woman. This definition aims to exclude the treatment of ectopic pregnancies and emergency contraception from the scope of this Bill.

Other than in emergency situations, doctors who can certify in regard to a real and substantial risk to the woman of loss of life that can only be averted by a medical procedure in the course of which or as a result of which unborn human life is ended must be registered by the Medical Council in its Specialist Division. **"Relevant**

speciality", "obstetrician/gynaecologist" and **"psychiatrist"** are terms used in the Bill in connection with the certification process. **"Relevant specialty"** is defined with reference to specialist knowledge to ensure doctors involved in the certification process have a high level of knowledge and skills but it is not further limited in order to ensure that all clinical specialities that might be relevant are included in the definition. In relation to the definitions of **"obstetrician/gynaecologist"** and **"psychiatrist"**, again it is considered that Specialist registration is required in order to ensure that all doctors involved in certification procedures fulfil precise and formal criteria as regards levels of knowledge and skills. Further detail on certification is given in Head 2, 3, and 4.

"Reasonable opinion"

The definition of "reasonable opinion" requires that this opinion must be formed in good faith and must have regard to protect and preserve unborn human life where practicable. The registered medical practitioner(s) will be obliged to record this opinion in writing if certifying a procedure that will end unborn human life. This definition is intended to place a duty on certifying medical practitioners to preserve the life of the unborn as far as practicable, and is influenced by the Twenty-fifth Amendment of the Constitution (Protection of Human Life in Pregnancy) Bill 2001 (section 1).

The Bill provides that terminations permitted under the Bill may only be carried out by registered medical practitioners. **"Registered medical practitioner"** means a doctor registered by the Medical Council, under the Medical Practitioners Act 2007, which indicates a person permitted by law to practice as a medical practitioner in the State. In the performance of their professional activities, all such medical practitioners are, as a matter of law, subject to the ethical and professional control of the Medical Council. It is not intended that it should be possible for a person other than a qualified doctor to undertake the procedures involved in this Bill.

'**Unborn**' The definition suggested above is based on the Supreme Court judgment in *Roche v Roche & Others*[1] which deemed that embryos acquire legal protection under Article 40.3.3 of the Constitution only from the moment of implantation. This definition of 'unborn' protects the foetus from implantation until birth, including a foetus in the course of being born, thereby closing off a potential legal irregularity in legislation identified by the Expert Group in its report on the *A,B,C v Ireland* Judgement.

[1] [2012] IRRM 411.

Head 2 Risk of loss of life from physical illness, not being a risk of self destruction

Provide that

(1) It is not an offence to carry out a medical procedure, in accordance with this head, in the course of which or as a result of which unborn human life is ended, where –

(a) that procedure is carried out by a registered medical practitioner at an appropriate location, and
(b) two medical practitioners, have, in accordance with this head, jointly certified in good faith that –

(i) there is a real and substantial risk of loss of the pregnant woman's life other than by way of self-destruction, and

(ii) in their reasonable opinion this risk can be averted only by that medical procedure.

(2) One of the two medical practitioners referred to in *paragraph (b)* of *subhead (1)* shall be an obstetrician/gynaecologist, who must be employed at that location, and one shall be a medical practitioner who is registered on the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007 under a relevant specialty.

(3) (a) In forming their opinion, at least one of the two medical practitioners referred to in paragraph (b) of subhead (1) shall consult with the pregnant woman's general practitioner where practicable.
(b) In forming the aforesaid opinion both medical practitioners should examine the woman.

(4) Where two medical practitioners referred to in *subhead (2)* have jointly certified an opinion referred to in *paragaph (b)* of *subhead (1)*, the certifying obstetrician/gynaecologist referred to in subhead (2) shall forward the certificate to a location referred to in paragraph (a) of subhead (1) and shall make arrangements for carrying out the procedure at that location.

(5) It will always be a matter for the patient to decide if she wishes to proceed with a termination following a decision that it is permissible under this Act.

Explanatory Notes

Head ~~3~~ 2 provides that it is not an offence to carry out a medical procedure in the course of which or as a result of which unborn human life is ended. The criteria are those laid out in the *X* case judgment, where a termination of pregnancy is permissible if it is established as a matter of probability that:

1) there is a real and substantial risk to the life of the mother; and
2) this risk can only be averted by the termination of her pregnancy.

Under subhead (1), a termination is lawful if each of the following requirements is met:

(1) the termination is carried out in an appropriate location, i.e. a public obstetric unit. There are currently 19 public obstetric units around the country.

(2) the procedure is undertaken by a registered medical practitioner

(3) two registered medical practitioners qualified to act under the legislation have jointly certified their opinion that there is a real and substantial risk to the life of the mother arising from a physical illness, not being a risk of self-destruction, and this risk can only be averted by the termination of her pregnancy.

The Supreme Court judgment in the *X* case indicated that it is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate, as this approach insufficiently vindicates the pregnant woman's right to life.

Looking to other areas of medical practice, the case of involuntary detention under the Mental Health Act 2001 provides guidance in that, given the serious consequence arising from the medical assessment, the opinion of more than one doctor is required. In light of the fundamental constitutional rights involved in this clinical decision-making process, i.e. the right to life of the pregnant woman and of the unborn, subhead (1) provides that two doctors will be required to form an opinion and jointly certify that a termination of pregnancy is required to avert a real and substantial risk to the life of the mother. Subhead (2) provides that one doctor must be an obstetrician/gynaecologist, while the other medical practitioner must be of a specialty relevant to the clinical assessment of the woman. One of these medical practitioners must be employed at the location where the termination is due to take place.

The Bill does not specify that the two doctors examine the woman together or that they examine the woman at the same location. It is expected that a decision would be reached following a multi-disciplinary discussion in accordance with medical best practice.

