Houses of the Oireachtas
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An Comhchoiste um Shláinte agus Leanaí

Tuarascáil ar

an mBille um Chosaint na Beatha le linn Toirchis, 2013 (Ceannteidil an Bhille)

Imleabhar 2

Bealtaine 2013

Houses of the Oireachtas

Joint Committee on Health and Children

Report on

Protection of Life during Pregnancy Bill 2013 (Heads of)

Volume 2

31/HHCN/012

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Anthony Kenny

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Barbara Hewson

Bernard Hayes

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Monica O'Reilly

Mrs K Cronin

National Women's Council of Ireland

Neil Johnston

Noel McKervey

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Norma Morrison

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Paul Kelly

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Presentation Sisters

Pro Life Campaign

Prof. Patricia Casey

Pro-Life Cork-North West

Rachel Doyle

Ray O'Regan

Raymond Keogh

Rev Dr. Vincent Twomey

Rev Francis Mac Ateer

Richard Boyd Barret

Rita O'Connell

Robert Hurley

Rosemary Watters

Salvador Ryan

Sarah Roche

Sean O'Shaughnessy

Shiela

Signatures for Loreto Community School, Milford, Co. Donegal

Siobhan O'Sullivan

Sr Consilio Fitzgerald

Stewart Doyle

Stuart McGovern

Susan Dillon

Suzanne Mahon

Tarlach O'Donnchadha

Terence O'Neill

Teresa Casey

Teresa McDonnell

Teresa Tier

Terminations for Medical Reasons

Tom Ascough

Tom Malone

Tomás Hayes

Tony Ryan

Ursula Nusgen (Dr)

Valentine Bowen

Waterford Concerned Citizens

William Spencer

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Appendix 6 Request for Submissions by Joint Committee

PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013 - REQUEST FOR SUBMISSIONS

The Oireachtas Joint Committee on Health and Children (the Committee) is seeking written submissions from interested individuals and groups in respect of its consideration of the Outline Heads of the ***Protection of Life During Pregnancy Bill 2013.***

Written submissions should be submitted electronically by email (PDF / MsWord or equivalent) and received by Mr Paul Kelly, Principal Clerk, Joint Committee on Health and Children, ***healthandchildren@oireachtas.ie*** not later than 5.00 p.m. on **Wednesday 8th May 2013.**

Submissions should be succinct and to the point and should be of a reasonable size. Submissions should be detailed on a "Head by Head" basis and should not contain any unnecessary or superfluous material that does relate directly to the Heads of Bill, which can be accessed on the Houses of the Oireachtas website via the link at the end of this document.

Submissions and communications should only be sent to the email address above and not to individual members of the Committee. Please note that the Clerk to the Committee will ensure that all members of the Committee receive, in due course, copies of all submissions and communications received.

With and separate from your electronic submission, please include a covering note outlining in brief why you are making a submission. The covering note should also include your name, postal address, email address and contact telephone number.

If you are making a submission as a group/organisation, please supply the name and contact details of the group/organisation and the names and contact details of the officers, if any, of the group/organisation. Please indicate in the covering note if you or your group/organisation are prepared to appear and discuss your submission with the Committee in Public Session at a future Committee meeting. (Public Hearings to be scheduled for mid May 2013).

NB: The submission itself must contain the following, in the following order:-

1. A brief introduction outlining any experience you or your group have or any work that you or your group have engaged in that is relevant to this issue.
2. An **executive summary** of your submission. (1-2 pages maximum)
3. A list of recommendations you or your group would like to be considered by the Committee. These should be summarised in the executive summary, on a "Head by Head" basis.
4. The main body of your submission. This should be concise and to the point and should highlight any factual information or commentary that you or your group have to offer on a "Head by Head" basis. The Committee may draw conclusions from this information and may put it to other witnesses or parties for their comments.

Please also ensure that the submission itself is signed and dated by you or by an authorised officer of the group making the submission. In the case of a submission submitted by a group of individuals, it should be signed by all the individuals represented by the submission.

The Committee will consider all submissions received in Private Session or in Public Session at its own discretion. The Committee will not disclose details of its considerations in Private Session.

The Committee, at its own discretion, shall invite a number of witnesses to address it in due course. The Committee reserves the right to invite the authors of certain submissions, as it so decides, but also to invite other witnesses on its own initiative. The Committee reserves the right not to discuss its reasons for inviting or not inviting any given witnesses to address it.

The Committee is not obliged to discuss your submission with you. The Committee may publish any submission it receives, but it is not obliged to do so. This is totally at the discretion of the Committee and you should be aware that the Committee may publish your submission either as part of a Committee Report or separately, at its own discretion. **All submissions shall be deemed eligible for publication unless the author of the submission clearly indicates that it should be treated as confidential and not for publication.**

A more detailed document (Ms Word version) outlining the guidelines for making a written submission is available at the following link:-

http://www.oireachtas.ie/parliament/media/committees/factsheets/Fact-Sheet-5--Making-Submissions-and-Presentations-to-Oireachtas-Committees.doc

For information purposes only, a link to the Joint Committee's Report on Public Hearings on the Implementation of the Government Decision following the publication of the Expert Group Report on A, B, and C vs Ireland is accessible at the following link:-

http://www.oireachtas.ie/parliament/oireachtasbusiness/committees_list/health-and-children/

Appendix 7

Submissions Accepted by Joint Committee

Submission to the Oireachtas Joint Committee on Health and Children in respect of its consideration of the General Scheme of the Protection of Life during Pregnancy Bill 2013

May 2013

Introduction

The Abortion Rights Campaign (ARC) is an alliance of pro-choice groups and individuals in Ireland and Northern Ireland who believe that women's lives matter, and women's health matters. Like other personal healthcare decisions, choosing whether to continue with a pregnancy is a decision that should be made between a woman and her doctor. The Abortion Rights Campaign aims to dismantle the many barriers to women's full reproductive rights so that women and their families can make their own decisions, for themselves.

In February 2013, the ARC launched its first major campaign 'Greetings from Ireland: Postcards to your TD'. As part of the campaign, members of the public will send 30,000 postcards to TDs between February and July 2013 reminding them to legislate for X to save women's lives.

The ARC has also engaged in media work on this issue and the organisation of public events to promote abortion rights in Ireland. It is a volunteer-run campaign, supported by small fundraising events and online donations from members of the public.

Executive Summary

The Abortion Rights Campaign (ARC) accepts that the publication of the Heads of Bill for the Protection of Life during Pregnancy Bill 2013 marks a step toward securing access to safe and legal abortion in Ireland. However, ARC is deeply disappointed by several sections of the draft legislation and believes that certain elements of the Bill will still prevent women from accessing their constitutional right. In particular, the campaign is extremely alarmed by the inclusion of the assessment of four doctors (one obstetrician/gynaecologist, two psychiatrists and a general practitioner) for termination when a woman is at risk of suicide, and Head 19, which replaces the relevant sections of the Offences against the Person Act 1861. While X case legislation is a step in the right direction, what remains is the need to repeal the 8th Amendment, to provide for the needs of rape and incest survivors, women carrying unviable foetuses, and others who slip through the cracks of this legislation who will still have to travel to access health care. The ARC will continue to campaign for access to free, safe, and legal abortion in Ireland.

The Abortion Rights Campaign recommends:

Title:

- The Bill should be re-titled the 'Protection of Maternal Life during Pregnancy Bill 2013'

Head 1:

- All references to 'unborn' should be replaced with 'embryo or foetus' in order to bring legal clarity for medical practitioners.
- The legislation should clarify that the 'real and substantial risk' to a woman's life does not need to be inevitable or immediate.

Head 2:

- Reduce from two to one the number of medical practitioners required to certify a termination where there is a risk of loss of life from physical illness, not being a risk of self-destruction, but provide that the medical practitioner may, as an option, consult one colleague.
- Remove the mandatory nature of the requirement for the medical practitioner to consult with the pregnant woman's general practitioner and place in accompanying guidelines as an option for medical practitioners. Availing of this option should not add to delays in treatment.

Importantly, it must be stated that a woman's consent is required before a medical practitioner can contact her general practitioner.

Head 3:

- This section should be extended to include risk of loss of life from self-destruction in a medical emergency.

Head 4:

- Replace the requirement of three medical practitioners to unanimously agree on a suicidal woman's right to a termination with a provision stating that this is a decision between a woman and her doctor, and where a second opinion is needed no more than two medical practitioners (one of which should be a psychiatrist) should be involved in the assessment.

- Expand the qualifying criteria for psychiatrists to include Child Psychiatrists in order to accommodate minors.

- Remove the mandatory nature of the requirement for the medical practitioner to consult with the pregnant woman's general practitioner and place in accompanying guidelines as an option for medical practitioners. Availing of this option should not add to delays in treatment. Importantly, it must be stated that a woman's consent is required before a medical practitioner can contact her general practitioner.

Head 12:

- Include a provision which states that, regardless of any conscientious objection, medical practitioners have a duty to provide treatment to a pregnant woman in emergency situations where no other medical practitioner is available.

Head 19:

- Remove all criminal sanctions against women who have had, or intend to have, abortions.

Head 20:

- The Protection of Maternal Life during Pregnancy Act 2013 should come into force in its entirety on enactment.

Main Body of the Submission

Title

The current title of the Bill does not reflect its purpose, which is the protection of women's lives during pregnancy. The legislation should be re-titled to reflect this.

Recommendation:

- ***The Bill should be re-titled the 'Protection of Maternal Life during Pregnancy Bill 2013'***

Head 1: Interpretation

Given that the aim of this legislation is, as stated by An Taoiseach Enda Kenny, to provide clarity and certainty for both pregnant women and medical practitioners, the definition of 'unborn' should be deleted as it is not a recognised medical term and therefore does not provide clarity for medical practitioners. It should be replaced by 'embryo or foetus'.

The legislation should also highlight that a 'real and substantial risk' to a woman's life need not be inevitable or immediate in order to reassure medical practitioners that they have the flexibility to determine whether, as a matter of probability, there is a real and substantial risk to a woman's life. This is acknowledged in the Explanatory Notes of the Scheme but it is unclear whether it will be clarified in the legislation itself.

Recommendation:

- ***All references to 'unborn' should be replaced with 'embryo or foetus' in order to bring legal clarity for medical practitioners.***
- ***The legislation should clarify that the 'real and substantial risk' to a woman's life does not need to be inevitable or immediate.***

Head 2: Risk of loss of life from physical illness

The Abortion Rights Campaign preference is that the legislation should reduce from two to one the number of medical practitioners required to certify a termination where there is a risk of loss of life

from physical illness, not being a risk of self-destruction. However, ARC acknowledges that, as a matter of good practice, doctors often choose to consult and work in teams and this should remain an option to medical practitioners under the legislation.

The Executive must ensure there are sufficient resources in place to accommodate this. Due to the time-sensitive nature of these matters, a pregnant woman must be able to determine whether or not she is entitled to a termination in an efficient manner. Unnecessary delays could make the difference between a minor medical procedure and a more invasive one.

The mandatory nature of the requirement for the medical practitioner to consult with a pregnant woman's general practitioner should be removed from the legislation and placed in accompanying guidelines as an option for medical practitioners. Availing of this option should not add to delays in treatment. Importantly, it must be stated that a woman's consent is required before a medical practitioner can contact her general practitioner.

Recommendation:

- ***Reduce from two to one the number of medical practitioners required to certify a termination where there is a risk of loss of life from physical illness, not being a risk of self-destruction, but provide that the medical practitioner may, as an option, consult one colleague.***

- ***Remove the mandatory nature of the requirement for the medical practitioner to consult with the pregnant woman's general practitioner and place in accompanying guidelines as an option for medical practitioners. Availing of this option should not add to delays in treatment. Importantly, it must be stated that a woman's consent is required before a medical practitioner can contact her general practitioner.***

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

The Abortion Rights Campaign welcomes this section which states that the reasonable opinion of one medical practitioner is sufficient to certify that a termination is immediately necessary to save the life of a pregnant woman. It is also welcome that such a termination may be carried out in a location other than a public obstetric unit. However, the Abortion Rights Campaign is of the opinion that this provision must be extended to include psychiatric emergencies as there is no medical basis for the

distinction this legislation creates between a medical emergency and a psychiatric emergency. Again, this is necessary in order to bring legal clarity for medical practitioners.

Recommendation:

- ***This section should be extended to include risk of loss of life from self-destruction in a medical emergency.***

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

The requirement to have an already vulnerable woman assessed by at least three medical practitioners, and potentially seven, is cruel, impracticable, and arguably fails to satisfy the European Court of Human Rights judgment in *A, B, and C v Ireland* which states that Ireland has a legal obligation to put in place and implement 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.

The requirement of three medical practitioners (one obstetrician, two psychiatrists) to unanimously agree on a woman's right to a termination should be replaced by a provision stating that this is a decision between a woman and her doctor, and where a second opinion is needed no more than two medical practitioners should be involved in the assessment. This second opinion should come from a psychiatrist as an obstetrician/gynaecologist is not qualified to assess suicide risk. Furthermore, the qualifying criteria for psychiatrists outlined in the Bill should be extended to include Child Psychiatrists who deal with children up to the age of 18.

Combined with Head 8, the requirements outlined in Head 4 are so onerous on suicidal pregnant women that it is likely that a woman with means will travel abroad for a termination, rather than facing the torturous process of being scrutinised by up to seven separate doctors to prove the real risk of ending her life if she is denied access to a termination. As a result, those disproportionately affected by this will be vulnerable women who are unable to travel such as migrants, asylum-seekers, minors, women living in poverty, women who are too ill to travel, and women under the control of abusive partners.

As with risk of loss of life from physical illness, the Executive must ensure there are sufficient resources in place to accommodate this. Due to the time-sensitive nature of these matters, a pregnant

woman must be able to determine whether or not she is entitled to a termination in an efficient manner. Unnecessary delays could make the difference between a minor medical procedure and a more invasive one.

The mandatory nature of the requirement for the medical practitioner to consult with a pregnant woman's general practitioner should be removed from the legislation and placed in accompanying guidelines as an option for medical practitioners. Availing of this option should not add to delays in treatment. Importantly, it must be stated that a woman's consent is required before a medical practitioner can contact her general practitioner.

Recommendation:

- ***Replace the requirement of three medical practitioners to unanimously agree on a suicidal woman's right to a termination with a provision stating that this is a decision between a woman and her doctor, and where a second opinion is needed no more than two medical practitioners (one of which should be a psychiatrist) should be involved in the assessment.***
- ***Expand the qualifying criteria for psychiatrists to include Child Psychiatrists in order to accommodate minors.***
- ***Remove the mandatory nature of the requirement for the medical practitioner to consult with the pregnant woman's general practitioner and place in accompanying guidelines as an option for medical practitioners. Availing of this option should not add to delays in treatment. Importantly, it must be stated that a woman's consent is required before a medical practitioner can contact her general practitioner.***

Head 12: Conscientious Objection

This section should include a provision stating that, regardless of any conscientious objection, medical practitioners have a duty to provide treatment to pregnant women in emergency situations where there is no other medical practitioner available. This is acknowledged in the Explanatory Notes accompanying Head 12, but not specifically referred to in the outline of the Section. The Explanatory Notes state, "[A]n 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 a medical emergency."

Recommendation:

- ***Include a provision which states that, regardless of any conscientious objection, medical practitioners have a duty to provide treatment to a pregnant woman in emergency situations where no other medical practitioner is available.***

Head 18: Repeals and consequential amendments of other Acts

The Abortion Rights Campaign welcomes Head 18 which repeals Sections 58 and 59 of the Offences Against the Person Act 1861.

Head 19: Offences

This section, which outlines a possible penalty of 14 years in prison for illegal abortion in Ireland, is chilling. To threaten women facing this difficult decision with imprisonment is not only wrong in and of itself, but it may prevent women from disclosing information about previous abortions to their doctors, or seeking medical care in the event of complications from an illegal abortion. We know from media reports that women are already ordering medication online in order to terminate pregnancies at home.[1] [2]

Furthermore, given that citizens rejected a proposal to punish unlawful abortions by up to 12 years imprisonment as part of the 2002 referendum on the Twenty-fifth Amendment of the Constitution (Protection of Human Life in Pregnancy) Bill 2001, it is clear that a possible penalty of 14 years imprisonment would be viewed as disproportionate and unduly harsh by a majority of the Irish people.

The prospect of an unlimited fine being imposed on a woman or a medical practitioner is also unacceptable The Abortion Rights Campaign opposes the criminalisation of women who have had, or intend to have, abortions.

[1] 'Women warned of dangers from illegal abortion pills sold online', *The Irish Independent,* September 10th 2012
[2] 'Dublin clinic reports increase in amateur abortions', *The Irish Times,* May 2nd 2013

The Abortion Rights Campaign is further concerned that the interpretation of 'intent to destroy unborn life' as outlined in this section could lead to the investigation of women who present with miscarriages. This section also holds the potential to deter women from seeking medical treatment following a self-induced but incomplete abortion.

The United Nations Special Rapporteur on the Right to Health, Anand Grover, has called for the decriminalisation of abortion stating, "Criminal laws and other legal restrictions on sexual and reproductive health may have a negative impact on the right to health in many ways, including by interfering with human dignity. Dignity requires that individuals are free to make personal decisions without interference from the State, especially in an area as important and intimate as sexual and reproductive health. Criminalisation also generates and perpetuates stigma and restricts the woman's ability to make full use of available sexual and reproductive health-care goods, services and information."[3]

Recommendation:

- ***Remove all criminal sanctions against women who have had, or intend to have, abortions.***

Head 20: Commencement

The Abortion Rights Campaign welcomes the government's commitment to enacting this long overdue legislation before the Dáil adjourns for the summer recess. Given the importance of this legislation, it is recommended that the Act come into force in its entirety on enactment.

Recommendation:

- ***The Protection of Maternal Life during Pregnancy Act 2013 should come into force in its entirety on enactment.***

[3] 'Decriminalisation of abortion highlighted by UN Special Rapporteur in Dublin', NWCI press release, December 17th 2012

Action on X submission to the Oireachtas Joint Committee on Health and Children in respect of its consideration of the General Scheme of the Protection of Life During Pregnancy Bill 2013.

EXECUTIVE SUMMARY / INTRODUCTION

Action on X is a pro-choice advocacy group that campaigns for, as a bare minimum, the enactment of accessible and appropriate legislation that gives full effect to the 1992 judgement of the Supreme Court in the *X Case*. This legislation must include:

- The risk of suicide as grounds for abortion
- No more than the opinion of two doctors to approve an abortion
- Publically funded, state-wide access – near to women's homes
- Provisions for abortion if a foetus has a fatal abnormality and cannot survive
- The decriminalization of abortion.

Action on X accepts that the publication of the General Scheme of the Protection of Life during Pregnancy Bill 2013 (the 'Scheme') on 1st May 2013 represents a significant advance in that it marks the beginning of the very long awaited process of setting out in legislative terms the circumstances under which abortion is permissible in Ireland. Nonetheless, while supportive of the move to introduce legislation we hold very grave concerns around core aspects of legislation. Action on X would argue that the provisions in the Scheme are impractical and fail to address the legal problems identified in the European Court of Human Rights (ECHR) judgement in *A, B and C v Ireland*.

Action on X notes with great disappointment that the Bill as proposed fails to provide legal certainty to women. Indeed, it actually creates obstacles that prevent women from exercising their legal rights. Therefore Action on X calls for the introduction of substantial amendments to ensure that the legislation:

(a) fully meets the needs of women with life-threatening pregnancies
(b) recognises the specific and unique needs of minors
(c) does not add to the distress of women and addresses their needs in a humane and timely manner with respect for human rights, justice and equality

(d) fulfils the ECHR requirement for clarity.

(e) does not criminalise vulnerable women

In our submission we comment first on the context of the Bill, then provide a critique of the proposed legislation, and draw attention to significant omissions from the Bill. We conclude our submission by offering a comment on the Scheme and make specific recommendations for amendments.

CONTEXT

In 1992, in a landmark judgment the Supreme Court ruled that a woman was entitled to a lawful abortion in Ireland when there is "a real and substantial risk to her life", including the risk of suicide. Furthermore, in delivering his judgment in this case Chief Justice Finlay stated that the risk need not be "inevitable or immediate". Two subsequent referendums, in 1992 and in 2002, attempted to exclude suicide as grounds for lawful abortion in Ireland; this was conclusively rejected on both occasions by the electorate. However, due to the failure of six successive governments to set out in legislation the circumstances under which abortion is permissible in Ireland, a dangerous legal vacuum has existed in Ireland for 30 years.

In 2009 three women, known as A, B and C, challenged Ireland's restrictive abortion laws at the European Court of Human Rights. The three applicants, all of whom became pregnant unintentionally, argued that the impossibility of obtaining an abortion in Ireland made the procedure unnecessarily expensive, complicated and traumatic. In particular, they argued that Ireland's restrictive abortion laws stigmatised and humiliated them and risked damaging their health and, in the third applicant's case, her life. The third applicant, Ms C, was in remission from cancer when she became pregnant. Unaware of this she underwent a series of check ups contraindicated during pregnancy. Ms C argued that she could not obtain clear advice about the risks to her own health and life or that of the foetus if she continued to term. The Court ruled unanimously that the lack of clarity in Ireland's abortion law violated Ms C's right to a private and family life as there was no clear framework within which she could determine whether she was entitled to a lawful termination, the

Court stated:

> *The Court considers that the uncertainty generated by the lack of legislative implementation of Article 40.3.3°, and more particularly by the lack of effective and accessible procedures to establish a right to an abortion under that provision, has resulted in a striking discordance between the theoretical right to lawful abortion in Ireland on grounds of a relevant risk to a woman's life and the reality of its practical implementation.*

Therefore, the purpose of any legislation has to be to set out the terms under which abortion is legal in Ireland.

RECOMMENDATIONS

General Note: Where the phrase 'real and substantial risk of loss the pregnant woman's life' occurs, clarification that this risk need not be inevitable nor immediate must be inserted.

General Note: Replace all occurrences of the term 'It is not an offence' with 'It shall be lawful' (or a variant thereof) throughout the Bill.

General Note: Either insert a new dedicated section or embed details in each existing section setting out the duty of care owed to the woman in obtaining treatment option information, availing of treatments and, where applicable, engaging in the review process.

General Note: Insert a new dedicated section delineating the means by which cases of pregnant minors are to be addressed under the terms of the Bill.

Head 1: Delete all reference to 'implantation', including its definition, and substitute 'foetus' (or an appropriate variant thereof) for all references to 'unborn'.

Head 1: Delete the definition for 'reasonable opinion', substitute 'opinion' for 'reasonable opinion' throughout the Bill and delete all uses of 'in good faith' from the Bill.

Head 1: Ensure that any definition of 'unborn' is unambiguous for medical and legal communities alike; does not limit the ability of a women seeking to end a pregnancy due to the presence of a fatal foetal abnormality, should she so choose; and, does not curtail the availability of contraceptives.

Head 1: Delete the definition for 'woman' as it is surplus to requirements should a section dealing specifically with cases concerning minors be introduced to the Bill.

Head 2: Reduce to one the number of clinicians required to certify the appropriateness of a termination as treatment of a risk to the woman's life from physical illness, not being a risk of self destruction.

Head 2: Remove the mandatory requirement that at least one clinician certifying the appropriateness of a termination as treatment of a risk to the woman's life from physical illness, not being a risk of self destruction, contact her general practitioner and reclassify such consultation as an available option.

Head 2: Remove the mandatory requirement that all clinicians certifying the appropriateness of a termination as treatment of a risk to the woman's life from physical illness, not being a risk of self destruction, examine the woman and reclassify such examination as an available option.

Head 3: Ensure that reporting requirements relating to emergency medical interventions be in keeping with standard medical practice in comparable clinical treatments.

Head 4: Reduce the certification requirement where a termination is carried out in relation to a risk of loss of life from self destruction, to one psychiatrist, remove the requirement for the participation of one obstetrician/gynocologist in determinations concerning suicidality, thereby reducing certification requirement to one psychiatrist.

Head 4: Either remove or amend the requirement that psychiatrists involved in certification be employed at a centre registered by the Mental Health Commission to ensure that, where appropriate, child psychiatrists may be qualified to participate in the certification process. Such amendment or removal should not in any way be construed as a requirement to increase the number of clinicians involved in the certification process.

Head 4: Remove the mandatory requirement that all clinicians certifying the appropriateness of a termination as treatment of a risk to the woman's life from self destruction examine the woman and reclassify such examination as an available option.

Head 4: Remove the mandatory requirement that all clinicians certifying the appropriateness of a termination as treatment of a risk to the woman's life from physical illness, not being a risk of self destruction, examine the woman and reclassify such examination as an available option.

Head 5: Specify that the opinion must be communicated to the woman in a fashion consistent with standard medical practice; specify the standard timeframes within which opinions are required to be delivered (while also providing for deviation therefrom in exceptional circumstances); and, specify that record keeping requirements be in line with comparable procedures performed in clinical settings.

Head 6: Specify the standard timeframes within which review committee opinions are required to be delivered (while also providing for deviation therefrom in exceptional circumstances).

Head 6: The period within which the review committee is to be established, convened and within which it delivers its judgement must be reduced to an aggregated total of no more than 3 days. It must also be specified that the decision of the committee be communicated to the woman within that timeframe.

Head 7 & Head 8: Amalgamate Heads 7 and 8 which set out the framework within which a review of a decision under this Bill is to be carried out in order that no difference exists between processes concerning cases of suicidality and physical illness.

Head 11: Ensure that reporting requirements relating to medical interventions under this Bill are in keeping with standard medical practice in comparable clinical treatments.

Head 12: Insert a specific section pertaining to conscientious objection indicating a duty to engage in treatment in emergency situations.

Head 13: Amend all sections of the Regulation of Information (Services Outside the State for Termination of Pregnancies) Act, 1995 that could act to criminalise clinicians in advising women as to the appropriateness of termination as a means of averting a risk to life.

Head 19: Any and all prospects of criminal sanction against women undergoing termination procedures must be removed from the Bill; the standard sanctions pertaining to clinical malpractice ought to apply to clinicians providing unlawful abortion services in the State as opposed to the criminal sanctions set out under this head; and, any other person purporting to carry out unlawful abortion services ought to be subject to criminal prosecution under the terms specified.

Head 20: In light of the lacuna that presently exists in the law pertaining to lawful abortion services in Ireland it is advisable that this Bill commence fully upon enactment.

ACTION ON X RESPONSE TO PROPOSED LEGISLATION

Action on X has a number of specific objections to the proposed legislation which are outlined below:

1. **Abortion is legal in Ireland**

Abortion is legal in Ireland in limited circumstances, yet the Bill fails to clearly state this obvious fact.

The word ‘lawful’ is absent from the Scheme, which instead uses the expression ”It shall not be an offence”. The Bill must explicitly indicate the precise terms and circumstance under which abortion is lawful.

2. Protect women’s lives

The aim and purpose of the Bill is to provide for the protection of maternal life during pregnancy and it seems particularly odd that the purpose of Bill is not reflected in the title. Action on X proposes that objective of the legislation - the protection of woman's life during pregnancy - be clearly stated.

3. No second psychiatrist necessary

There are serious and obvious concerns about the use of a panel of doctors to ascertain suicidal risk. Women in distressed and difficult situations should not be subjected to repeated and intrusive examinations and assessments. There is no medical or clinical justification for a second psychiatrist as this requirement does not apply when a pregnancy is not involved. Only two doctors are required to involuntarily detain a person under the Mental Health Act, i.e. one GP and one Consultant Psychiatrist. This Bill however requires that a woman seeking an abortion arising from the threat of suicide be assessed by three doctors; two psychiatrists and an obstetrician and that they must jointly certify, i.e. be unanimous in their views. The doctors must also consult with the woman’s GP, which necessitates the involvement of a fourth doctor. The absence of a requirement that the woman consent to this consultation is a clear violation of a woman’s right to privacy. If the two psychiatrists concur that the suicidal threat could be averted by a termination, the obstetrician, who has no specialised training in assessing suicidal risk, could, in theory, veto the two psychiatrists.

Action on X recommends that no more than two doctors be required. A woman may appeal the decision of the assessment panel, however this process will again involve three doctors, one obstetrician and two psychiatrists, who are again required to make a unanimous decision. Both the number of doctors – a possible total of seven – and the requirement for unanimity are excessive to the point of rendering the process unworkable and of adding to the distress of the woman.

4. Dangerous timescales

Where doctors refuse to allow a woman an abortion, the woman has a right of appeal. However the legislation fails to specify a system that ensures a clear pathway for the woman and which avoids delays. The entire process as delineated in the Scheme could take up to 21 days. Best international practice is that a decision is made within 3 days. It is well documented that delays in accessing services where a pregnant woman's life is at risk can have significant impacts on her health. These delays could mean the difference between a minor procedure and a more invasive procedure that would involve additional health risks for the woman in question.

5. Arbitrary distinction between mental and physical health

The proposed legislation creates an arbitrary distinction between mental and physical health. The proposed Bill treats medical emergencies and psychiatric emergencies as different. Yet there is no medical or clinical basis for this distinction. Psychiatric emergencies are medical emergencies. It is the opinion of Action on X that this distinction has been made to further the interests of political expediency and not to protect the best interests of women. A crisis causing risk to life, due to risk of suicide arising from unwanted pregnancy, while not a mental illness under the terms of the 2001 Mental Health Act, is of equivalent severity and consequence as any other psychiatric or medical emergency and should be treated as such.

6. Artificial distinction between life and health

The proposed legislation creates an artificial distinction between a woman's life and a woman's health by failing to define a real and substantial risk to a woman's life. This omission also means that the X case judgement is only partially incorporated into the legislation. The Supreme Court ruling in X stated that in order to approve abortion medical practitioners did not have to be of the opinion that a risk to a woman's life was "inevitable or immediate" because to do so would insufficiently vindicate the pregnant woman's right to life. The case of Savita Halappanavar exemplifies the danger that this arbitrary distinction can create. Doctors in this case failed to identify the point at which real and substantial risk to health elided into real and substantial risk to life, the point at which a termination

becomes lawful. This creates inequality of access to medical treatment between women and men, as noted by Minister Alan Shatter on 27th November 2012 during the Second Stage Debate on the Medical Treatment (Termination of Pregnancy in Case of Risk to Life of Pregnant Woman) (No. 2) Bill 2012. Minister Shatter stated that legally, women are denied access to certain treatments (abortion) to protect their health, whereas men face no legal denials to any treatment: "The reality of course is that there is no impediment to men seeking and obtaining any required medical intervention to protect not only their life but also their health and quality of life." This inequality is particularly acute for women who do not have the financial wherewithal or are too ill to travel abroad for an abortion. For these women, permanent damage to health or avoidable shortening of life may be the outcome.

7. Conscientious objection

Action on X argues that conscientious objection clauses in the Bill are inadequate as this clause could be used to withhold access to abortion. Women should be entitled to receive objective medical advice regardless of their doctor's personal views for or against abortion. This is particularly important if the unanimous opinion of three doctors is required to access an abortion in cases where the woman is suicidal. Action on X argues that doctors with a conscientious objection to abortion must be legally required to make their views known to the patient and enable the patient to see another doctor without delay if that is the patient's wish.

8. Criminalisation

The ECHR argued that the existence of criminal penalties for having or assisting in an unlawful abortion created a significant "chilling factor":

> *Against this background of substantial uncertainty, the Court considers it evident that the criminal provisions of the 1861 Act would constitute a significant chilling factor for both woman and doctors in the medical consultation process, regardless of whether or not prosecutions have in fact been pursued under that Act. Both the third applicant and any doctor ran a risk of serious criminal conviction and imprisonment in the event that a decision taken in a medical consultation, that the woman was entitled to an abortion in Ireland given the risk to her life, was later found not to accord with Article 40.3.3°of the*

Constitution.

The fact that the proposed legislation retains criminal penalties for abortion and imposes a 14-year prison sentence will not only maintain the "chilling factor" it will inevitably enforce it. The criminalisation of abortion is incompatible with international human rights norms. Action on X would urge the Committee to take into account that these sanctions could be used against vulnerable women who, for example, buy abortion medication online. This clause essentially brands women as criminals if they obtain abortions in Ireland – yet the government is happy to see it done in Liverpool or London.

OMISSIONS

Action on X notes with particular concern the omission of two issues of great significance.

- **Situation of minors**

One of the most glaring omissions in the proposed legislation is the failure to make special provision for minors by conflating the specific and different need of adults and children. This is particularly curious given that the X case involved a 14-year-old minor. Indeed, child psychiatrists will not meet criteria, as they are not employed in a hospital or inpatient unit; rather they tend to work in outpatient clinics. The legislation also fails to make provision for the needs of adults in care (for example an adult with learning disabilities).