In light of this approach, the general scheme is silent on how the certification may come about. Clinical scenarios where the *X* case criteria might apply are bound to be complex. Due to the unpredictability and complexity of these rare medical cases it was felt not desirable to provide in legislation for a specific referral pathway. Rather, it is deemed that standard medical practice will provide an appropriate mechanism for the process through which an assessment would be accessed.

In this regard, it is important that professional guidance is developed by the relevant professional Colleges for their members on the operation of this legislation. In order to facilitate this and to ensure its timely development, the Department of Health will support and work very closely with all the relevant professional bodies (particularly, the Institute of Obstetrics and Gynaecology, the Royal College of Physicians and the Irish College of General Practitioners) in developing guidelines for their members on the implementation of the legislation following enactment of the Protection of Life during Pregnancy Bill. Steps have already been taken to establish the willingness of these Professional Medical bodies to work with the department on such guidance.

As mentioned in the Interpretation, it is considered that Specialist registration is required to ensure that all doctors involved in certification procedures fulfil precise and formal criteria as regards their levels of knowledge and skills.

Subhead 2 provides details on the professional expertise of the relevant certifying medical practitioners. Except in emergency circumstances, an obstetrician/gynaecologist will always be one of the certifying medical practitioners.

This provision is deemed appropriate for two reasons. Firstly, in accordance with current clinical practice, an obstetrician/gynaecologist is obliged to care for the pregnant woman and the foetus and, therefore has a duty of care to both patients and to have regard to protecting the right to life of the unborn and to bring that to bear on the care of the woman and her unborn child. Secondly, a termination of pregnancy will most likely be carried out by, or under the care of, an obstetrician/gynaecologist, and therefore their inclusion here should be central in accessing services and ensuring patient safety.

As the Expert Group's Report indicated General Practitioners often have a long-term relationship with their patients and, therefore, it may be appropriate that GPs are consulted as a matter of best practice in the course of the diagnostic process. This would provide access to their knowledge of the patient and establish continuity of care for the woman after the treatment has been delivered.

The aim of subhead (4) is to ensure that following certification of medical opinion, a woman can then access this treatment in the usual way, i.e. through referral by the appropriate specialist.

Subhead (1)(b)(ii) refers to a 'reasonable opinion'. This is defined in the Interpretation to mean an opinion formed in good faith, which has regard to the need to preserve unborn life where practicable. Again, as outlined earlier, this definition is intended to place a duty on certifying medical practitioners to preserve the life of the unborn as far as practicable, and is influenced by the Twenty-fifth Amendment of the Constitution (Protection of Human Life in Pregnancy) Bill 2001 (section 1). This emphasis on preserving unborn human life as far as practicable governs the actual medical procedure – the termination of pregnancy only and not whether there is a real and substantial risk to the life of the mother.

In circumstances where the unborn may be potentially viable outside the womb, doctors must make all efforts to sustain its life after delivery. However, that requirement does not go so far as to oblige a medical practitioner to disregard a real and substantial risk to the life of the woman on the basis that it will result in the death of the unborn.

Essentially the decision to be reached is not so much a balancing of the competing rights- rather, it is a clinical assessment as to whether the mother's life, as opposed to her health, is threatened by a real and substantial risk that can only be averted by a termination of pregnancy.

Head 3 Risk of loss of life from physical illness in a medical emergency

Provide that

(1) It is not an offence to carry out a medical procedure, in accordance with this head, in the course of which or as a result of which unborn human life is ended, where –

(a) that procedure is carried out by a medical practitioner,

(b) he or she in good faith believes that there is an immediate risk of loss of the pregnant woman's life other than by way of self-destruction, and

(c) the medical procedure is, in his or her reasonable opinion, immediately necessary to save the life of the woman.

(2) The opinion referred to in *subhead (1)* shall be certified by the registered medical practitioner referred to in *subhead (1)* in the form and manner prescribed by the Minister.

Explanatory Notes

The Bill must also take account of medical emergencies, while setting clear and appropriate parameters. These provisions apply in cases where the risk to the life of the woman is immediate and are limited to risks arising from physical conditions.

The requirements are set out in subhead 1 and are that:

(1) a registered medical practitioner is of the opinion that the termination is immediately necessary to save the life of the pregnant woman, and issues a certificate to that effect, and

(2) the termination has been undertaken by a registered medical practitioner.

Doctors should not be prevented from saving a woman's life in a situation of acute emergency, because, for example, the required numbers of doctors are not available to certify or the woman in question arrives at a health facility that is not covered as an appropriate location under this Bill i.e. not a public obstetric unit. Therefore, in emergency circumstances, the reasonable opinion of one medical practitioner is required to certify that the termination is immediately necessary to save the life of a pregnant woman, but the medical practitioner who carries out the procedure will be required to certify the reasons for his/her actions, and notification of all emergency terminations will be sent to the Minister. Again, this opinion must be formed in good faith and have regard to the need to preserve unborn life where practicable. Because of its emergency nature, this termination may be carried out in a location other than a public obstetric unit.

Head 4 Risk of loss of life from self-destruction

Provide that

(1) It is not an offence to carry out a medical procedure, in accordance with this head, in the course of which or as a result of which unborn human life is ended, where –

(a) that procedure is carried out by a registered medical practitioner at an appropriate location,

(b) one obstetrician/gynaecologist, who must be employed at that location, and two psychiatrists, both of whom shall be employed at a centre which is registered by the Mental Health Commission, and one of whom shall be attached to an institution where such a procedure is carried out, in accordance with this head, jointly certified in good faith that –

(i) there is a real and substantial risk of loss of the pregnant woman's life by way of self-destruction, and

(ii) in their reasonable opinion this risk can be averted only by that medical procedure.