- **Fatal Foetal Abnormality**

The legislation fails to provide for abortion where there is a fatal foetal abnormality incompatible with life. The definition of the unborn in the Bill contradicts the Irish State's own argument to the ECHR where it was accepted that fatal foetal abnormality could be "at least a 'tenable' argument" for abortion. In the D case, the Irish Government argued that: 'there was "at least a tenable" argument which would seriously be considered by the domestic courts to the effect that a foetus 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. In the absence of a domestic decision, it was impossible to foresee that Article 40.3.3 clearly excluded an abortion in the applicant's situation in Ireland.' Several legal experts, including Dr. Simon Mills, have argued that

abortion in terms of fatal foetal abnormality could be permissible under Article 40.3.3 for certain circumstances.

- **Rape and Incest**

We note the omission of any provision for abortion where the woman is a victim of rape or incest. Although the 14-year old child known as X was a victim of rape, these situations do not fall strictly within the parameters of the Supreme Court's interpretation of Article 40.3.3 in the 'X' case. They are however a matter of grave concern and require to be addressed.

ISSUES ARISING HEAD BY HEAD

1. Issues Arising throughout the Scheme

1.1 'Real and substantial risk of loss the pregnant woman's life'

Where the phrase 'real and substantial risk of loss the pregnant woman's life' occurs in the Bill it ought to be made absolutely clear that risk need not be a certainty or inevitability, but rather a possibility. This is consistent with the findings of the Supreme Court in *Attorney General v X and Others*[4] and is also consistent with the position set out in the explanatory notes under Head 2 of the Bill. That explanatory note correctly states that,

> The Supreme Court judgement 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.

[4] [1992] IESC 1; [1992] 1 IR 1 (5th March, 1992)

1.1.1 Recommendation: Where the phrase 'real and substantial risk of loss the pregnant woman's life' occurs, clarification that this risk need not be inevitable nor immediate must be inserted.

1.2 'Lawful' v 'Not an Offence'

The Bill as proposed is termed in language that specifies the circumstances in which the provision of an abortion is not an offence as distinct from when it is lawful. This places a significant onus upon criminality and not only perpetuates the current chilling effect of the Offences Against the Person Act 1861 but reinforces it by setting out the narrow parameters within which abortion is not an offence. It is recommended that all occurrences of the phrase 'it shall not be an offence' but substituted by 'it shall be lawful' in order to move away from a presumption of criminality to a presumption of legality.

1.2.1 Recommendation: Replace all occurrences of the term 'It is not an offence' with 'It shall be lawful' (or a variant thereof) throughout the Bill.

1.3 Duty of Care

There is an absence of a duty of care in respect of a women (including a minor) experiencing a risk to their life that is to be addressed through the termination of pregnancy. The Bill must identify those responsible for the care of the woman, this is particularly the case where minors are concerned, for the provision of information to her regarding her treatment options and how to navigate the system (including the review system).

The absence of a clear duty of care could serve to hinder women in availing of abortion services as, in the absence of a clear pathway for treatment and entitlement to medical attention (as distinct from lack of criminal liability attaching to treatment), the mechanisms being proposed in the Bill may well prove to be overtly difficult or time consuming to access.

The European Court of Human Rights in *A, B and C v Ireland*[5] was instructive in stating that the absence of a mechanism for availing of treatment was the key cause of the Article 8 rights violations experienced by Ms C; any absence of a duty of care that serves to construct delays or barriers to treatment access could well serve to perpetuate similar violations. Thus a clear demarcation of duty of care and the pathway to treatment while absent from the current Scheme must be introduced as a central feature in the Bill.

1.3.1 Recommendation: Either insert a new dedicated section or embed details in each existing section setting out the duty of care owed to the woman in obtaining treatment option information, availing of treatments and, where applicable, engaging in the review process.

1.4 Specific Provision for Minors

It is recommended that a specific section be inserted into the Bill setting out the particulars of how the mechanisms of the Bill are to be applied to cases of minors. This is particularly relevant in light of the X[6] and C[7] Cases of the 1990s wherein both minors had become pregnant as the result of rape and were suicidal as a result of their pregnancies.

Cases of minors experiencing threats to their lives due to pregnancy have their own distinct characteristics and complexities, for example in instances involving the risk of suicide provision must be made for the involvement of a child psychiatrist as opposed to an adult psychiatrist where appropriate. Moreover where a conflict exists, as was so in the C[8] Case, between the wishes of the pregnant minor and her parents, a mechanism must be clearly available wherein the needs and wishes of the minor can be taken account of in an environment conducive to the exercise of her rights.

[5] App No 25579/05 (ECHR, 16 December 2010)
[6] Attorney General v X and Others n1
[7] A and B v Eastern Health Board [1997] IEHC 176; [1998] 1 IR 464; [1998] 1 ILRM 460 (28th November, 1997)
[8] Ibid.

1.4.1 Recommendation: Insert a new dedicated section delineating the means by which cases of pregnant minors are to be addressed under the terms of the Bill.

2. Head 1 - Interpretation

As currently construed, three definitions contained in the Bill are problematic and will require amendment and or deletion.

2.1 'Implantation' and 'Unborn'

As these definitions are interrelated and make reference to one another they will be discussed in tandem.

The use of the term implantation and how it is to be applied according to the definition of 'unborn', it would seem, has been chosen arising from its use in *Roche v Roche & Others*[9] and as such is inappropriate given, *inter alia*, that the Supreme Court made absolutely and unequivocally clear that its deliberations in relation to this case did not concern, nor would it be appropriate for it to concern, an effort to define when life begins.

Roche v Roche & Others[10] specifically concerned the implantation into the womb of frozen embryos, therefore reference to implantation during this case clearly referred to the medical implantation of the embryo into the womb by way of invitro-fertilisation. Incorporating the term "implantation" in the present legislative proposal is ambiguous and could potentially lead to legal uncertainty surrounding the use of contraceptives, particularly emergency contraceptives, as, *inter alia*

1. It is unclear what exactly constitutes implantation, and
2. How, in circumstances other than medical implantation, will it be possible to determine whether a fertilized egg has been implanted into the womb?

[9] [2009] IESC 82 (15 December); This case was taken to determine whether, inter alia, the destruction of viable frozen embryos could be construed as being in violation of the right to life of the unborn articulated in Article 40.3.3° of the Constitution of Ireland.
[10] Ibid.

These definitions are overtly ambiguous in their current state, in particular they seek to use a term, i.e. implantation, used by the Supreme Court for purposes it was never intended, and therefore ought to be removed from the Bill.

Moreover, while it is incumbent upon the Oireachtas to define the meaning of the term 'unborn' it is inappropriate to do so in an ambiguous fashion that will jeopardise the ability of women to access services and treatments currently available to them. The term foetus is a clinically definable term that would suit the purposes of the Bill and would ensure there is no doubt as to the right of the women of Ireland to access contraceptives, including emergency contraceptives.

2.1.1 Recommendation: Delete all reference to 'implantation', including its definition, and substitute 'foetus' (or an appropriate variant thereof) for all references to 'unborn'.

2.2 'Unborn'

Notwithstanding the fact that the position of Action on X as to the term 'unborn' is that it's incorporation into the Irish legal landscape through Article 40.3.3° of the Constitution of Ireland is inappropriate given that it is a political as distinct from a recognised legal or medical term, it is advisable to introduce an element of legal and medical clarity concerning this term.

Any such definition must not act as a barrier to the provision of termination services to women choosing to end a pregnancy due to the presence of a fatal foetal abnormality. Moreover, any such definition must not in any way serve to limit the availability of contraceptives currently available to women in Ireland as such curtailment is statistically proven to heighten the occurrence of crisis pregnancy.

Should it be determined that the present legislation is the appropriate forum through which to introduce a definition of the term 'unborn' into Irish law, this term cannot, as discussed above, be of a generalised and ambiguous nature but rather must add to the certainty in law.

2.2.1 Recommendation: Ensure that any definition of 'unborn' is unambiguous for medical and legal communities alike; does not limit the ability of women seeking to end a pregnancy due to the presence of a fatal foetal abnormality, should she so choose; and, does not curtail the availability of contraceptives.

2.3 'Reasonable Opinion'

The spirit of this definition, and indeed its use throughout the Bill, is of significant concern as its inclusion suggests that clinicians do not usually provide medical opinions in good faith. A clinician that does not make a medical decision 'in good faith' would not be in compliance with standard medical guidelines; therefore the inclusion of this term is not only undesirable but is surplus to requirements.

Moreover, the phrase 'has regard to the need to preserve unborn human life as far as practicable' is problematic in that the very purpose of the Bill is to provide only for abortion where there is a real and substantial risk to the life of the woman. It is made clear in the procedures set out in the Scheme that clinicians may only provide such medical treatment lawfully where this is the case. Thus in specifying that medical decisions under such circumstances must 'have regard to the need to preserve unborn human life' an onus is placed upon clinicians to prioritise that preservation above the risk to life being experienced by the woman. This could potentially serve to foster hesitation and doubt in the minds of clinicians seeking to address the needs of the woman, thereby both undermining the woman's ability to access treatment and clinicians' understanding of the duties and obligations placed upon them under the Bill.

During the course of the hearings held by the Oireachtas Joint Committee on Health and Children concerning the Implementation of Government Decision Following Expert Group Report into Matters Relating to A, B and C v. Ireland[11], it was made clear my Dr. Rhona Mahony, Master of the National Maternity Hospital at Holles Street, that wherever a foetus is viable every effort is made to ensure it is delivered safely. Indeed Dr Mahony was unequivocal on numerous occasions in indicating that it is

[11] Tuesday 8th January 2013, 27

the standard approach of clinicians to strive towards the vindication of the life of the foetus and the woman where that is achievable, thus including the aforementioned phrase in the definition of what constitutes a 'reasonable opinion' fails to take account of current clinical norms and the commitment to the preservation of life that the clinicians of Ireland demonstrate on a daily basis.

The net result of inserting this definition is to embed mistrust in the 'good faith' with which clinicians currently carry out their duties, and to introduce uncertainty for clinicians in navigating the procedures being considered in this Bill. Placing explicit emphasis on the preservation of the life of the foetus when the Bill is in fact concerned with legislating for instances in which the life of the woman is under threat is problematic and likely to complicate matters for clinicians.

2.3.1 Recommendation: Delete the definition for 'reasonable opinion', substitute 'opinion' for 'reasonable opinion' throughout the Bill and delete all uses of 'in good faith' from the Bill.

3. Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

3.1 Section 1(b)

The requirement that two clinicians be involved in determining whether a termination is appropriate for a woman experiencing a risk to life from physical illness is excessive and not in keeping with current clinical norms.

It is standard practice that the opinion of one clinician as to the condition of a patient is sufficient to make a determination; this often includes life threatening situations. It follows that if such clinicians are sufficiently qualified to assess the general and obstetric / gynaecological health of women in regards to any other conditions and or courses of treatment, they must be considered suitably qualified to make such a determination in the context of the circumstances considered in this section.

Nevertheless, it is important to highlight that it is common medical practice for clinicians to consult colleagues in arriving at determinations, particularly in complex and or life-saving situations.

Therefore any reduction in the number of clinicians required to attest to the appropriateness of a termination under this section must not preclude such consultation, it would simply remove the barrier that may be presented by the requirement of shared responsibility for the woman.

3.1.1 Recommendation: Reduce to one the number of clinicians required to certify the appropriateness of a termination as treatment of a risk to the woman's life from physical illness, not being a risk of self destruction.

3.2 Section 3 (a)

The mandatory requirement that at least one of the practitioners in the course of forming their opinion contact the woman's general practitioner must be reclassified as an option available to clinicians subject only to the agreement of the woman; this must not be a requirement of the procedure. While the information that may be derived from a woman's general practitioner may be of use to the clinicians in forming their assessment of her condition and the appropriateness of a termination in addressing a risk to her life, to oblige physicians to make such contact is overtly onerous.

Moreover, should the woman not wish to have her case discussed with her general practitioner for whatever reason that may be, her wishes in this regard must be respected and the opinion formed in the absence of such contact.

3.2.1 Recommendation: Remove the mandatory requirement that at least one clinician certifying the appropriateness of a termination as treatment of a risk to the woman's life from physical illness, not being a risk of self destruction, contact her general practitioner and reclassify such examination as an available option.

3.3 Section 3 (b)

The mandatory requirement that both medical practitioners in forming their opinion examine the woman ought to be an available option but should not be a mandatory element of the procedure. Where complex cases are concerned it is standard practice for clinicians to consult colleagues as to the best course of action and it may also be necessary to call on those colleagues to examine a patient, however the clinicians in question should be trusted to determine whether dual examinations are necessary on a case by case basis.

In removing the requirement of dual examinations, undue delays to the formation of opinions may be avoided in some cases thereby reducing somewhat the stresses placed upon women seeking abortions necessary to avert risk to life. This would also have the net effect of ensuring that clinicians are not obstructed in ensuring that treatment is received by the woman at the earliest time available.

3.3.1 Recommendation: Remove the mandatory requirement that all clinicians certifying the appropriateness of a termination as treatment of a risk to the woman's life from physical illness, not being a risk of self destruction, examine the woman and reclassify such consultation as an available option.

4. Head 3 Risk of Loss of Life from Physical Illness in a Medical Emergency

4.1 Section 2

The requirement that a clinician carrying out a termination to vindicate the life of a woman experiencing a medical emergency furnish the Minister with notification of the procedure and the reasons it was undertaken must be formulated in such a fashion as not to impose an overtly onerous administrative burden on such clinicians. The detail of how this section is intended to be operated is given in the explanatory note therefore it is understood that the precise form of these reporting duties will be set out by way of Ministerial Order.

While it is of course of the utmost necessity to ensure quality of care in the context of acute medical emergencies, the reporting requirements as outlined must be in keeping with standard medical practice relating to comparable treatments.

4.1.1 Recommendation: Ensure that reporting requirements relating to emergency medical interventions be in keeping with standard medical practice in comparable clinical treatments.

5. Head 4 Risk of Loss of Life from Self Destruction

5.1 Section 1(b)

5.1.1 General Notes

The requirement that three clinicians (one obstetrician/gynaecologist and two psychiatrists) be involved in determining whether a termination is appropriate for a woman experiencing a risk to life due to a threat of suicide is excessive and not in keeping with current clinical norms.

The maximum number of clinicians involved in a certification process under the Mental Health Act 2001 is two, this concerns involuntary detention. Thus it is standard practice in instances other than such detention that the opinion of one psychiatrist as to the mental health of a patient is sufficient to make a determination; this includes determinations attaching to suicidality. It follows that if such specialists are sufficiently qualified to assess the mental health of women regarding any other mental health condition and or course of treatment, they must be considered suitably qualified to make such a determination in the context of the circumstances considered in this section.

5.1.2 Child Psychiatrists

Moreover, the requirement that both psychiatrists in question be employed at a centre registered by the Mental Health Commission is likely to pose a barrier to child psychiatrists, the majority of whom

are not employed in such institutions. This is relevant to instances of pregnancy among minors, the most notable example of which is of course that of Ms X[12], a 13 year old girl who having fallen pregnant as the result of rape became suicidal at the prospect of being compelled to continue with that pregnancy. In order to ensure that women such as Ms X are adequately provided for in the Bill the requirement that psychiatrists be employed in institutions registered by the Mental Health Commission must either to be removed outright, or amended to incorporate a caveat that an exception will be made in the case of a minor.

5.1.3 Obstetrician/Gynaecologist

Of further concern is that, while of course an obstetrician/gynaecologist must be involved in the care of and provide guidance as to the physical state of the woman and the various physical factors that may influence the viability of termination as a treatment option in her particular case, it is less than ideal to place such a specialist in the position of having to make a determination as to the mental health of the woman. The mandatory requirement to have an obstetrician/gynaecologist involved in the certification process must be removed, although it must again be restated that the involvement of such a specialist in the process ought to be encouraged as distinct from mandated.

Guidance on this matter ought to be sought by the relevant professional bodies that will be aware of the particular wishes of their members and the appropriateness of their skills in making determinations as to the mental health of women under this section. Nonetheless, it is an overtly onerous burden to place upon a clinician to require that they certify the appropriateness, or lack thereof as the case may be, of a therapeutic abortion in relation to a case which is outside their area of expertise. The most notable barrier to the engagement of obstetricians / gynaecologists in such cases is the criminal sanctions that could follow from a wrongful certification. This is an unfair burden to place on such clinicians and is likely to render abortion to avert the risk of suicide an unobtainable remedy for Irish women, thereby this requirement may well open the State to further action, *inter alia,* under the European Convention on Human Rights.

[12] Attorney General v X and Others n1

5.1.4 Recommendations:

5.1.4.1 Reduce the certification requirement where a termination is carried out in relation to a risk of loss of life from self destruction, to one psychiatrist, remove the requirement for the participation of one obstetrician/gynaecologist in determinations concerning suicidality, thereby reducing certification requirement to one psychiatrist.

5.1.4.2 Either remove or amend the requirement that psychiatrists involved in certification be employed at a centre registered by the Mental Health Commission to ensure that, where appropriate, child psychiatrists may be qualified to participate in the certification process. Such amendment or removal should not in any way be construed as a requirement to increase the number of clinicians involved in the certification process.

5.2 Section 2(a)

As discussed in Section 3.2 of this document, the following applies also to this section of the Bill.

The mandatory requirement that at least one of the practitioners in the course of forming their opinion contact the woman's general practitioner must be reclassified as an option available to clinicians subject only to the agreement of the woman; this must not be a requirement of the procedure. While the information that may be derived from a woman's general practitioner may be of use to the clinicians in forming their assessment of her condition and the appropriateness of a termination in addressing a risk to her life, to oblige physicians to make such contact is overtly onerous.

Moreover, should the woman not wish to have her case discussed with her general practitioner for whatever reason that may be, her wishes in this regard must be respected and the opinion formed in the absence of such contact.

5.2.1 Recommendation: Remove the mandatory requirement that at least one clinician certifying the appropriateness of a termination as treatment of a risk to the woman's life from self destruction contact her general practitioner and reclassify such consultation as an available option.

5.3 Section 3 (b)

As discussed in Section 3.3 of this document, the following applies also to this section of the Bill.

The mandatory requirement that both medical practitioners in forming their opinion examine the woman ought to be an available option but should not be a mandatory element of the procedure. Where complex cases are concerned it is standard practice for clinicians to consult colleagues as to the best course of action and it may also be necessary to call on those colleagues to examine a patient, however the clinicians in question should be trusted to determine whether dual examinations are necessary on a case by case basis.

In removing the requirement of dual examinations, undue delays to the formation of opinions may be avoided in some cases thereby reducing somewhat the stresses placed upon women seeking abortions necessary to avert risk to life. This would also have the net effect of ensuring that clinicians are not obstructed in ensuring that treatment is received by the woman at the earliest time available.

5.3.1 Recommendation: Remove the mandatory requirement that all clinicians certifying the appropriateness of a termination as treatment of a risk to the woman's life from self destruction examine the woman and reclassify such examination as an available option.

6. Head 5 Medical Opinion to be in the Form and Manner Prescribed by the Minister

6.1 Section 1

This section states that the medical opinions arrived at under heads 2, 3 and 4 shall be delivered in a form and manner prescribed by the Minister. The ambiguity of this provision is concerning.

In the first instance, the delivery of an opinion to the woman under heads 2, 3 and 4 of the Scheme must occur in a manner consistent with standard medical procedures and must occur at the earliest possible time following the forming of the said opinion.

With regard to the explanatory note stating that this section is 'intended to allow proper documentation of the certification process', it is of course of the utmost importance that comprehensive and appropriately detailed medical records are kept in a fashion that allows for suitable levels of oversight, this is the case in relation to all clinical supports and services provided within the State. Thus the form and manner prescribed by the Minister must be consistent both with current best practice and clinical norms in order that treatments provided under this Bill are recorded in a manner consistent with other treatments offered in the State.

6.1.1 Recommendation: Specify that the opinion must be communicated to the woman in a fashion consistent with standard medical practice; specify the standard timeframes within which opinions are required to be delivered (while also providing for deviation therefrom in exceptional circumstances); and, specify that record keeping requirements be in line with comparable procedures performed in clinical settings.

7. Head 6 Formal Medical Review Procedures

It is generally welcome that a mechanism for formal medical review procedures be incorporated into the Bill as an effective mechanism will provide the requisite procedural safeguards necessary to

ensure that women have a means of appealing decisions made in relation to them. Nonetheless, several aspects of the proposed mechanism are of concern.

7.1 Section 2

Reference is made to the option of the woman to have her case reviewed, *inter alia*, where an opinion sought has not been received. While welcome, this provision requires clarification as to the timescale within which a clinician is obliged to provide his or her opinion in regards to the woman's case.

Although Head 5 is intended to empower the Minister to prescribe the form and manner by which an opinion is to be communicated, pregnancies progress with each day and undue delay in obtaining an opinion could potentially exacerbate the risk to the woman's life and or become a limitation to her treatment options.

Therefore the setting out of parameters within which opinions must be provided by clinicians must be incorporated into the primary legislation on this matter to ensure clarity as to the legal entitlements of the woman and the obligations of the clinician. It would of course be possible to incorporate a caveat to such a declaration of parameters in order that exceptional circumstances which delay the delivery of an opinion be accommodated. Such an approach would balance the need for an element of flexibility in the requirements placed upon the clinicians with the need of the woman for consistency and clarity.

7.1.1 Recommendation: Specify the standard timeframes within which review committee opinions are required to be delivered (while also providing for deviation therefrom in exceptional circumstances).

7.2 Sections 5, 6 & 7

Section 5 states that the review committee shall be established and convened as soon as possible but no later than 7 days following submission of a written application, and section 6 states that the

committee shall review the case as soon as possible but no later than 7 days following its being convened. Thus the potential timeframe for a review under this mechanism is 14 days, in addition to which the timeframe for the delivery of a determination must be incorporated. This is entirely unacceptable and not in keeping with international best practice.

Three days, within which the committee is convened, arrives at its decision, and communicates that to the woman is standard practice in situations contemplated under this Bill (as seen in the Czech Republic). And although it is to be welcomed that the onus of the provision is for the process to be commenced and completed 'as soon as possible', by providing for such an extended period as 14 days before a determination is communicated to a woman, the prospect of undue delay arises and this has the potential to exacerbate any existent risk to the life of the woman as well as to limit her treatment options.

In particular, where a woman's life is at risk by virtue of the threat of suicide 14 days is a dangerously protracted length of time to allow for any review of her case.

Moreover, faced with the prospect of awaiting an outcome for up to 14 days (after which time there is no guarantee that an application for treatment will be granted), women may be deterred from engaging with the review process and instead opt to travel to another jurisdiction to avail of abortion services. Should this become a standard response among those initially refused treatment, it may be argued that the overtly extended timeframes within which reviews may be conducted act as a barrier to accessibility thereby rendering the State negligent in providing women with an accessible remedy to a divergence of opinion with their clinician(s). This again could open the State to the prospect of further actions under, *inter alia,* the European Convention of Human Rights.

Finally, Section 7 states that the form and manner by which the review committee is required to communicate its findings to the woman is to be prescribed by the Minister. And while this is acceptable, it is necessary that the Bill itself specify the timeframe within which the decision be

furnished to the woman. This is vitally important as it is necessary to ensure women are aware of their entitlements under this section.

7.2.1 Recommendation: The period within which the review committee is to be established, convened and within which it delivers its judgement must be reduced to an aggregated total of no more than 3 days. It must also be specified that the decision of the committee be communicated to the woman within that timeframe.

8. Head 7 & Head 8 Review Where Risk Arises from Physical Illness and from Self Destruction

8.1 Heads 7 and 8

There is little logic to setting out the provisions of review pertaining to physical illness and the risk of self destruction separately as the cases to come before the review committee concern cases with equal gravity of consequence.

8.1.1 Recommendation: Amalgamate heads 7 and 8 which set out the framework within which a review of a decision under this Bill is to be carried out in order that no difference exists between processes concerning cases of suicidality and physical illness.

9. Head 12 Conscientious Objection

9.1 Insert a further Section

The vindication of the right of the individual to conscientiously object to participation in the treatment of a woman under the terms of this Bill is hugely important and this head is broadly welcomed as a means of ensuring such vindication. However, for the sake of clarity, express

provision must be made for emergency situations in which the right to such objection is to be superseded by the woman's right to life. Additional to which the duty of care owed to the woman must be made clear within the parameters of this section in order that in non-emergency situations the woman has a clear pathway to treatment.

As set out in the explanatory note accompanying this Head the current Medical Council Ethical Guidelines state that 'Conscientious objection does not absolve you from responsibility to a patient in emergency circumstances' however in order to ensure there is no room for doubt as to whether the right enumerated in this Bill supersedes those guidelines, this should be restated under this head.

9.1.1 Recommendation: Insert a specific section pertaining to conscientious objection indicating a duty to engage in treatment in emergency situations.

10. Head 13 Travel and Information

10.1 Insert a further Section

The restatement of the woman's right to travel and to obtain information pertaining to abortion services available outside the State is welcome. However, to ensure absolute clarity in the law, it is advisable to amend the Regulation of Information (Services Outside the State for Termination of Pregnancies) Act, 1995 (the 'Act of 1995') in order that clinicians are fully protected in advising their patients as to their treatment options.

While it is set out in this Act that providing information on services lawfully available is not an offence and it thereby regulates the manner in which information on services available outside the State may be provided, this Act is explicit in stating in a number of sections that the information provided shall 'not advocate or promote, and is not accompanied by any advocacy or promotion of, the termination of pregnancy'. Such restriction on advocacy of abortion as a treatment option and the attaching criminal sanctions may pose a chilling factor for clinicians in advising patients as to their treatment options.

Let us not forget that the termination services being legislated for in this Bill pertain to treatments necessary to avert a risk to the life of the woman, it is therefore of paramount importance that clinicians not feel in any way uncertain as to the advice they are allowed to provide to their patients. The amendment of the Act of 1995 is advisable to ensure absolute legal clarity as to the freedom of clinicians to advise their patients freely, placing centrally the well-being of the woman and without the threat of prosecution in mind.

10.1.1 Recommendation: Amend all sections of the Regulation of Information (Services Outside the State for Termination of Pregnancies) Act, 1995 that could act to criminalise clinicians in advising women as to the appropriateness of termination as a means of averting a risk to life.

11. Head 19 Offence

11.1 Section 2

Section 2 of this Head is of significant concern and is in need of substantial amendment. The first point to note is that a penalty of 14 years imprisonment and or an unlimited fine is an extraordinarily onerous set of sanctions and, as opposed to addressing it, without question would carry forward the chilling effect of the Offences Against the Person Act 1861 ('Act of 1861') into the present Bill.

Significant attention was paid by the EctHR in its deliberations in *A, B and C v Ireland*[13] to the threat of criminal prosecution under the Act of 1861, the severity of the sanctions likely to be imposed upon conviction thereunder, and the chilling effect this had upon clinicians in their willingness to make determinations and treat women in need of lawful termination services. The proposal to put in place a 14 year prison term for those found to have wrongfully provided or in some way facilitated abortion services, and indeed for a woman who has availed of such services, will not in any way eliminate that chilling effect, rather it is likely to exacerbate it given the novelty of its introduction to the statute book.

[13] (ECHR, 16 December 2010) n2

This regime, if introduced, is likely to act as a significant barrier to clinicians and women alike in engaging in service provision under this Bill. One would have to question whether a woman who is freely able to travel is likely to open herself to the prospect of indictment under this Head when such threat would not exist should she avail of services in neighbouring jurisdictions. Moreover, as this option clearly does not exist for women who do not have the option of travelling, such as asylum seekers and those with visa restrictions, these women would be placed in the unenviable situation of availing of termination services in Ireland which carry the possibility of imprisonment of up to 14 years should it later be found that her eligibility for a lawful abortion has been called into question; the alternative being to risk leaving the threat to life unaddressed.

The criminalisation of women under this Head is thus highly likely to act as a significant deterrent to women in seeking services under this Bill, thus if enacted in its current form this Head could open the State to further prosecution under, *inter alia,* the European Convention on Human Rights as an inaccessible remedy is tantamount to no remedy in international law.

Moreover, in setting out such a punitive regime pertaining to unlawful termination, clinicians are likely to err on the side of refusing to certify women seeking terminations under this Bill in order to certainly avoid prosecution. This would act as a further barrier to women in obtaining services to which they are constitutionally entitled and, as previously highlighted, should such reluctance to treat take hold in the medical community may open the State to action under , *inter alia,* the European Convention on Human Rights.

11.1.1 Recommendation: Any and all prospects of criminal sanction against women undergoing termination procedures must be removed from the Bill; the standard sanctions pertaining to clinical malpractice ought to apply to clinicians providing unlawful abortion services in the State as opposed to the criminal sanctions set out under this head; and, any other person purporting to carry out unlawful abortion services ought to be subject to criminal prosecution.

12. Head 20 Commencement – With Short Title

Recommendation: In light of the lacuna that presently exists in the law pertaining to lawful abortion services in Ireland it is advisable that this Bill commence fully upon enactment.

To: Mr Paul Kelly, Principal Clerk, Joint Committee on Health and Children,

healthandchildren@oireachtas.ie

I would like to make the following scientific and human rights points in relation to the 'Protection of Life during Pregnancy Bill 2013':

It is an observable scientific fact that a human being, genetically distinct from his or her parents, begins at fertilization. This is not a matter of opinion or a position or a belief. It is simply a fact.

Human rights are not granted us by others. Rather we simply acknowledged them to be ours by the very fact of our being human. Likewise they cannot be withdrawn or denied by anyone. They simply are.

The most basic human right is the right to life itself ie. the right not to be *intentionally* killed, since no other right can be recognised or asserted without presupposing and accepting the reality of this right.

If this right is not recognised no other rights can be recognised or asserted including any so called 'right to choose'. Anyone who maintains that there is a right to choose would necessarily have to choose life to maintain such a right. To claim that there is a right to intentionally kill an innocent human being would contradict every assertion to every human right, including any right to choose.

Pregnancy is a temporary condition. We can medicate for suicidal tendencies for the duration but we cannot medicate to bring a child back from the dead.

We may medicate for suicidal tendencies even if such medication might *unintentionally* harm or indeed kill the child while nevertheless acknowledging and upholding the right of every human being not to be *intentionally* killed. To *allow* the death of a innocent human being as an *unintended* side effect from a necessary action to preserve the life of another does not deny the most basic human right not be be *intentionally* killed.

If there is a proportionally serious reason for acting in the first place (preserving the life of the mother) and there is no better alternative such an action may be acceptable in Irish medical ethics.

If the action itself (the administration of medicine appropriate to the treatment of suicidal thoughts) is good and the bad effect (the harming or even death of the child) is not intended and the good effect (on the mother) does not come from the bad effect (on her child) and if there is a serious and proportional reason for acting in the first place and no better alternative (that would not harm either mother or child) then the bad effect on the child may be tolerated.

Having said this I do not know of any medication appropriate to the treatment of suicidal thoughts that would seriously harm the child.

Intentionally killing the child however does harm the child, denies the most basic of human rights and does nothing to preserve the life or even the health of a suicidal mother.

It is the responsibility of governements to uphold human rights. This bill (particularly *Head 4 (1)*

***(i)*) denies the most basic of human rights – the right to life itself and the government should not**

proceed with it.

Thank you for taking time to consider these points.

Aengus Ó Briain, B.Sc. (Hons) Life Sciences.

20 Lohunda Drive, Clonsilla, Dublin 15. 087-2161199.

Aidan Lonergan <aidanlonergan@live.ie>
08/05/2013 15:52 To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
ATTN: Paul Kelly : Protection of Human Life in Pregnancy Bill 2013

RE: Submission to Oireachtas for above bill

To whom it may concern

It is with dismay that I read the heads of bill for this piece of legislation. As an Irish citizen I am extremely disillusioned with a government that claims to have the best interests of all its people (including the unborn) at heart. This bill allows for the direct and intentional killing of an unborn child where the mother is deemed to be suicidal as a result of the pregnancy.

As it is the government who wish to introduce such bewildering legislation it is their responsibility to provide concrete evidence to prove that abortion can be a treatment for suicidal ideation. However as we all know this is impossible as it has been proven that it is not a treatment and never will be. To think an innocent and vulnerable child may be killed because a mother is suicidal is a harrowing thought indeed.

Please open up this debate to the Irish people and make sure we don't take innocent life because of the lobbying of pro-abortion groups. Lets not forget what an abortion actually is, that it kills an innocent human being.

Yours,

Aidan Lonergan

Aileen Lehane <ailcon08@gmail.com>
08/05/2013 13:53 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Abortion legislation

Dear Paul,
I am writing to declare my complete objection to the current plans to legalise abortion. In no circumstance is it ok to take the life of the unborn at any stage of its development. Aborting a child is not the answer to women who are feeling suicidal, counselling, love and care most certainly is. We need to stand strong and fight for those who do not yet have a voice.