(2) (a) At least one of the three medical practitioners referred to in paragraph (b) of subhead (1) shall consult with the pregnant woman's general practitioner where practicable.

(b) In forming the aforesaid opinion, the medical practitioners should examine the woman.

(3)Where three medical practitioners referred to in this head have jointly certified an opinion referred to in *paragraph (b)* of *subhead (1*), the certifying obstetrician/gynaecologist referred to in paragraph (b) shall forward the certificate to a location referred to in *paragraph (a)* of *subhead (1)* and shall make arrangements for the carrying out of the procedure at that location.

(4) It will always be a matter for the patient to decide if she wishes to proceed with a termination following a decision that it is permissible under this Act.

Explanatory notes

Head 4 is concerned with risk of loss of life from self destruction. The criteria are again based on the judgment in the *X* case, this time focusing on cases where a termination of pregnancy is permissible if it is established as a matter of probability that:

1) there is a real and substantial risk to the life of the mother arising from suicide intent; and
2) this risk can only be averted by the termination of her pregnancy.

It is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate as this approach insufficiently vindicates the pregnant woman's right to life.

This head provides that three doctors are required to form an opinion and jointly certify that a termination is required to avert a real and substantial risk to the life of the mother. This provision arises from the recognised clinical challenges in accurately assessing suicidal intent, and the absence of objective clinical markers. In these cases the Bill provides that the opinion will be jointly certified by an obstetrician/gynaecologist and two psychiatrists. Both of these psychiatrists must be employed in a hospital or other in-patient facility for the care and treatment of persons suffering from mental Illness or mental disorder registered by the Mental Health Commission under the Mental Health Act 2001. Also, one of these shall be attached to the institution where such a procedure is carried out.

The Bill does not specify that the three doctors examine the woman together or that they examine the woman at the same location. It is expected that a decision would be reached following a multi-disciplinary discussion in accordance with medical best practice.

In light of this approach, the general scheme is silent on how the certification may come about. Clinical scenarios where the *X* case criteria might apply are bound to be complex. Due to the unpredictability and complexity of these rare medical cases it was felt not desirable to provide in legislation for a specific referral pathway. Rather, it is deemed that standard medical practice will provide an appropriate mechanism for the process through which an assessment would be accessed.

As mentioned in the Interpretation, it is considered that Specialist registration is required to ensure that all doctors involved in certification procedures fulfil precise and formal criteria as regards their levels of knowledge and skills.

As the Expert Group's Report indicated General Practitioners often have a long-term relationship with their patients and therefore have in-depth knowledge of a patient's personal circumstances. The GP may be able to provide valuable insight into her clinical history; knowledge which might be particularly useful when assessing a real and substantial risk to life through suicide. Therefore, it may be appropriate that GPs are consulted as a matter of best practice in the course of the diagnostic process. This would provide access to their knowledge of the patient and establish continuity of care for the woman after the treatment has been delivered. In this regard, it is important that professional guidance is developed by the relevant professional Colleges for their members on the operation of this legislation. In order to facilitate this and to ensure its timely development, the Department of Health will support and work very closely with all the relevant professional bodies (particularly the Irish College of Psychiatry, the Institute of Obstetrics and Gynaecology, and the Irish College of General Practitioners) in developing guidelines for the their members on the implementation of the legislation following enactment of the Protection of Life during Pregnancy Bill. Steps have already been taken to establish the willingness of these Professional Medical bodies to work with the department on such guidance.

The aim of subhead (3) is to ensure that following certification of medical opinion, a woman can then access this treatment in the usual way, i.e. through referral by the appropriate specialist.

Subhead (1)(b)(ii) refers to a 'reasonable opinion'. This is defined in the Interpretation to mean an opinion formed in good faith, which has regard to the need preserve unborn life where practicable. Again, as outlined earlier, this definition is intended to place a duty on certifying medical practitioners to preserve the life of the unborn as far as practicable, and is influenced by the Twenty-fifth Amendment of the

Constitution (Protection of Human Life in Pregnancy) Bill 2001 (section 1). This emphasis on preserving unborn human life as far as practicable governs the actual medical procedure – the termination of pregnancy only and not whether there is a real and substantial risk to the life of the mother.

In circumstances where the unborn may be potentially viable outside the womb, doctors must make all efforts to sustain its life after delivery. However, that requirement does not go so far as to oblige a medical practitioner to disregard a real and substantial risk to the life of the woman on the basis that it will result in the death of the unborn.

Essentially the decision to be reached is not so much a balancing of the competing rights- rather, it is a clinical assessment as to whether the mother's life, as opposed to her health, is threatened by a real and substantial risk that can only be averted by a termination of pregnancy.

Head 5 Medical opinion to be in the form and manner prescribed by the Minister

(1) A medical opinion referred to in *heads* 2, 3*, or 4* shall be given in the form and manner prescribed by the Minister.

Explanatory Notes

This head provides that medical opinions in heads 2, 3, or 4 must be certified in the form and manner prescribed by the Minister. This is intended to allow proper documentation of the certification process.

Head 6 Formal Medical Review Procedures

(1) Where a medical practitioner qualified to certify in accordance with head 2 or as the case may be head 4 has been consulted by a pregnant woman in relation to whether there is a real and substantial risk of loss to her life that can only be averted by a medical procedure in the course of which or as result of which unborn human life may be terminated and the practitioner is not of an opinion referred to in head 2 or head 4, he or she shall inform the pregnant woman that she may make an application as set out in *subhead* (2) of this head.

(2) A pregnant woman or a person on her behalf with her consent may apply in writing to the HSE in the form and manner prescribed by the Minister to have her case reviewed if she has consulted a medical practitioner qualified to certify in accordance with head 2, or as the case may be, head 4, and the medical practitioner is not of the opinion referred to in those heads or has not given an opinion in relation to the matter.

(3) The Executive shall establish and maintain a panel of medical practitioners meeting the requirements in relation to certification under head 2 and head 4 and of sufficient size and composition for the purposes of a review referred to in *subhead (2)* on the nomination of

(a) Institute of Obstetricians and Gynaecologists
(b) Irish College of Psychiatry
(c) Royal College of Surgeons in Ireland
(d) Royal College of Physicians of Ireland

(4)The Executive shall appoint and authorise one or more of its employees with appropriate qualifications and experience for the purposes of establishing and convening a committee in accordance with subhead 5.

(5) As soon as possible but no later than 7 days after receiving a completed written application in accordance with *subhead* (2), an authorised person referred to in *subhea*d (4) shall establish and convene a committee drawn from the panel established and maintained by the Executive under *subhead* (3).

(6) As soon as possible but no later than 7 days after having been convened in accordance with subhead (5), the committee shall review the case and shall form an opinion in good faith as to whether or not there is a real and substantial risk of loss of life of the pregnant woman that can only be averted by a termination of her pregnancy.

(7) Notification in the form and manner prescribed by the Minister of the outcome of the committee's review shall be given to
(a) the woman who made the application and if applicable the person who made the application on her behalf and
(b) the Executive.

(8) A medical practitioner may not be a member of a committee established and convened under *subhead* (5) to review a case where he or she has previously been consulted by the woman who is the subject of the application in relation to whether there is a real and substantial risk of loss of her life that can only be averted by a

medical procedure in the course of which or as a result of which unborn human life is ended.

Explanatory Notes

The establishment of a formal framework providing for an accessible, effective and timely medical review mechanism is one of Ireland's obligations under the judgment in *A, B and C v Ireland.* This formal review pathway is in addition to and not in substitution for the option of the woman seeking a second opinion as with normal medical practice.

The European Court of Human Rights in this judgment emphasised the necessity for a review mechanism in cases in which there is a difference of medical opinion as to whether a woman requires an abortion or when the woman disputes the medical diagnosis. The Court stated that there must a be 'framework' whereby

> '…*any difference of opinion between the woman and her doctors or between different doctors consulted, or whereby an understandable hesitancy on the part of a woman and her doctor, could be examined and resolved through a decision which would establish as a matter of law whether a case presented a qualifying risk to a woman's life such that a lawful abortion might be performed'*.[2]

The judgment in *Tysiąc v Poland* is of particular relevance in setting out the detailed requirements envisaged by the Court. The Court indicated that a right to legal abortion must be supported by procedural safeguards to ensure the law is correctly applied, and the need for such safeguards is particularly acute in cases where there is a disagreement as to whether the preconditions for a legal abortion are satisfied.

The Court stated that 'in such situations the applicable legal provisions must, first and foremost, ensure clarity of the pregnant woman's position'[3]. It continued

> *'In this connection, the Court reiterates that the concepts of lawfulness and the rule of law in a democratic society command that measures affecting fundamental human right be, in certain cases, subject to some form of procedure before an independent body competent to review the reasons for the measures and the relevant evidence... In ascertaining whether this condition has been satisfied, a comprehensive view must be taken of the applicable procedures.. In circumstances such as those in issue in the instant case, such a procedure should guarantee to a pregnant woman at least the possibility to be heard in person and to have her views considered. The competent body should also issue written grounds for its decision.*
>
> *In this connection the Court observes that the very nature of the issues involved in decisions to terminate a pregnancy is such that the time factor is of critical importance. The procedures in place should therefore ensure that such decisions are timely so as to limit or prevent damage to a woman's health which might be occasioned by a late abortion.'*[4]

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[2] *A, B and C v Ireland* at paragraph 253.
[3] *Tysiąc v Poland* at paragraph 116.
[4] *Tysiąc v Poland* at paragraph 117.

In light of the above it would appear that the review mechanism put in place must have, *inter alia*, the following attributes. It must be:

- independent,
- competent to review (i) the reasons for the decision and (ii) the relevant evidence,
- the procedures should include the possibility for the woman to be heard
- it should issue written opinion
- decisions must be timely.

The aim of Head 6 is to make provisions to fulfil the judgment's requirement to set up a formal mechanism to allow a woman to seek a review of her case. The purpose of the review committee is to provide a formal mechanism to review the clinical assessment made by the original treating doctor or team to the effect that a woman does not require a termination in line with the *X* case criteria, or when she has been unable to obtain an opinion in this regard. A duty is placed on the relevant medical practitioner to inform the woman of this formal review option in subhead 1.

Subhead 2 clarifies that recourse to the formal review process should usually be at the request of the woman only but may be initiated on her behalf with her consent. It should also be noted that the intention of the Bill is to confer procedural rights on the person most centrally involved, namely a woman who believes she has a life-threatening condition, so that she can have certainty as to whether or not she requires this treatment. Conferring these procedural rights upon her does not deprive any other person of any right they may enjoy and any person who believes they may have a right to take action will be free to exercise their right of access to the courts to challenge a decision which they believe to be wrong.

Subhead 3 provides for the HSE to establish a panel of relevant experts for the purposes of a formal medical review. Members will be nominated by the Institute of Obstetricians and Gynaecologists, the Irish College of Psychiatry, the Royal College of Surgeons in Ireland, and the Royal College of Physicians of Ireland. The HSE will draw from this panel when it needs to establish a review committee to consider an application made under this Head.

Subhead 4 provides that the HSE must appoint one or more of its employees to act as a Convenor of the formal review process.

Subheads 5 and 6 provide for a response to occur in a timely manner when a request for a medical review is received.