Thanks,
Aileen.

Submission to the Oireachtas Joint Committee on Health and Children regarding the Protection of Life During Pregnancy (Heads of) Bill 2013

7th May 2013

1. Introduction

I am making this submission to the Committee because I am a woman, I am a psychologist and I am pregnant. This is a personal submission based on my own experiences and concerns as a pregnant woman in Ireland based on the fact that this legislation is designed for me and women like me.

2. Executive Summary

I am a woman, I am a psychologist and I am pregnant. This legislation is meant for me. It is meant to make me feel more protected in pregnancy, but it does not. I know that as things currently stand in Ireland without any legislation, if I contract a life-threatening illness or if I get gravely ill and need treatment to save my life, I will get it. I know that I will not be denied any treatment needed to save my life even if it leads to the unintentional death of my baby. I feel fully protected by that.

This new legislation does not give me any more protection but gives my baby far less. My husband and I have been given a poor prognosis for our baby. That was very hard to hear. Pregnancy is stressful and while I'm lucky, I know as a psychologist that if I added a few more risk factors to my situation, mental health problems would not be a million miles away. I can understand that even though suicidal ideation is much rarer in pregnancy, it is possible. But the idea that killing the baby in the womb and discarding it would magically cure suicidal ideation is absurd. The idea that it is the 'only medical procedure' than can avert the loss of life of the pregnant woman, as stated in Head 4, is simply not supported by medical evidence. There is not one medical textbook that recommends abortion as a treatment for suicidal ideation and we saw 113 psychiatrists come out in the last few weeks attesting to this fact.

I know that many have argued that the government are just legislating for the X case, but I have a number of problems with this. Firstly, the X case was 20 years ago and we cannot ignore twenty years of medical evidence since then. We would not write into law any medical treatment that may have been acceptable twenty years ago but that has no current place in medical textbooks today. For example, as you will be aware, several drugs have been withdrawn from the market in the last twenty years. Best medical practice today is not the same as it was twenty years ago as medicine is constantly evolving. Therefore it would be unwise and wrong to write into law a treatment that has no place in medical textbooks today despite it being the believed to be acceptable at the time.

The second point is that the government is not required to legislate for the X case; regulations and guidelines for doctors are an alternative solution. I fully support the introduction of guidelines for doctors which may clarify when to intervene if the life of the mother is at risk, but this can be done without legislation.

Therefore I am asking the Committee, as a pregnant woman and a citizen of this country, to hear my views and not pass this proposed legislation. This legislation is meant for me and women like me, and I do not want it and do not need it. I am already fully protected in pregnancy without it. I am urging the Committee to oppose the

proposed legislation because by doing so, you are not only continuing to protect women like me, you will also be saving the lives of countless babies who will die if it is introduced.

3. Recommendations:

- Instead of legislation for Heads 2 and 3, introduce guidelines and regulations for doctors to clarify when there is a risk to life of the mother and how this should be treated

- Provide guidelines and regulations to psychiatrists to help them deal with women who are suicidal in pregnancy to address issues outlined in Head 4. These should be in line with current best medical practice, which does not include abortion as a treatment. There is certainly no evidence that it is the 'only medical procedure' that can avert the loss of life of the mother in pregnancy.

4. Main body of submission

(Please see Executive Summary and Recommendations above)

Yours Sincerely,

Aileen McCauley

Association for Improvements in Maternity Services Ireland (AIMSI)

Email: support@aimsireland.com Website: www.aimsireland.com

Wednesday, May 3, 2013

EXECUTIVE SUMMARY

Introduction: Information About AIMS Ireland

AIMSI was founded in 2007 and its mission is to support a woman's human rights and her choices in childbirth by promoting best international practice guidelines and the use of evidence-based research in maternity care settings. We lobby on behalf of pregnant women as well as provide information and support to women. The majority of women contacting AIMSI are looking for support in relation to traumatic birth experiences, many of whom complain of feeling undermined or not listened to during pregnancy, labour and birth. Recurring issues are: lack of informed consent and informed refusal.

Recommendations and comment on a head by head basis:

Head 1 – Interpretation

AIMSI have difficulties with the terms 'unborn' and 'woman' as they are not clearly defined and can lead to ambiguous interpretation. The Bill should also revert to its original title.

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

This is theoretically an improvement on current legislation but in pratice Article 40.3.3 still dictates that there must be a "real and substantial risk to a woman's life" before a termination can be carried out

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

Again, this is theoretically an improvement on current legislation but it is still narrowly restricted by Article 40.3.3

Head 4 – Risk of loss of life from self destruction

A general lack of knowledge of mental health difficulties and suicidal ideation means that this head incorporates an excessively cumbersome treatment pathway for a pregnant woman who is suicidal and is choosing to terminate her pregnancy. The idea of a woman having to be assessed by a potential 6 doctors and to also have her confidential details shared with her GP is untenable. Rather than doing anything to help mitigate the stigma attached to both mental health difficulties and abortion, it continues to distance the medical profession and the government from the woman at the heart of the matter. If a woman can maintain her privacy and dignity (and she can afford to pay for it), she will more than likely make the choice to go to another jurisdiction to access abortion services, rather than face undue interrogation in Ireland.

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

It is reasonable to expect that there is proper documentation of any and all medical procedures and interventions in all obstetric units in the Republic of Ireland. In fact, AIMSI would welcome the same kind of rigorous and detailed data collection when it comes to documenting all surgical and non-emergency interventions performed on women in the maternity services

Head 6 to 9 - Formal Medical Review Procedures

The review procedure for Heads 2 and 4 is thorough but it is also not timely if a woman is seriously physically ill or if she is intent on ending her life. The time given to convene a panel, to review the case and to report whether there is real and substantial risk to the life of the woman could potentially take up to two weeks. In the case of pregnancy and the legal right to abortion, if there is a real and substantial risk to a woman's life, every hour and every day counts. Women who are facing a pregnancy that is threatening their very existence should not be made to wait weeks in order to have a final decision on her legal right to act on her decision.

Head 10 - Formal medical review reports to Minister

While review reports can help to track the frequency and grounds for review, it may also be worthwhile to track the frequency and grounds for why women forego the review panel and choose to terminate their pregnancy in another jurisdiction.

Head 11 – Notifications

As it stands, there is absolutely no comparison data for Irish women who must travel abroad to access abortion services. This major gap in data renders the proposed notifications data statistically invalid. The data that will be gathered on these notifications will only be able to describe discrete or skewed data – ie. it will only represent a very small sample with narrowly defined parameters.

Head 12 - Conscientious Objection

Due to the sensitive nature of the issue of abortion it is reasonable to allow a conscience clause for practitioners. This must be balanced with the rights of a woman to be treated in a non-judgmental and dignified manner.

Head 13 - Travel and Information

This is a reasonable and standard provision for this legislation.

Head 14 to 17 - Regulations and certification of opinions referred to in this Act

This is a reasonable and standard provision for this legislation.

Head 18 – Repeal and consequential amendments

The repeal of Sections 58 and 59 of the Offences Against the Person Act 1861 is welcome; however, the stark reality for pregnant woman in Ireland is that Article 40.3.3 hangs like a spectre over her care as there are myriad instances where her human rights are overridden by this ambiguously worded and legally flawed amendment.

Head 19 – Offence

The laws in Ireland with regards to abortion are draconian and outdated. They have not kept pace with the changing culture, women's rights, human rights and the values of the Irish people. There is nothing "clear" or "modern" about the threat of incarcerating a pregnant woman for intending to procure an abortion in the country of her residence, while turning a blind eye to the thousands of women annually who make the trip to the UK – this can only be described as hypocrisy.

Head 20 – Commencement

This is a reasonable and standard provision for this legislation.

Conclusion

The obvious conclusion is that even if a country has legal restrictions on abortion, women will continue to choose to terminate their unintended pregnancies. To deny that this is happening in Ireland is to deny the very personal and intimate reproductive choices of thousands of Irish women. It also denies the reality that thousands of women, who can afford it, make the annual journey to the UK or elsewhere in Europe to access an abortion.

Introduction: Information About AIMS Ireland

In 2007, the Association for Improvement in Maternity Services Ireland (AIMSI) was started by a group of women who collectively declared that the maternity services in Ireland had treated them in a manner that was less than satisfactory – many of them claiming to have suffered an outright breach of their human rights. The mission of AIMSI is to highlight the rights of women to be autonomous in their reproductive choices and to promote practices that are supported by evidence-based research and international best practice. Improving the Irish maternity services includes many factors that rely heavily on a woman's right to make choices about all aspects of her care in pregnancy, labour and birth. For example, a woman should be allowed to choose where and how she gives birth in line with supportive scientific evidence and international best practice that is documented by the World Health Organisation (WHO). AIMSI would like to see *National Guidelines*, the annual publication of *Obstetrical Clinical Reports* and a clear *Charter of Patient's Rights in Maternity Services* among other changes that fully support a woman during her pregnancy, labour and birth.

While AIMSI lobbies and campaigns on behalf of women, we also provide support and information to women. We receive hundreds of emails and phone calls annually to our voluntary Support & Information Officers. Many of these contacts tell a compelling story of being badly let down by the maternity care providers in Ireland. Most of these harrowing stories involve women being forced to undergo procedures and interventions, which are often unnecessary, without giving their informed consent or informed refusal. It is far

too common for women to experience being operated on, rather than collaborated with, when it comes to their maternity care.

Recommendations on a Head by Head Basis:

- **Head 1 - Interpretation**

While it is understandable that the definitions in this Bill must succinctly and clearly be defined, it is somewhat disconcerting to see "unborn" and "woman" being given interpretation. "Unborn" is not a scientific term and is only necessary to define because of the relationship it has to Article 40.3.3 of the Constitution. It is not a legal definition, as such, and it is arguably a term based more on moral ideology than scientific evidence. The Government has redefined "unborn" for the purpose of this Bill (ie. life begins at implantation, not at conception), which seems arbitrary and unnecessarily restrictive. If the definition of "unborn" is fluid, then why have it defined at all OR why not extend the definition to mean 6, 12 or 24 weeks post-conception? It is an intentionally emotive term and AIMSI would argue that it is not medically or scientifically evidenced.

With regard to defining a "woman", it would seem that this Bill discriminates against those individuals who may identify as one gender but have the sex traits of another. While this may seem like a small detail, it is thought to be of great consequence in many other jurisdictions. For example, in March 2013, the Canadian government passed Bill C279 that ensures equality for transgendered people. Where does a transgendered individual in Ireland (particularly one who may find themselves with an unintended pregnancy) go to seek support and does the law protect them? It seems rather archaic that a "woman" must be defined for the sake of any legislation and it starkly highlights the simplicity with which the government wants to define women. The X case, itself, involved a 14 year old girl, not a "woman" by legal definition, but a child or minor. Does the law protect them, as well? AIMSI takes exception to the complete removal of any reference to women in the title of this Bill and would ask that it revert to its original name: The Protection of Maternal Life Bill 2013.

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

This is reasonable; however, the restrictive nature of this legislation and the spectre of Article 40.3.3 remove any clarity, respect and dignity for women who may have to make the choice to terminate a pregnancy due to physical illness. One would hope that what transpires through legislation and medical regulation is that women who are in need of a termination in order to preserve their life do not have to undergo what women before them have had to endure – particularly those women who ended up losing their lives due to delays in getting the medical treatment for which they were allegedly entitled *vis a vis* the 1992 Supreme Court ruing on the X case. While the explanatory note states that as per the X case ruling, "it is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate" (p.7), this still leaves a chilling effect as to what constitutes a "real and substantial risk to the woman's life" as it is still seen as distinct from her health. The recent death and subsequent inquest of Savita Halappanavar demonstrated that a lack of legal clarity between a risk to a woman's life and her health underpinned the delay of a termination that would have saved her life, according to expert witness, Dr Peter Boylan (Cullen, P, Irish Times, April 18, 2013)

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

This is reasonable as in an emergency there may only be one doctor present; however, a medical practitioner should never have to be concerned about whether or not she/he is committing a criminal offense when carrying out a termination due to a medical emergency. It seems safe to assume that doctors will always be working according to a strict ethical and professional medical code that preserves life unless otherwise clinically indicated. Similarly to Head 2, Article 40.3.3 legally binds the medical practitioner to determining if there is a "real and substantial risk to a woman's life", even in a medical emergency.

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

This is reasonable as it allows for a termination of pregnancy in accordance with the 1992 Supreme Court ruling on the X case. However, this still lacks significantly in providing clarity for the practical approach to caring for a suicidal pregnant woman. Much of the confusion on this particular head can be explained by a general lack of knowledge about suicide and the difficulty in predicting who will go on to complete a suicide and who will not. It stands to reason that if a woman is suicidal and pregnant, she may not want to face an obstetrician and two psychiatrists, and possibly the input of her GP. It is highly unlikely that this opens up any opportunity for a distressed, and possibly suicidal, pregnant woman to feel supported and cared for by her medical team in her choice to undergo a termination when she is faced with assessment by 3 doctors and a possible review by a further 3 doctors. It seems more likely and practical that a woman will want to seek anonymity and far less judgment by traveling to another jurisdiction for a termination. It is disconcerting to read a reference to the 25th Amendment (Protection of Human Life in Pregnancy, 2001) in the explanatory notes in this section (and in heads 1, 2 and 12), particularly as this is an amendment that was defeated by popular vote in a referendum in 2002. It is unclear why it is being referenced, except to further emphasise the position of the government.

Perhaps the two most worrying aspects of this head are as follows:

(1) That it is acceptable for a woman's right to confidentiality to be breached even if she has not agreed to the sharing of her information with other medical doctors, namely her GP. The decision whether sensitive medical information is shared should rest solely with the consent of the woman involved. If a woman refuses consent, her desire to maintain confidentiality should be upheld and if this is breached, then appropriate guidelines and sanctions should be issued to protect a woman's right to privacy and confidentiality in this situation

(2) That rather than doing anything to help mitigate the stigma attached to both mental health difficulties and abortion, it continues to distance the medical profession and the government from the woman at the heart of the matter and it further perpetuates a negative stereotype. The discrimination of women who find themselves in this emotionally devastating position – of carrying an unintended pregnancy and of *seeing no way out of this difficulty* - only serves to isolate women and to highlight power differences. Link and Phelan (2006) found in their research on stigma and abortion that on an individual level, those being stigmatized feel shame, guilt and disgrace, leaving them with little power to access resources that can change their situation. The stigma and the stereotype of the woman who seeks an abortion separate her from the 'morally upright' woman, which results in the woman seeking an abortion as being "blamed for their own exclusion".

The stigma and negative social attitudes of some people towards abortion should not be ignored as this has far reaching effects on the women who have experienced abortion care. In Ireland, this means that the vast majority of women who have had abortions have had to travel to other jurisdictions to obtain a legal abortion. For the Irish government to ignore this cold fact means that it is complicit in promulgating the secrecy and shame inherent in social attitudes to abortion. This can have a devastating impact on a woman's health as if she has experienced any complications due to an abortion, she may be reticent about seeking treatment due to the pervasive negative attitudes and stigma associated with this choice. Recent research supports the expansion of service providers to combat the "isolation of women undergoing abortion by attending not only to clinical/technical aspects of the procedure but also to women's psychological/emotional sensitivities surrounding the event" (Astbury-Ward et al., 2012). This would be a much more compassionate and humane way of providing a service to women who are threatening suicide and finding it impossible to cope with an unintended pregnancy.

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

It is reasonable to expect that there is proper documentation of any and all medical procedures and interventions in each and every obstetric unit in the Republic of Ireland. In fact, AIMSI would welcome the same kind of rigorous and detailed data collection when it comes to documenting all surgical and non-emergency interventions performed on women in the maternity services.

- **Heads 6 – 9 Formal Medical Review Procedures**

The review procedure for Heads 2 and 4 is thorough but it is also not timely if a woman is seriously physically ill or if she is intent on ending her life. The time given to convene a panel, to review the case and to report whether there is real and substantial risk to the life of the woman could potentially take up to two weeks. In the case of pregnancy and the legal right to abortion, if there is a real and substantial risk to a woman's life, every hour and every day counts. Women who are facing a pregnancy that is threatening their very existence should not be made to wait weeks in order to have a final decision on her legal right to act on her decision. This scenario should be regarded as a medical emergency and, therefore, provision should be made to treat a woman in the same manner as outlined in Head 3.

- **Head 10 – Formal medical review reports to Minister**

This is a reasonable, if not mandatory, requirement to ascertain how women are availing, or not, of the new legislation. With regards to the subheads (a) to (e), AIMSI are particularly concerned with (d) the outcome of the review. The explanatory note says:

"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"(p. 21).