Subhead 8 is intended to ensure that a doctor who has already given an opinion on the case or has been consulted by the pregnancy woman in regard to the case cannot be part of the review of that case.

Head 7 Review where risk arises from physical illness, not being a risk of self destruction

(1) In the case of a pregnant woman who believes there may be a real and substantial risk of loss of her life other than by way of self-destruction, a committee established by an authorised person shall consist of an obstetrician/gynaecologist who must be employed at an appropriate location and one medical practitioner who is registered on the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007 under a relevant specialty.

(2) As soon as possible but no later than 7 days after receiving a completed written application in accordance with *subhead* ~~7~~ 6(2), an authorised person referred to in *subhea*d ~~7~~6(4) shall establish and convene a committee drawn from the panel established and maintained by the Executive under *subhead* ~~7~~ 6(3).

(3) As soon as possible but no later than 7 days after having been convened in accordance with subhead 6(5), the committee shall review the case and shall form an opinion in good faith as to whether or not there is a real and substantial risk of loss of life of the pregnant woman that can only be averted by a termination of her pregnancy.

(4) Notification in the form and manner prescribed by the Minister of the outcome of the committee's review shall be given to

(a) the woman who made the application and if applicable the person who made the application on her behalf, and

(b) the Executive.

(5) Where a committee referred to in *subhead (1)* forms an opinion referred to in head 2, the committee shall jointly certify this opinion in the form prescribed by the Minister and the certifying obstetrician/gynaecologist shall make arrangements for the procedure to be carried out in an appropriate location.

(6) The procedures set out in this Head are without prejudice to Head 3, which shall apply where there is a material deterioration in the health of a pregnant woman such that there is an immediate risk of loss of her life other than by way of self destruction, and thereupon the provision of Head 3 shall apply irrespective of review procedures which are in train.

Head 8 Review in case of risk of loss of life through self-destruction

(1) In the case of a pregnant woman who believes there may be a real and substantial risk of loss of her life arising from self-destruction the committee shall consist of one obstetrician/gynaecologist who must be employed at an appropriate location and two psychiatrists both of whom shall be employed at a centre which is registered by the Mental Health Commission and one of whom shall be employed at an appropriate location.

(2) As soon as possible but no later than 7 days after receiving a completed written application in accordance with *subhead* ~~7~~6(2), an authorised person referred to in *subhea*d ~~7~~6(4) shall establish and convene a committee drawn from the panel established and maintained by the Executive under *subhead* ~~7~~6(3).

(3) As soon as possible but no later than 7 days after having been convened in accordance with subhead 6(5), the committee shall review the case and shall form an opinion in good faith as to whether or not there is a real and substantial risk of loss of life of the pregnant woman that can only be averted by a termination of her pregnancy.

(4) Notification in the form and manner prescribed by the Minister of the outcome of the committee's review shall be given to

(b) the woman who made the application and if applicable the person who made the application on her behalf and

(b) the Executive.

(5) Where a committee referred to in *subhead (1)* forms an opinion referred to in head 4, the committee shall jointly certify this opinion in the form prescribed by the Minister and the certifying obstetrician/gynaecologist shall make arrangements for the procedure to be carried out in an appropriate location.

Head 9 General provisions for Committee
(1) A committee established under head 6 to review a case, or an authorised person at its request, may direct in writing any relevant medical practitioner to produce to the committee any document or thing in his or her possession or control that is specified in the direction.

(2)The committee or an authorised person at its request may direct in writing any medical practitioner to attend before it on a date and at a time and place specified in the direction.

(3) At her request, the committee shall enable

(a) a woman who has made an application or on whose behalf an application has been made, or
(b) a person on her behalf,

to be present at a meeting of the Committee to present her case to the committee.

(4) A person who –

(a) having been directed under *subhead* (2) to attend before the committee without just cause or excuse disobeys the direction,
(b) fails or refuses to send any document or things legally required by the committee under *subhead* (1) to be sent to it by the person without just cause or excuse,

shall be guilty of an offence and shall be liable on summary conviction to a class C fine (not exceeding €2,500).

(5) Summary proceedings for an offence under *subhead* (3) may be brought and prosecuted by the HSE.

(6) A member of a committee established under head 6(5) shall be paid by the Executive out of funds at its disposal, remuneration and allowances for expenses, if any determined under *subhead* (8) .

(7) A medical practitioner who attends a review committee under subhead (2) shall be paid by the Executive out of funds at its disposal, remuneration and allowances for expenses, if any determined under *subhead* (8).

(8) With the consent of the Minister for Public Expenditure and Reform, the Minister may determine the remuneration and allowances for expenses, if any, payable to members of a review committee and medical practitioners attending a review committee under *subhead* (2).

Explanatory Notes

Head 9 aims to empower the review committee to obtain whatever manner of clinical evidence it requires to reach a decision, and to call any relevant medical practitioners to give evidence in person and to vindicate a woman's right to present her case at the meeting of the Review Committee or someone authorised on her behalf. The wording in this head has been adapted from the Mental Health Act 2001. The penalties for not complying with any direction issued by the Review Committee have

also been adapted from the Mental Health Act 2001 and the corresponding penalties for not complying with directions issued in relation to a mental health tribunal contained therein. It is intended that bringing of prosecutions in this regard would be a matter for the HSE.

Head 10 Formal medical review reports to Minister
(1) The Executive shall in each year, at such times and in such manner as the Minister may determine, provide the Minister with a general report on applications made during the previous year indicating

(a) the total number of applications received
(b) the number of reviews carried out
(c) in the case of reviews carried out, the reason why the review was sought
(d) the outcome of the review and
(e) any other information specified by the Minister.

Explanatory Notes

Head 10 provides that the Executive will have a duty to report annually on the workings of the formal medical review process to the Minister. This information is required to monitor the implementation of the legislation to ensure that the principles and requirements of the system are being upheld. Furthermore, if it were to transpire that all terminations that had taken place had gone through the formal review process, this might indicate that further guidance is required from the professional bodies.

Head 11 Notifications

(1) The person in charge of an appropriate location or other establishment, at which a medical procedure permitted under this Bill is carried out, shall keep a record in the form and manner prescribed by the Minister.

(2) Where a medical procedure permitted under this Bill has been carried out, the person carrying on the business of the premises at which the procedure is carried out, shall, no later than 28 days after the medical procedure has been carried out, notify the Minister of the such procedure and such notification shall include any information as maybe prescribed for this purpose.

(3) No notification under this head shall give the name or address of the woman in respect of whom the termination was carried out.

(4)The Freedom of Information Act 1997 shall not apply to any record under this head.

Explanatory Note

There is a need to keep records on the terminations carried out and the medical reasons that gave rise to the treatment for clinical purposes. This is provided for in *subhead* (1). The intention is that *subhead* (1) will encompass all terminations carried out under the Bill including any terminations carried out in an emergency situation.

Information is also required to inform policy, as well as to ensure that the principles and requirements of the system are being upheld. The Minister must receive notification of all terminations carried out under this Bill.

It is not intended that the Freedom of Information Act 1997 will apply to these records.

Regulation under the Bill will provide that notification of all terminations carried out under this Bill will include the following details:

- Location
- Grounds for termination
- Names of medical Practitioners involved
- Gestation

Head 12 Conscientious Objection

Provides that

(1) Nothing in this Bill shall be construed as obliging any medical practitioner, nurse or midwife to carry out, or to assist in carrying out, a lawful termination of pregnancy.

(2) Nothing in subhead (1) shall affect any duty to participate in treatment under Head ~~4~~3.

(3) No institution, organisation or third party shall refuse to provide a lawful termination of pregnancy to a woman on grounds of conscientious objection.

(4) In the event of a doctor or other health professional having a difficulty in undertaking a required medical procedure, he or she will have a duty to ensure that another colleague takes over the care of the patient as per current medical ethics.

Notes

Article 9(1) of the European Convention on Human Rights states that: "everyone has the right to freedom of thought, conscience and religion…'. An individual's right to conscientious objection is provided for in most ethical guidelines and has existed with good reason for many centuries. The Medical Council *Ethical Guidelines* state:

'10.2 If you have a conscientious objection to a course of action, you should explain this to the patient and make the names of other doctors available to them.

10.3 Conscientious objection does not absolve you from responsibility to a patient in emergency circumstances.'[5]

Similarly, the *Code of Conduct for each Nurse and Midwife* makes reference to an entitlement to conscientious objection that may be relevant to professional practice[6].

However, an individual's right to conscientious objection is not absolute and often has limitations. This is because the right to conscientious objection must be balanced against someone else's competing rights, for example, the right to life in the case of a medical emergency. The balance is reflected by the provisions of the European Convention on Human Rights in which freedom of conscience is qualified by Article 9(2), "Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others".

Subhead 1 provides a right to conscientious objection but clarifies that this right only applies to medical and nursing personnel and pharmacists. It is adapted from section 3 of the Twenty-fifth Amendment of the Constitution (Protection of Human Life in Pregnancy) Bill 2001 as passed by Dáil Éireann. The effect of this provision is that a medical or other health professional will not be obliged to carry out a procedure to which he or she has a conscientious objection, even though it may not constitute an offence under the Bill. In the event of a doctor or other health professional having a difficulty in undertaking a required medical procedure, he or she will have a duty to

[5] Medical Council: 2009, pg. 16.
[6] An Bord Altranais, 2000.

ensure that another colleague took over the care of the patient as per current medical ethics.

Subhead (3) refers to the fact that the right to conscientious objection is a human right and, as such, applies only to individuals and not institutions.

Head 13 Travel and Information

(1) This Act does not limit freedom to travel between the State and another state or freedom to obtain or make available in the State, in accordance with conditions for the time being laid down by law, information relating to services lawfully available in another state.

(2) This Act does not operate to restrict any person from travelling to another state on the ground that his or her intended conduct there would, if occurred in the State, constitute an offence under head 19 of this Act.

Notes

It was decided to include the subheads above 'for the avoidance of doubt'.

Subhead 1 reaffirms the freedom to travel and freedom to information which the People voted to insert into Article 40.3.3 of the Constitution in 1992. The Thirteen and Fourteenth Amendments to the Constitution added a second and third paragraph to Article 40.3.3 of the Constitution so as to ensure that the Article would not be invoked in order to limit either freedom to travel to another state or to obtain or make available, in the State, subject to such conditions as may be laid down by law, information relating to services lawfully available in another state.

Subhead 2 provides that the Bill does not restrict a person from travelling to another state on grounds that their conduct would be illegal, if it occurred in Ireland. Its intention is to address any concerns that a person could be prevented from travelling outside the State to have an abortion, on the grounds that such an abortion would not be legal in Ireland.

Head 14 Regulations

(1)The Minister may make regulations that the Minister considers necessary or expedient for purposes under this Act.

(2) Without limiting the generality of subhead (1), the Minister may make regulations –

(a) for any purpose in relation to which regulations are provided for in this Act,
(b) prescribing any matter or thing referred to in the act as prescribed or to be prescribed, and
(c) generally for the purpose of giving effect to this Act.

(3) A regulation under this head may contain such consequential supplementary and ancillary provisions as the Minster considers necessary or expedient.

Note
This is a standard provision in regard to Ministerial powers to make regulations.