Equally, it may indicate that further guidance is needed if this data reveals that women who are suicidal are making the decision to forego the review panel and to travel, if they have the means and accessibility, rather than undergoing a procedure that should be legally and medically available to them in Ireland. It should be

documented if these women are continuing to leave Irish soil to access abortion services simply because the pathways of care are cumbersome and excessively stringent at a time when these women should be treated with compassion and support.

- **Head 11 – Notifications**

This is a reasonable and necessary step in order to begin gathering accurate records on the frequency of terminations carried out in Ireland (not just under this legislation but in all circumstances). It is important to keep in mind that any data recorded on abortions in Ireland will be confounded by the missing data – namely the thousands of women annually who make the trip to other jurisdictions to access abortion services and those who manage to access abortifacient medications. Statistics have been used in the past to egregiously support maternal mortality rates in Ireland, with many individuals misrepresenting the data as supporting one of the "best places in the world to have a baby". These same individuals ignored the fact that the maternity mortality rate in Ireland doubled overnight when the Confidential Maternal Death Enquiry Report (2012) was published.

While Ireland still remains a relatively safe place to have a baby in terms of maternal mortality, the statistics completely ignore maternal morbidity and therefore deny hundreds, if not thousands, of women who have experienced adverse events in their maternity care. Likewise, the data that is being gathered in relation to abortion in Ireland under this proposed legislation will only reveal a tiny subset of the total number of women who are accessing abortion services, here and abroad. It would be prudent to begin gathering data on abortion that is valid and reliable so that these numbers will be useful for future policy reviews. As it stands, there is absolutely no comparison data for Irish women who must travel abroad to access abortion services. This major gap in data renders the proposed notifications data statistically invalid. The data that will be gathered on these notifications will only be able to describe discrete or skewed data – ie. it will only represent a very small sample with narrowly defined parameters.

- **Head 12 – Conscientious Objection**

Every individual has the right to freedom of conscience and should, therefore, be given scope to express this right. However, this right is qualified in that a medical practitioner must balance their right to individual moral and ethical conscience with their duty of care to the patient. The idea of introducing conscientious objection into this legislation is one that is necessary but it also seems equally important to state that under this proposed contentious legislation "the exercise of conscience may not involve invidious discrimination or result in excessive harms/burdens to patients. In addition, health care professionals may not cross the line that separates refusal from obstruction" (Wicclair, M, 2011, p. 133).

In the case of Irish medical practitioners who consider themselves conscientious objectors in relation to this proposed legislation, it will be very difficult for women who are physically ill or who are experiencing suicidal ideation to be faced with doctors who have an ethical and moral objection to what a woman feels is her best and only course of action – an abortion. How will a woman be assured that her case will be heard in a non-judgmental way, without being influenced by the moral and ethical biases of the medical practitioner? The Irish Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* clearly states, in Sections B 10.1 and 10.2: "As a doctor, you must not allow your personal moral standards to

influence your treatment of patients [and that] 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" (p. 16). It seems cruel to expose pregnant women who are suicidal, or facing a physical illness or a medical emergency, to the added distress of a practitioner who conscientiously objects to abortion.

A woman should be given unbiased and clear information and referrals to other doctors should she encounter a medical practitioner who conscientiously objects to being involved in her abortion care. The cases that are frequently brought to the courts in Poland highlight how conscientious objection can lead to lengthy delays, moral judgment and sometimes outright criminal harassment of women, even if the law supports her decision. The *Report of the Expert Group* even cautioned that "the measures that are introduced to give effect to this existing constitutional right should not act as obstacles to any woman who is legitimately entitled to seek a termination on lawful grounds" (DOHC, 2012, p.27). It would be judicious to include in this legislation clear legal safeguards that will protect a woman from having to endure the intentional obstruction or delay to abortion services due to conscientious objection.

- **Head 13 – Travel and Information**

This provides clarification that if a woman seeks an abortion in Ireland (ie. under head 2 or 4) but she encounters undue delays or unsatisfactory treatment, she is legally entitled to travel to another jurisdiction to access abortion, as the current laws allow.

- **Head 14 – 17 Regulations and certification of opinions referred to in this Act**

This is a reasonable and standard provision for proposed legislation.

- **Head 18 – Repeal and consequential amendments**

The repeal of Sections 58 and 59 of Offences Against the Person Act 1861 is a welcome change to legislation, as recommended on numerous occasions during the Oireachtas hearings in January 2013. However, it is the 8th Amendment, Article 40.3.3, that has caused the greatest amount of controversy and 'grey area' in relation to abortion. The lack of legal clarity of the terms used in Article 40.3.3 were highlighted by several TDs, Ministers, legal experts and Attorneys General when it was proposed in 1983. It is a highly unusual amendment in that it is the only one that is not a Government amendment and it is the only one where the wording was bitterly contested by several members of government before it was hastily brought to the people in a referendum. The legacy of this amendment is one that has created a chilling effect and a tangible barrier to women's equality and human rights in Ireland. As recently as last month (April 2013) the inquest into the death of Savita Halappanavar concluded with expert testimony declaring that "obstetricians [are] working in a legal 'vacuum' as to when a mother's risk of dying was high enough for them to be legally allowed to terminate a pregnancy" (Holland, K and Cullen, P, The Irish Times, April 17, 2013).

AIMSI believes that taking a decision to terminate a pregnancy is one that should be made solely between a woman and her doctor. When legal restrictions and moral guidelines are put in place to limit a woman's choice, it makes it very difficult to delineate where a risk to a mother's health ends and a risk to her life begins. How does a medical team make a decision in this kind of urgent situation on what to do with regards to the

foetus? The enduring lack of clarity caused by article 40.3.3 as a constitutional guideline in such matters (notwithstanding the repeal of sections 58 and 59 of the 1861 Offenses Against the Person Act), means that the woman's life continues to be seen as equal to that of an embryo or foetus. The risk to the mother may not only be one that involves her health, and her life, but it appears to also involve a legal grey area that is trying to define what her rights are as a human being versus the rights of the foetus (as described by such notable legal experts as Peter Sutherland SC, AG in 1981 and Patrick Connolly SC, AG in 1982 in the recently released 1981 amendment papers).

AIMSI highlighted in an earlier submission to the Joint Oireachtas Committee that from a human rights perspective, the idea that a woman's life is equal to a foetus creates what Elizabeth Prochaska, human rights lawyer, calls 'foetal supremacy'. According to Prochaska, there is no basis in law for foetal supremacy. In fact, Prochaska strongly argues that "the questions being raised over abortion rights have a close relationship to a woman and her pregnancy. It is a woman's body and that's what makes human rights in childbirth some of the most fundamental human rights there are, because it involves choices a woman makes over her body" (Carpenter, L., The Guardian, December 16, 2012). The United Nations and other international organisations patently agree with Elizabeth Prochaska: that a woman's right to health is paramount and that multiple human rights instruments support her right to not only health and life, but also her right to equality and reproductive self-determination (Center for Reproductive Rights, 2008).

The stark reality for a pregnant woman in Ireland is that Article 40.3.3 hangs like a spectre over her care as there are myriad instances where this ambiguously worded and legally flawed amendment overrides a pregnant woman's human rights. For example, in the latest HSE Draft National Consent Policy, section 7.8.1 on Informed Consent for pregnant women states:

"The consent of a pregnant woman is required for all health and social care interventions; however, because of the constitutional provisions on the right to life of the unborn, there is legal uncertainty regarding whether a woman's right to refuse treatment extends to the refusal of treatment which puts the rights to life of the foetus at serious risk" (p.34)

Recent media reports also suggest that Article 40.3.3 was a critical piece of legislation that led to an emergency sitting of the High Court in the case of a woman who wished to delay a caesarean section for 2 days. In this case, Senior Counsel for the hospital argued that what was at issue was "the mother's right to refuse treatment [at odds] with the right to life of the unborn" (Mac Cormaic, R, The Irish Times, March 11, 2013). The issues of informed consent and a pregnant woman's rights conflict in many aspects of the maternity services because they are determined by 'risks' rather than 'rights'. This conflict can be squarely attributed to Article 40.3.3 and the difficulties in trying to determine equal rights for both the woman and the fetus. This appears to be one of the most serious and tragic details in the Savita Halappanavar inquest, as testimony from a Consultant Obstetrician explained - namely, that there was a refusal to permit a termination until the medical team were convinced that there was a balance of probabilities (51%) of a risk to the life of the mother (Houston, M, The Irish Times, April 11, 2013). These probabilities cannot, and never will, be determined by the proposed legislation and nothing in head 3 would materially change the outcome of the Savita Halappanavar case. As long as Article 40.3.3 remains as an impervious legal barrier to a woman's right to a termination in these circumstances, the risk to a mother's life will precariously hang in the balance.

- **Head 19 – Offence**

While it is commendable that this proposed legislation includes the repeal of Sections 58 and 59 of the Offences Against the Person Act 1861, it is shocking that it also includes the possibility of up to 14 years imprisonment for a woman who undergoes an abortion that falls outside the scope of this legislation in Ireland. It appears to be a disproportionate penalty for medical treatment that a woman (who can afford it) can access in the UK. The other concern that AIMSI has about this head is that if a woman is forced through her personal and family circumstances to access abortifacient drugs to self-induce an abortion, this leaves mariginalised and vulnerable women in an inequitable position to those who are financially and socially able to access an abortion in another jurisdiction.

In 2009, the Irish Medicines Board confirmed that 1,216 packages of drugs known to induce abortions were seized by Irish customs authorities (O'Brien, C, The Irish Times, October 26, 2010). In essence, this means that somewhere in the region of 1200 women would be potentially liable to conviction and a prison sentence for resorting to illegal means to terminate a pregnancy due to the restrictive laws in Ireland. In comparison with violent crimes, such as rape and domestic abuse, the punishment proposed for a woman who is desperately attempting to terminate an unintended pregnancy is ludicrous and unjust. The proposal of these kinds of harsh penalties imposed on women whose biggest crime is more than likely attributed to the poverty, lack of resources or disability they endure makes a telling statement on how Ireland treats its vulnerable women. This is incongruous with the Ireland that emerged as a leading economy and cultural stalwart in the 21st century. The days of locking up or isolating 'fallen women' are gone. This country can do better than threatening women with 14 years in jail if they see no other way out of their life-altering predicament. The laws in Ireland with regards to abortion are draconian and outdated. They have not kept pace with the changing culture, women's rights, human rights and the values of the Irish people. There is nothing "clear" or "modern" about the threat of incarcerating a pregnant woman for intending to procure an abortion in the country of her residence, while turning a blind eye to the thousands of women annually who make the trip to the UK – this can only be described as hypocrisy.

- **Head 20 – Commencement**

This is a reasonable and standard provision for proposed legislation.

Conclusion

What we expect from maternity services in Ireland should be in line with what is expected internationally as best practice. This reflects Minister James Reilly's statement released on December 18, 2012: "the Government is committed to ensuring that the safety of pregnant women in Ireland is maintained and strengthened. We must fulfill our duty of care towards them" (MerrionSt.ie). The WHO guidelines for maternal and reproductive health are the most widely used evidence-based research that supports women's rights in pregnancy, labour and childbirth. These guidelines recommend the most effective intervention and treatment of the more common complications in maternity settings such as: hypertensive disorders of pregnancy, haemorrhage, placental anomalies and puerperal infection. The other guidelines that the WHO issued in 2012 were on *Safe Abortion: technical and policy guidance for health systems* (2nd Ed). While the guidelines are

geared towards making abortion safer in developing countries, Ireland finds itself standing among these countries when it comes to the issue of supporting women's maternal, sexual and reproductive health.

In addition to these guidelines, human rights legislation exists as a method of removing barriers and protecting women's right to reproductive and sexual health. The *International Covenant on Economic, Social and Cultural Rights* (ICESCR), part of the *International Bill on Human Rights* - ratified in Ireland in December 1989 - guarantees women the legal right to the highest attainable standard of physical and mental health and equal rights between men and women. The *European Convention on Human Rights* (ECHR) (2010) and the *European Social Charter* (ESC) (1961; 1996; 1999) also guarantee the right to health and to equality of women and men. Current restrictive abortion policies, including this proposed legislation, continue to violate international human rights law.

The main thrust of the argument for supporting the rights of women across the maternity services, whether they are choosing a home birth, a cesarean section, an intervention-free birth or an abortion is summed up succinctly by Anand Grover, UN Special Rapporteur on the Right to Health, who recently spoke at the National Women's Council of Ireland seminar on Women's Right to Health. At a UN General Assembly in August 2011, Mr Grover presented a report, in accordance with the Human Rights Council entitled: *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health.* This report is seen as a milestone in the area of rights to reproductive and sexual health as it plainly articulates the reasons why legal restrictions in this area constitute a violation of a woman's right to health and an "unjustifiable form of State-sanctioned coercion" (UN, 2011, p. 5). The report is disparaging of the human rights violations that are perpetuated in the few remaining countries, such as Ireland, where abortion is completely criminalised or where it is only allowed to save the life of a woman. Anand Grover said at the UN General Assembly meeting, when presenting this report:

"Realization of the right to health requires the removal of barriers that interfere with individual decision-making on health-related issues and with access to health services, education and information, in particular on health conditions that only affect women and girls. In cases where a barrier is created by a criminal law or other legal restriction, it is the obligation of the State to remove it. The removal of such laws and legal restrictions is not subject to resource constraints and can thus not be seen as requiring only progressive realization. Barriers arising from criminal laws and other laws and policies affecting sexual and reproductive health must therefore be immediately removed in order to ensure full enjoyment of the right to health." (UN, 2011, p. 2)

The countries that have legalised abortion have generally found that abortion rates do not suddenly increase when legislation changes. In fact, many countries report that over the years abortion rates have stayed the same, or decreased, as increased information and knowledge is disseminated on the proper and effective use of contraception. A comprehensive global study by Sedgh et al., 2012, found that there was a substantial decrease in abortion rates from 1995 to 2003 and that these rates have been relatively stable since 2003. The most salient information that the researchers gleaned from this study was that regardless of the status of abortion laws, unintended pregnancies continue to occur in all societies and woman will continue to access an abortion, whether the law restricts this or not. Evidence from countries with the most restrictive abortion laws

suggests that the use of unsafe methods such as abortifacients like misoprostol is increasing widely (Sedgh et al., 2012).

The obvious conclusion is that even if a country has legal restrictions on abortion, women will continue to choose to terminate their unintended pregnancies. To deny that this is happening in Ireland is to deny the very personal and intimate reproductive choices of thousands of Irish women. It also denies the reality that thousands of women, who can afford it, make the annual journey to the UK or elsewhere in Europe to access an abortion. The loneliness and the stigma attached to this denial should not be underestimated in relation to the impact that having to leave one's family, primary care provider and supportive surroundings to access legal treatment elsewhere has on women. This is particularly poignant for women who are seriously ill or have been medically advised to seek a termination for medical reasons (ie. cancer, heart disease or fatal fetal abnormalities).

In Ireland, we have seen a sea change in attitudes over the last few decades in relation to contentious issues such as contraception, divorce and abortion. Irish citizens have become more global - living and learning in different countries and coming back to Ireland with adapted cultural values and more tolerance and acceptance of others' views. This has been demonstrated by the thousands of people who came out to support legislating for the X case in the wake of the death of Savita Halappanavar or the consistent increase in support over the last decade in the various opinion polls on abortion in Ireland. AIMSI believes that these domestic changes in attitudes combined with international human rights laws and policies uphold the need for the Irish government to introduce legislation that regulates access to the highest attainable standard of maternity care, including abortion, without interfering with a woman's right to life, health, privacy, freedom from cruel and inhumane treatment and non-discrimination.

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IRELAND:

SUBMISSION TO THE OIREACHTAS COMMITTEE ON HEALTH AND CHILDREN IN RESPONSE TO:

GENERAL SCHEME OF THE PROTECTION OF LIFE DURING PREGNANCY BILL 2013

Amnesty International is a global movement of more than
3 million supporters, members and activists in more than 150
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of human rights.

Our vision is for every person to enjoy all the rights enshrined
in the Universal Declaration of Human Rights and other
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We are independent of any government, political ideology,
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SUBMISSION TO THE OIREACHTAS

COMMITTEE ON HEALTH AND

CHILDREN IN RESPONSE TO:

GENERAL SCHEME OF THE

PROTECTION OF LIFE DURING

PREGNANCY BILL 2013

1. BRIEF INTRODUCTION

Amnesty International is a non-governmental organization with a global membership of some 3 million individuals. Amnesty International's mission is to conduct research and generate action to prevent and end grave abuses of human rights—including the rights to life, health, private life, equality, non-discrimination, and freedom from torture and other cruel inhuman and degrading treatment—and to demand justice for those whose rights have been violated in all parts of the world. The organization works independently and impartially to promote respect for human rights, based on research and on legal standards agreed by the international community.

Amnesty International is concerned with the systematic violation of sexual and reproductive rights across the globe. In our experience and research, these violations contribute to continued gender-based discrimination and prevent an effective response to poverty, maternal mortality and morbidity, and gender-based violence, in developing and developed countries alike.

2. EXECUTIVE SUMMARY

Amnesty International considers that the legislative proposal does not discharge Ireland's international human rights obligations with regard to access to abortion.

Amnesty International notes that the 'X' case ruling established the right to access abortion services within the state where the 'life as distinct' to the health of the woman is at risk. The Committee must nonetheless propose legislation, which ensures that this is not so narrowly interpreted as to reduce this right to an immediate and imminent risk to the woman's life.

The proposal fails to acknowledge the human right to the highest attainable standard of physical and mental health, fails to make allowance for the right of women to access abortion where the pregnancy is as a result of rape or incest, and makes no provision for abortion in the case of non viable pregnancies. The bill also does not decriminalise abortion fully, as

required for Ireland to be in compliance with its human rights obligations on the rights to health, life, non-discrimination, freedom from torture and other cruel, inhuman and degrading treatment, physical integrity, freedom of thought, conscience, and religion, and the right to determine the number and spacing of children.

Even within the narrow construction of legislation allowing for access to abortion where there is a "real and substantial" risk to the life of the pregnant woman or girl, Amnesty International considers this proposal to be inadequate. It is not possible in medical science to definitely distinguish between risk to health and risk to life. The health risks arising from a relatively minor infection, for example, can quickly become threatening to a person's life, depending on the overall health of the patient, contextual issues such as access to medicine and trained care, and many other factors. Moreover, in the context of abortion, it is

uncontested that denial of access to abortion on health grounds can put women's lives at risk.

The proposed legislation further fails to recognise the suicide-risk associated with the denial of care, and does not weigh longer-term risks, such as deteriorating health leading to early demise, which might be associated with carrying a pregnancy to term despite serious health complications.

The obligation to give effect to women's human rights by allowing them to access abortion on both life and health grounds requires states to structure their domestic legal system appropriately.1 All women in Ireland are entitled to equal access to the care they need. Failure to fully decriminalise abortion and to provide for abortion access on health grounds or after rape in Ireland results in unequal outcomes for different groups of women – those able to travel and those unable to do so.

In this connection, Amnesty International reminds the government that international human rights law does not allow Ireland to invoke constitutional provisions as a justification for the imposition of legislation that violates human rights.

Amnesty International is also concerned that the proposed legislation undermines the right of patients to autonomous decision-making in the most intimate sphere of their lives. We remind the government of its obligation to ensure that women, adolescents, and—in the case of younger girls in particular—their guardians are always the main and final decision-makers with regard to access to care, including decisions to terminate an abortion.

The government is presented with a unique legislative opportunity to repeal the 150-year old law subjecting women and girls and medical professionals to criminal sanctions for obtaining abortions and for providing health care that upholds the human rights of women. Targeting the criminal law against women, girls and their health care providers is an ineffective means of discharging the constitutional obligation in Bunreacht na hEireann to protect unborn

1 See CESCR, General Comment 14 (the right to the highest attainable standard of health (art. 12)), UN Doc E/C.12/2000/4, para. 36: "The obligation to fulfil requires States parties, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health."

human life that leads to violations of the human rights of girls and women living in Ireland.

The legislation must repeal the relevant sections of the Offence Against the Person Act 1861 and no law should not mete out punishment for the provision or seeking of health care.

Finally, Amnesty International is not convinced that the legislation defines conscientious objection in a manner that guarantees equal access to care for all women and girls in Ireland, regardless of their place of residence, immigration status, age, or other considerations.

3. LIST OF RECOMMENDATIONS

Head 2 Risk of loss of life from physical illness

The legislation should clarify that a pregnant woman's life cannot be properly preserved without adequately attending to her right to the highest attainable standard of physical and mental health.

The legislation must further clarify that women, adolescents, and, in the case of younger girls, their guardians are the ultimate decision-makers on their own health. This means that no medical provider, judge, or other third person is allowed to determine what the individual determines is better for their health and life.

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

The proposed legislation must explicitly refer to medical providers' obligation to

provide full, accurate, and scientific information about health risks and options.

The legislation must further explicitly clarify that no medical provider will be prosecuted for providing care—including abortion—which he or she believes will prevent a medical situation from escalating into an emergency.

Head 4 Risk of loss of life from self-destruction

The proposed legislation must recognise that pregnancy-related suicidal tendencies most likely are related to the perception of limited choices and should not apply any assessment or test that places the determination of care in hands of medical providers or other third persons.

Head 6 Formal medical review procedures

The proposed legislation must recognise that a two-week review timeline is unrealistic and potentially severely damaging for situations of life- or health-threatening pregnancies.

The proposed legislation must ensure that review panels do not include medical providers or others who are opposed to the provision of abortion, across the board.

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

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As per above

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

As per above

Head 12 Conscientious Objection

The proposed legislation must ensure that all women and girls have access to legal

care within a reasonable timeline and without facing undue burdens due to the conscientious objection of medical providers and others. In practice, this means that the legislation must:

- ensure that non-objecting providers are accessible and available to provide care for women and girls throughout the Irish territory; and
- ensure that medical providers are not allowed to object to providing emergency care.

Head 19 Offence

The proposed legislation must repeal any mention of abortion in the Offence Against Persons Act. The government must ensure that no person is penalised for seeking or providing quality health care services as needed, including abortions.

4. MAIN BODY SUBMISSION

HEAD 2 RISK OF LOSS OF LIFE FROM PHYSICAL ILLNESS

As recent events in Ireland confirm, it is not possible in medical science to definitely distinguish between risk to health and risk to life. The health risks arising from a relatively minor infection, for example, can quickly become threatening to a person's life, depending on the overall health of the patient, contextual issues such as access to medicine and trained care, and many other factors. Moreover, in the context of abortion it is uncontested that denial of access to abortion on health grounds can put women's lives at risk. The proposed legislation does not reflect this, as it draws a false distinction between risk to life and risk to health of the pregnant woman or girl.

In fact, because the proposed legislation insists that medical providers draw a distinction between risk to health and risk to life in the context of abortion, doctors are forced to separate patients into those who are "close enough" to death to receive full attention and care, and those whose health must deteriorate before they can be treated. As such, this kind

of legislation prevents doctors from properly advising patients who might avoid life-threatening situations by having an abortion. In this manner, the law contributes to generating preventable and unnecessary risk to life of pregnant women.

Further, ignoring certain health risks in pregnancy can heighten the probability of early death in some women. A UK review of available data published in 2007, concluded that overall

mortality rate after preeclampsia more than doubled, all other things being equal, 14.5 years after a person has given birth.2 In other words: it is not possible to define life and health risk, as this legislation does, by solely looking at the health emergencies that arise in the limited hours before and after birth.

Human rights bodies have long recognised the complexity of this situation and have provided guidance on states' obligations in respect of abortion not just in terms of the right to life but also in respect of the right to the highest attainable standard of health, and the rights to non-discrimination, equality under the law, and freedom from torture and other cruel, inhuman, or degrading treatment.

The Convention on the Elimination of Discrimination Against Women (CEDAW) Committee has characterised "laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures" – among which criminal abortions laws must be counted – as "barriers to women's access to appropriate health care" contravening states' human rights obligation in the context of women's right to non-discrimination and equality relating to the right to the highest attainable standard of health.3

The CEDAW Committee has expressed specific concern with abortion legislation that restricts access to care where the pregnant woman's health is in danger. For example, the CEDAW

Committee expressed regret at the failure of Chile to decriminalise abortion "including those [sic] where the health or life of the mother are at risk, in cases of serious foetus malformation or rape" and called for abortion to be decriminalised "in cases of rape, incest or threats to the health or life of the mother."4

The Committee on Economic, Social and Cultural Rights has urged Nicaragua "to review its legislation on abortion and to study the possibility of providing for exceptions to the general prohibition on abortion in cases of therapeutic abortion or pregnancies resulting from rape or incest."5 Prior to the total ban on abortion which the Committee thus criticised, Nicaraguan law had recognised "therapeutic abortion" as legal. The law was interpreted in practice to permit abortion to be performed when the life or health of the woman or girl was at risk from continuation of pregnancy and, on particular occasions, in cases of pregnancy as a result of rape.6

The Committee on Economic, Social and Cultural Rights also noted its concern that the Philippines' legal system made abortion illegal "in all circumstances, even when the woman's life or health is in danger or pregnancy is the result of rape or incest."7 (italics added)

The Human Rights Committee, the Committee on Economic, Social and Cultural Rights, the

2 See Leanne Bellamy, Juan-Pablo Casas, Aroon D Hingorani, David J Williams, "Pre-eclampsia and risk of cardiovascular disease and cancer in later life: systematic review and meta-analysis," British Medical Journal (2007) pp.335—974.

3 CEDAW Committee, General Recommendation 24 on women and health (1999), para. 14

4 CEDAW/C/CHL/CO/5-6, 12 November 2012

5 CESCR concluding observations on Nicaragua, UN Doc E/C.12/NIC/CO/4, para. 26

6 Amnesty International, Nicaragua: The total abortion ban in Nicaragua: Women's lives and health endangered, medical professionals criminalised, AI Index AMR 43/001/2009, 27 July 2009, footnote 3

7 CESCR concluding observations on the Philippines, UN Doc E/C.12/PHL/CO/4 (2008), para. 31

CEDAW Committee and the Committee on the Rights of the Child have all welcomed the Colombian Constitutional Court ruling which decriminalised abortion in cases when pregnancy poses a serious risk to her life or health and when the foetus displays signs of serious malformations that make its life outside the womb unviable (as well as when the woman is a victim of rape or incest).8

Further, Ireland is obligated under article 2 of the Convention against Torture to take "effective legislative, administrative, judicial or other measures to prevent acts of torture." In its General Comment 2, the Committee against Torture has explained that article 2 requires states to ensure "implementation of … positive measures of prevention and protection."9 These are to be motivated by "continual evaluation" to "identify, compare and take steps to remedy discriminatory treatment that may otherwise go unnoticed and unaddressed."10 In the context of the regulation of abortion, positive measures of prevention and protection against torture and other cruel, inhuman or degrading treatment include ensuring women and girl's access to safe and legal abortion services.

By focusing on physical illness, the proposed legislation ignores Ireland's obligations to promote the right to the highest attainable standard of mental and physical health, which is linked to the World Health Organisation's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Amnesty International knows, from its research and experience that the emotional distress that accompanies a wanted but severely unhealthy pregnancy is such that women often desire a termination. Amnesty International believes that women's rights to life and health in

such cases can only meaningfully be upheld where doctors can legally apply a full range of therapeutic tools to address the health needs and wishes of the patient. The proposed legislation compromises this possibility by downplaying the link between life and health, and by ignoring mental health altogether.

The proposed legislation makes the legality of a specific health intervention—abortion—dependent upon a determination of the severity of a pregnant woman or girl's health condition. This legal structure makes medical professionals the ultimate decision-makers on the termination of a pregnancy. Accordingly, the role of the woman or girl11 is one restricted

8 Human Rights Committee concluding observations on Colombia, UN Doc. CCPR/C/COL/CO/6 (2010), para. 19. Committee on Economic, Social and Cultural Rights concluding observations on Colombia, UN Doc. E/C.12/COL/CO/5 (2010), para. 5, CEDAW Committee concluding observations on Colombia, UN Doc. CEDAW/C/COL/CO/6 (2007), para. 22; Committee on the Rights of the Child concluding observations on Colombia, UN Doc. CRC/C/COL/CO/3(2006), para. 3c and 70

9 UN Committee against Torture, General Comment no. 2, Implementation of article 2 by States parties, UN Doc CAT/C/GC/2, 24 January 2008, para. 21

10 Id., para. 23

11 The Convention on the Rights of the Child requires states to "assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, [such views] being given due weight in accordance with the age and maturity of the child" (Article 12(1). In xxxx, UNICEF published its interpretation of this issue in the context of medical counselling, noting that "[t]he child's right to received medical counselling without parental consent is vital in cases in which the child's views and/or interests are distinct from, or may be in conflict with, those of parents."

to giving informed consent to the treatment offered rather than the treatment desired.12 This is particularly worrisome in emergencies.

International human rights standards are clear that individuals—or in the case of younger children, their guardians—must have the main and final say in their health care.13 The CEDAW Committee has put this in the strongest terms possible: “Decisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government.”14 The UN Committee on Economic, Social and Cultural Rights has likewise noted that autonomy is key to the realisation of the right to health: “The right to health … includes the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference.”15 Affirming “the right of all human beings, in particular women, to respect for their physical integrity and to freedom to control their own bodies”, the Parliamentary Assembly of the Council of Europe has stated that “the ultimate decision on whether or not to have an abortion should be a matter for the woman concerned, who should have the means of exercising this right in an effective way.”16 It has invited member states of the Council of Europe to “allow women freedom of choice and offer the conditions for a free and enlightened choice without specifically promoting abortion.”17

HEAD 3 RISK OF LOSS OF LIFE FROM PHYSICAL ILLNESS IN AN EMERGENCY SITUATION

As mentioned above, it is not possible to draw a clear distinction between a life-threatening emergency and a non-life-threatening emergency situation in the context of abortion. The denial of needed health care services, including in some circumstances abortion, can put women’s lives at additional risk and situations can rapidly escalate from worrying to critical. This unnecessary and preventable escalation of ill health—imposed by the state through legislation—is contrary to state obligations with regard to the rights to life, health, non-discrimination, and freedom from cruel, inhuman, and degrading treatment.

HEAD 4 RISK OF LOSS OF LIFE FROM SELF-DESTRUCTION

Suicide during pregnancy is a relatively unstudied phenomenon, in part because it is not included in the classification of maternal mortality. A scholarly article in 1994 reviewed

UNICEF further notes that a child may have a right to receive independent medical counselling before he or she is deemed capable of consenting independently to medical treatment, and that, in all cases, the child's best interests should be the central guiding principle. See Rachel Hodgkin and Peter Newell, Implementation Handbook for the Convention on the Rights of the Child (New York: UNICEF, 2002), pp. 8-9.

12 Expert Group Report, p. 19.

13 There may be narrow limitations to this principle where an individual is temporarily or permanently unable to make decisions for herself or himself.

14 CEDAW Committee, General Recommendation 21 on Equality in Marriage and Family Relations (1994), para. 22.

15 Committee on Economic, Social and Cultural Rights, General Comment 14, The Right to the Highest Attainable Standard of Health, U.N. Doc. E/C.12/2000/4 (2000), para. 8.

16 Parliamentary Assembly of the Council of Europe Resolution 1607 (2008) Access to safe and legal abortion in Europe, para. 6

17 Parliamentary Assembly of the Council of Europe Resolution 1607 (2008) Access to safe and legal abortion in Europe, para. 7.3

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available international literature on this issue at the time, and found that suicide during pregnancy often is related to the limited choices women face during an unwanted pregnancy,

such as for example limits on access to safe and legal abortion.18 While there are very few figures on pregnancy-related suicide, there is some quantification of the factors that might compound the desperation felt by those confronting a crisis pregnancy, such as the fact that the pregnancy is the result of rape. A 1996 study in the United States noted that approximately 5 percent of rape victims of reproductive age get pregnant as a result of the rape, and that this rate is higher for adolescent girls. The study also found that a large proportion of rape victims do not discover they are pregnant until late in the pregnancy, further narrowing their options.19

While it is not possible to establish clear cause-effect links between rape, pregnancy, and suicide, it is noteworthy that the one factor which has been documented to heighten pregnancy-related suicide risk—limited choices—is likely to be compounded by one of the issues the current legislative proposal seeks to ignore, namely rape.

It is also noteworthy that pregnancy-related suicidal tendencies are related to the perception of limited options. This perception is likely to be enhanced by any test or assessment that places the decision over future options in the hands of third persons, as the legislation does. As such, the legislative proposal is likely to lead to further suffering for the pregnant woman or girl, and ultimately could create, rather than resolve, emergencies. Denied and delayed care is not just a matter of the rights to life, health, and non-discrimination, but also engages obligations with regard to the prevention of torture and other cruel, inhuman, and degrading treatment.