Head 15 Regulations respecting certification of opinions referred to in this Act

(1) Without limiting the generality of head 14, the Minister shall make regulations

- (a) respecting the written form and manner in which an opinion referred to head 2, 3 or 4, and
- (b) respecting the notification where the review committee is not of the opinion referred to in head 2 or 4.

(2) Without limiting the generality of subhead (1), regulations under paragraphs (a) and (b) of that subhead shall specify that certifications shall indicate the clinical reason or reasons for the opinion referred to in head 2, 3 or 4.

Explanatory note

This head requires that certain regulations must be made. Under heads ~~3~~ 2 and ~~19~~ 4, a termination of pregnancy is not an offence where two or three relevant medical practitioners, as specified, have certified that in their reasonable opinion there is a real and substantial risk of loss of life of a pregnant woman and this risk can only be averted by the termination of her pregnancy. In an emergency situation, (head 3) a termination is not an offence when carried out by a medical practitioner when he or she is of the reasonable opinion that the procedure is immediately necessary to save the life of the pregnant woman. This does not apply in situations where the threat to life arises from self destruction. The Minister will be required to make regulations prescribing the form and manner in which these opinions are to be certified by the relevant doctors, or by the doctor acting in an emergency. Regulations will require certificates to indicate the clinical grounds (physical / self-destruction) for the opinion.

The Minister will also be required to make regulations regarding the notification to be given where the review committee is not of the opinion that there is a real and substantial risk of loss of life to a pregnant woman that can only be averted by the termination of her pregnancy.

Head 16 Regulations respecting notifications to the Minister

(1) Without limiting the generality of head 14, the Minister shall make regulations respecting the form and manner information is notified to the Minister under head ~~10~~ 11.

Head 17 Laying of regulations before Houses of the Oireachtas

(1) The Minister shall ensure that every regulation made by the Minister under this Act other than an order under head 11 is laid before each House of the Oireachtas.

(2) Either House of the Oireachtas, by resolution passed within 21 sitting days after the day on which a regulation is laid before it under this head, may annul the regulation.

(3)The annulment of a regulation under subhead (2) takes effect immediately on the passing of the resolution concerned, but does not affect the validity of anything done under the regulation before the passing of the resolution.

Note
This is a standard provision in relation to regulations.

Head 18 Repeal and Consequential Amendments

Provide that

(1) Sections 58 and 59 of the Offences Against the Person Act 1861 are hereby repealed.

Notes
This head provides for the repeal of Sections 58 and 59 of the Offences Against the Person 1861 Act, as they are replaced by the provisions in Head 2 of this Bill.

Section 58 provides for an offence of unlawfully using drugs or instruments to procure a miscarriage. Section 59 provides for an offence of unlawfully supplying or procuring poison or instruments for the purpose of procuring a miscarriage.

In so far as we are aware there is no extant common law offence of abortion which requires abolition.

The need for consequential amendments is being considered. Section 19 of the Health (Family Planning) Act 1979 provides *inter alia* that nothing in the 1979 Act shall be construed as authoring the procuring of an abortion, or the doing of any other thing the doing of which is prohibited by section 58 or 59 of the 1861 Act. The reference to the 1861 Act will require amendment to refer to the current piece of legislation.

Additional subhead being prepared in regard to consequential amendments

Head 19 Offence

Provide that

(1) It shall be an offence for a person to do any act with the intent to destroy unborn human life.

(2) A person who is guilty of an offence under this head is liable on conviction on indictment to a fine or imprisonment for a term not exceeding 14 years or both.

(3) Where an offence under this Act —

(*a*) is committed by a body corporate, by a person purporting to act on behalf of a body corporate or by an individual or an unincorporated body of persons, and
(*b*) is proved to have been committed with the consent or approval of, or to have been attributable to any neglect or connivance on the part of, any person who, when the offence was committed, was—
(i) a director, member of the committee of management or other controlling authority of the body concerned, or
(ii) the manager, secretary or other officer of the body concerned,

that person shall also be deemed to have committed the offence and may be proceeded against and punished accordingly.

(4) A prosecution for an offence under this head may be brought only by or with the consent of the Director of Public Prosecutions.

Explanatory Notes

This section restates the general prohibition of abortion in the State in clear, modern terms. It seeks to bring legal clarity to the existing situation; it does not confer any new substantive rights to a termination of pregnancy. Its provisions will replace and update those in sections 58 and 59 of the Offences against the Person Act 1861.

Subhead (1) protects the right to life of the unborn by prohibiting any act that would intentionally destroy unborn human life in a pregnant woman.

Penalties are provided for in subhead (2). There is a penalty of up to 14 years in prison or an unlimited fine, or both, for a person who intentionally performs or effects an abortion. Due to the gravity of the crime a maximum of 14 years in prison is considered an appropriate penalty. Other offences subject to a maximum of 14 years include the offence of assisting the commission of a suicide (Criminal Law (Suicide) Act 1993), and assaults causing serious harm (section 4 of the Non-fatal Offences against the Person Act 1997).

The penalty of up to 14 years imprisonment may apply to any person, including the pregnant woman. While it is recognised that the potential criminalisation of a pregnant woman is a very difficult and sensitive matter, this provision reflects the

State's constitutional obligation arising from Article 40.3.3. It would also be inequitable to have, as a matter of course, a significant penalty for the person performing a termination but none at all for the woman undergoing the procedure. The sentence to be applied in any particular case is a matter for the Court involved.

The offence applies to an individual and to a body corporate or company. In addition, in the case of a company or body corporate, subhead (3) provides for offences by directors and members of the committee of management or other controlling authority of the body concerned, or the manager, secretary or other officer of the body concerned.

Subhead (4) provides that a prosecution may be brought only by or with the consent of the Director of Public Prosecutions. This is to ensure that frivolous or mischievous cases cannot be brought before the Courts.

Head 20 Commencement – with short title

(1) This Act comes into operation on such day or days as the Minister may appoint by order.

(2) Different days may be appointed under this head for different purposes or different provisions of this Act.

Note
This head is included on the assumption at this stage that the Act is not to come into force on enactment.

Appendix 4

Terms of Reference

a. Functions of the Committee – derived from Standing Orders [DSO 82A; SSO 70A]

(1) The Select Committee shall consider and report to the Dáil on—

(a) such aspects of the expenditure, administration and policy of the relevant Government Department or Departments and associated public bodies as the Committee may select, and

(b) European Union matters within the remit of the relevant Department or Departments.

(2) The Select Committee may be joined with a Select Committee appointed by Seanad Éireann to form a Joint Committee for the purposes of the functions set out below, other than at paragraph (3), and to report thereon to both Houses of the Oireachtas.

(3) Without prejudice to the generality of paragraph (1), the Select Committee shall consider, in respect of the relevant Department or Departments, such—

(a) Bills,

(b) proposals contained in any motion, including any motion within the meaning of Standing Order 164,

(c) Estimates for Public Services, and

(d) other matters

as shall be referred to the Select Committee by the Dáil, and

(e) Annual Output Statements, and

(f) such Value for Money and Policy Reviews as the Select Committee may select.

(4) The Joint Committee may consider the following matters in respect of the relevant Department or Departments and associated public bodies, and report thereon to both Houses of the Oireachtas:

(a) matters of policy for which the Minister is officially responsible,

(b) public affairs administered by the Department,

(c) policy issues arising from Value for Money and Policy Reviews conducted or commissioned by the Department,

(d) Government policy in respect of bodies under the aegis of the Department,

(e) policy issues concerning bodies which are partly or wholly funded by the State or which are established or appointed by a member of the Government or the Oireachtas,

(f) the general scheme or draft heads of any Bill published by the Minister,

(*g*) statutory instruments, including those laid or laid in draft before either House or both Houses and those made under the European Communities Acts 1972 to 2009,

(*h*) strategy statements laid before either or both Houses of the Oireachtas pursuant to the Public Service Management Act 1997,

(*i*) annual reports or annual reports and accounts, required by law, and laid before either or both Houses of the Oireachtas, of the Department or bodies referred to in paragraph (4)(*d*) and (*e*) and the overall operational results, statements of strategy and corporate plans of such bodies, and

(*j*) such other matters as may be referred to it by the Dáil and/or Seanad from time to time.

(5) Without prejudice to the generality of paragraph (1), the Joint Committee shall consider, in respect of the relevant Department or Departments—

(a) EU draft legislative acts standing referred to the Select Committee under Standing Order 105, including the compliance of such acts with the principle of subsidiarity,

(b) other proposals for EU legislation and related policy issues, including programmes and guidelines prepared by the European Commission as a basis of possible legislative action,

(c) non-legislative documents published by any EU institution in relation to EU policy matters, and

(d) matters listed for consideration on the agenda for meetings of the relevant EU Council of Ministers and the outcome of such meetings.

(6) A sub-Committee stands established in respect of each Department within the remit of the Select Committee to consider the matters outlined in paragraph (3), and the following arrangements apply to such sub-Committees:

(*a*) the matters outlined in paragraph (3) which require referral to the Select Committee by the Dáil may be referred directly to such sub-Committees, and

(*b*) each such sub-Committee has the powers defined in Standing Order 83(1) and (2) and may report directly to the Dáil, including by way of Message under Standing Order 87.

(7) The Chairman of the Joint Committee, who shall be a member of Dáil Éireann, shall also be the Chairman of the Select Committee and of any sub-Committee or Committees standing established in respect of the Select Committee.

(8) The following may attend meetings of the Select or Joint Committee, for the purposes of the functions set out in paragraph (5) and may take part in proceedings without having a right to vote or to move motions and amendments:

(*a*) Members of the European Parliament elected from constituencies in Ireland, including Northern Ireland,

(*b*) Members of the Irish delegation to the Parliamentary Assembly of the Council of Europe, and

(*c*) at the invitation of the Committee, other Members of the European Parliament.

b. Scope and Context of Activities of Committees (as derived from Standing Orders [DSO 82; SSO 70]

(1) The Joint Committee may only consider such matters, engage in such activities, exercise such powers and discharge such functions as are specifically authorised under its orders of reference and under Standing Orders.

(2) Such matters, activities, powers and functions shall be relevant to, and shall arise only in the context of, the preparation of a report to the Dáil and/or Seanad.

(3) It shall be an instruction to all Select Committees to which Bills are referred that they shall ensure that not more than two Select Committees shall meet to consider a Bill on any given day, unless the Dáil, after due notice given by the Chairman of the Select Committee, waives this instruction on motion made by the Taoiseach pursuant to Dáil Standing Order 26. The Chairmen of Select Committees shall have responsibility for compliance with this instruction.

(4) The Joint Committee shall not consider any matter which is being considered, or of which notice has been given of a proposal to consider, by the Committee of Public Accounts pursuant to Dáil Standing Order 163 and/or the Comptroller and Auditor General (Amendment) Act 1993.

(5) The Joint Committee shall refrain from inquiring into in public session or publishing confidential information regarding any matter if so requested, for stated reasons given in writing, by—

(a) a member of the Government or a Minister of State, or

(b) the principal office-holder of a body under the aegis of a Department or which is partly or wholly funded by the State or established or appointed by a member of the Government or by the Oireachtas:

Provided that the Chairman may appeal any such request made to the Ceann Comhairle / Cathaoirleach whose decision shall be final.