HEAD 6 FORMAL MEDICAL REVIEW PROCEDURES

In accordance with the procedure set out in the proposed legislation, a woman seeking a review of a decision to deny her access to “a medical procedure in the course of which or as a result of which unborn human life is ended” may wait up to two weeks to receive notification of the review’s outcome. The women entitled to lawful abortion access under the

Bill's provisions confront a real and substantial risk of loss of life if they cannot access this medical procedure. For these women and girls, waiting period of up to two weeks risks a considerable worsening of their medical situation, potentially to the point of making the risk to their lives immediate if not inevitable, with health professional unable to intervene appropriately while awaiting the review decision.

Timeliness for a review decision in the sense referred to in the European Court of Human Rights' judgment in Tysiac v Poland20 is very context-dependent. In the case of lawful medical treatment under this Bill, the timeframe must be short enough to take sufficient account of the particular gravity of the medical situation in question, including the risk of

18 See S. Frautschi, A. Cerulli, D. Maine, "Suicide during pregnancy and its neglect as a component of maternal mortality," in International Journal of Gynecology & Obstetrics, Volume 47, Issue 3, December 1994, pp. 275–284.

19 See Melisa M. Holmes, MD, Heidi S. Resnick, PhD, Dean G. Kilpatrick, PhD, Connie L. Best, PhD, "Rape-related pregnancy: Estimates and descriptive characteristics from a national sample of women," American Journal of Obstetrics and Gynecology, Volume 175, Issue 2, August 1996, pp. 320–325.

20 Tysiac v Poland, judgment of the European Court of Human Rights of 20/03/2007, para. 117

irreversible harm or damage to the woman's health from delays in medical intervention. This risk – and the risk of the woman moving into the category of "medical emergency", set out under Head 3 – must be minimised by shortening the proposed review timeline as well as ensuring that – in case of finding in favour of permitting abortion access – the procedure can be undertaken without any further delay.

For women's claims to have been denied medical care unlawfully to be adjudicated fairly, the

law must ensure that panel of medical practitioners that reviews complaints of denial of access to abortion excludes individuals who hold conscientious objections to abortion. Permitting those conscientiously opposed to abortion to participate in review panels would constitute a bias prejudicing fair consideration of a woman's entitlement to access to abortion services under Irish law.

HEAD 7 REVIEW WHERE RISK ARISES FROM PHYSICAL ILLNESS, NOT BEING A RISK OF SELF DESTRUCTION

As per above

HEAD 8 REVIEW IN CASE OF RISK OF LOSS OF LIFE THROUGH SELF DESTRUCTION

As per above

HEAD 12 CONSCIENTIOUS OBJECTION

The legislation's provision on conscientious objection does not – but must – reflect the duty of medical practitioners, nurses or midwives to provide necessary health care to a patient in an emergency situation even if they otherwise object to providing such care.21 The World Health Organisation states: "Individual health-care providers have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk. In such cases, health-care providers must refer the woman to a willing and trained provider in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the health-care professional who objects, must provide safe abortion to save the woman's life and to prevent serious injury to her health."22 The legislation should also clarify how the duty to provide emergency care and the duty to ensure effective referral in non-emergency cases (point (4) under Head 12) will be enforced. The right to conscientious objection is linked to the right to manifest one's religion or beliefs, protected, for example, in article 18(3) of the International Covenant on Civil and Political

Rights. This right is not absolute, and may be subject to certain limitations as stipulated in the Covenant. Limitations must be "prescribed by law" and "necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others." With this in mind, it is incumbent upon states to regulate the right to conscientious objection in the

21 See Medical Council Ethical Guidelines referred to in the General Scheme of the Protection of Life During Pregnancy Bill 2013, notes under Head 12: "10.3 Conscientious objection does not absolve you from responsibility to a patient in emergency circumstances."

22 World Health Organisation, Safe abortion: technical and policy guidance for health systems, Second edition, http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf

health field in such a way as to protect both the right to manifest one's religion and beliefs and the rights to life, health, non-discrimination, and other rights of those potentially denied services.

The CEDAW Committee has repeatedly expressed concerns with the denial of abortions due to conscientious objection. For example, the Committee noted its concern in Croatia "about information regarding the refusal, by some hospitals, to provide abortions on the basis of conscientious objection of doctors." The Committee further noted that it "considers this to be an infringement of women's reproductive rights."23 With regard to Italy, the Committee "expressed particular concern with regard to the limited availability of abortion services in southern Italy, as a result of the high incidences of conscientious objection among doctors and hospital personnel." In that case, the Committee "strongly recommended that the Government take steps to secure the enjoyment by women, in particular, southern Italian

women, of their reproductive rights by, inter alia, guaranteeing them access to safe abortion services in public hospitals."24

In this connection, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) has stated that "if health service providers refuse to perform [health] services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers".25

The Human Rights Committee has recommended, specifically in the context of guaranteeing access to legal abortion in Poland, that the Polish government "introduce regulations to prohibit the improper use and performance of the 'conscience clause' by the medical profession".26

In his 2011 report to the United Nations General Assembly, the Special Rapporteur on the right to health cites inadequate regulation of conscientious objection as a legal restriction that contributes to making legal abortions inaccessible: "Conscientious objection laws create barriers to access by permitting health-care providers and ancillary personnel, such as receptionists and pharmacists, to refuse to provide abortion services, information about procedures and referrals to alternative facilities and providers."27 He recommends that states "ensure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available in cases where the objection is raised by a service provider".28

In the context of the present review, Amnesty International highlights that guidelines must clarify that, in emergency situations where no referral or alternative service is available, accessible or adequate, there can be no room for conscientious objection.

23 Committee on the Elimination of Discrimination against Women, "Report of the Committee on the Elimination of Discrimination against Women," UN Doc A/53/38 (1998) part I, para 109.

24 Committee on the Elimination of Discrimination against Women, "Report of the Committee on the

Elimination of Discrimination against Women," UN A/52/38/Rev.1 (1997), part I, paras. 353 and 360.

25 CEDAW Committee, General Recommendation 24 on women and health (1999), para. 11.

26 Human Rights Committee, concluding observations on Poland, U.N. Doc. CCPR/C/POL/CO/6, para. 12.

27 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, U.N. Doc. A/66/254, para. 24.

28 Ibid., para 65(m).

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HEAD 19 OFFENCES

Human rights law obliges states to take measures that are protective of prenatal life by entitling pregnant girls and women to support during pregnancy, childbirth and motherhood.29 By contrast, the criminalisation of girls and women for abortion does not serve the purpose of protecting of prenatal life and violates the human rights of girls and women.

The legislative context of this Bill provides the Irish government with an opportunity to enhance human rights protection in Ireland by repealing – rather than replacing and updating – the Offences against the Person Act 1861. If the government fails to take this opportunity to repeal the criminalisation of girls and women for having an abortion, it actively perpetuates the violations of the human rights of girls and women stemming from criminalisation by manifesting its intention to investigate, prosecute and punish girls and women for having had an abortion outside of the very narrow scope of the law.

As a general proposition, the legislature is presumed to mean what it says in enacting a law and to intend the consequences that necessarily flow from a law it creates. This presumption of legislative intent is reinforced by reference to the legislative history, including the debates among lawmakers and the information put before them.30 If the Irish government fails to take

the opportunity offered by the Bill to decriminalise abortion, it must be concluded that the government endorses the consequences already flowing from the 1861 Act. This conclusion is of concern in particular given that there is no evidence that criminalisation of abortion is an effective means for the task of preventing abortion. The World Health Organisation has stated: "Whether abortion is legally restricted or not, the likelihood that a woman will have an abortion for an unintended pregnancy is about the same. […] Legal restrictions on abortion do not result in fewer abortions."31

There can be no doubt that the criminalisation of abortion causes severe pain and suffering to those girls and women whose unwanted or non-viable pregnancy falls outside the narrow scope of the law.32 Apart from denial of access to abortion services, the effect of criminalisation includes affected girls' and women's mental anguish at being confronted with – and living with the consequences of – a stark choice between two options within the Republic of Ireland: to continue the pregnancy against their wishes and/or at a cost to their health or risk to their lives, or to commit a criminal offence and risk criminal investigation, prosecution and punishment on a par with those suspected of assaults causing serious harm.

As any girl or woman may find herself in the situation of needing to access abortion services

29 Thus, for instance, the UN Committee on the Rights of the Child calls on states, in implementing the child's right to the highest attainable standard of health, to undertake appropriate measures "[t]o ensure appropriate pre-natal and post-natal health care for mothers". (Convention on the Rights of the Child Article 24.2(d))

30 See, for example, Peter de Cruz, "A Comparative Study of Statutory Interpretation," in Comparative Law in a Changing World, 2d ed., 1999, pp. 265-92. See also Claire M. Germain, "Approaches to Statutory Interpretation and Legislative History in France," Duke Journal of Comparative and International Law, vol. 13 (2003), pp. 195-206.

31 World Health Organisation, Safe abortion: technical and policy guidance for health systems, Second

edition, http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf

32 Amnesty International, The impact of the complete ban on abortion in Nicaragua – Briefing to the United Nations Committee against Torture, AMR 43/005/2009

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outside the narrow scope of the law, the intent to continue criminalising these girls and women for making a choice that is crucial to their lives, health and well-being means putting Irish girls and women at large under suspicion of criminal conduct.

AI notes that international and regional human rights bodies mandated by states to give authoritative interpretations of human rights law have long emphasized that criminal sanctions for the procurement or provision of voluntary abortion information or services raise serious human rights concerns. At risk are the human rights to life, health, non-discrimination, liberty, privacy, information, security of person, and freedom from cruel, inhuman, and degrading treatment and punishment, as well as the right to decide on the number and spacing of children, to benefit from scientific progress, and to freedom of thought, conscience and religion.

In this regard, AI draws particular attention to General Recommendation 24 of the CEDAW Committee on women and health. In this General Recommendation—which should assist states in their implementation of the Convention on the Elimination of All Forms of Discrimination against Women—the CEDAW Committee affirms states' obligation to respect women's access to reproductive health services and to "refrain from obstructing action taken by women in pursuit of their health goals."33 It explains that impermissible "barriers to women's access to appropriate health care include laws that criminalize medical procedures

only needed by women and that punish women who undergo those procedures."34 Abortion is clearly a medical procedure only needed by women.

The CEDAW Committee specifically recommends that "[w]hen possible, legislation criminalizing abortion could be amended to remove punitive provisions imposed on women who undergo abortion."35 This serious concern with the criminalisation of abortion has been repeated in various concluding observations with regard to numerous countries by the Human Rights Committee36 and the Committee on Economic, Social and Cultural Rights.37

In the Platform for Action resulting from the Fourth World Conference on Women in 1995,

33 CEDAW Committee, General Recommendation 24, Women and Health (Article 12), U.N. Doc. No. A/54/38/Rev.1 (1999) (hereinafter General Recommendation 24), para. 14.

34 Ibid., para. 14.

35 Ibid., para. 31(c).

36 See e.g. Human Rights Committee, concluding observations on Ireland, U.N. Doc. CCPR/C/IRL/CO/3 (2008), para. 13; the Philippines (advanced unedited version), U.N. Doc. CCPR/C/PHL/CO/4 (2012), para. 13; Dominican Republic, U.N. Doc. CCPR/C/DOM/CO/5 (2012), para. 15; Guatemala, U.N. Doc. .CCPR/C/GTM/CO/3 (2012), para. 20; Jamaica, U.N. Doc. CCPR/C/JAM/CO/3 (2011) para. 14; Kazakhstan, U.N. Doc. CCPR/C/KAZ/CO/1 (2011), para. 11; El Salvador, U.N. Doc. CCPR/C/SLV/CO/6 (2010), para. 10; Poland, U.N. Doc. CCPR/C/POL/CO/6 (2010), para. 12; Cameroon, U.N. Doc. CCPR/C/CMR/CO/4 (2010), para. 13; and Mexico, U.N. Doc. CCPR/C/MEX/CO/5 (2010), para. 10. Similar calls have been made in many other concluding observations dating further back.

37 See e.g. CESCR, concluding observations on Ecuador, U.N. Doc. E/C.12/ECU/CO/3 (Advanced unedited version) (2012), para. 29; Peru, U.N. Doc. E/C.12/PER/CO/2-4 (2012), para. 21; Chile, U.N. Doc. E/C.12/1/Add.105 (2004), para. 25 and Kuwait, U.N. Doc. E/C.12/1/Add.98 (2004), para. 43. The Committee on Economic Social and Cultural Rights

has made repeatedly calls for states to facilitate access to abortion, including by legalizing the procedure, lowering the cost of abortions, and implementing broad-ranging policies to prevent unwanted pregnancies.

states committed to "consider reviewing laws containing punitive measures against women who have undergone illegal abortions."38 The United Nations Special Rapporteur on the right to health has noted:

"Criminal laws penalizing and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realization of women's right to health and must be eliminated. These laws infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health. Moreover, such laws consistently generate poor physical health outcomes, resulting in deaths that could have been prevented, morbidity and ill-health, as well as negative mental health outcomes, not least because affected women risk being thrust into the criminal justice system. Creation or maintenance of criminal laws with respect to abortion may amount to violations of the obligations of States to respect, protect and fulfil the right to health."39

Based on this analysis, the Special Rapporteur has called for the removal of punitive sanctions against women who have had abortion, and for the full decriminalisation of abortion.40

Several studies on access to abortion in countries with partial decriminalisation—such as in Ireland—have concluded that as long as abortion is generally criminalised, medical service providers will be deterred from even providing care that is legal.41 In its ruling in the case of A, B and C v Ireland, the European Court of Human Rights said it considered it "evident"

that the criminal provisions on abortion "would constitute a significant chilling factor for both women and doctors in the medical consultation process" and that women would be deterred from seeking legal and necessary care, and doctors from providing it, because of this chilling effect.42

In the context of these repeated and forceful calls for the removal of punitive sanctions for all abortion, guaranteeing access to abortion services that have been legal (but inaccessible) in Ireland for decades is, while positive, clearly an insufficient step. The government should decriminalise abortion in all circumstances. Women and girls must not be subject to criminal sanctions for seeking or obtaining an abortion under any circumstances. Medical health practitioners must not be criminalised solely for providing abortion services that are safe.

The Irish State can regulate access to abortion in a manner that takes into account the evolving protection needs of the foetus and the health needs and autonomy entitlements of the pregnant woman or girl. Such legislation, however, must be proportionate to the

38 Platform for Action of the Fourth World Conference on Women, U.N. Doc. A/CONF.177/20 (1995), para. 106k.

39 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, U.N. Doc. A/66/254, para. 21

40 Ibid., para. 65(h) and Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, U.N. Doc. E/CN.4/2004/49 (2004), para. 30.

41 Human Rights Watch, A State of Isolation: Access to Abortion for Women in Ireland, January 2010; Human Rights Watch, The Second Assault: Obstructing Access to Abortion after Rape in Mexico, March 2006.

42 European Court of Human Rights, Case of A, B and C v. Ireland, Judgement of 16 December 2010, para 254.

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objective, and cannot substitute foetal considerations for the human rights of women and girls. Gestational limits that provide no exemption for protecting the life of the woman, for example, would not be considered reasonable under international human rights standards.

5. GENERAL CONSIDERATIONS

OBLIGATION TO AMEND CONSTITUTION

Amnesty International would like to take this opportunity to remind the Irish government that the criminalisation of abortion is gender-discriminatory, punishing women and girls for seeking health treatment that only they need.43 Only women and girls risk physical and mental suffering or losing their lives as a result of delays in or denial of medical treatment if complications arise during pregnancy. Only women and girls are compelled to continue a medically dangerous or unwanted pregnancy or face imprisonment. Only women and girls suffer the mental anguish and physical pain of an unsafe abortion, risking their health and life in the process. Amnesty International reminds the government that the UN Human Rights Committee, in the context of its review of Ireland's compliance with the International Covenant on Civil and Political Rights in 2008, reiterated previous concerns "regarding the highly restrictive circumstances under which women can lawfully have an abortion."44 In fact, limiting abortion access to cases of real and substantive risk to life can lead to prolonged physical and mental pain and suffering (rising to a level covered by the prohibition of cruel, inhuman, and degrading treatment), as well as preventable risk of ill-health and death.

Therefore, Ireland's international human rights obligations with regard to the rights to life, health, non-discrimination, and freedom from torture and other cruel, inhuman and degrading treatment require the full decriminalization of abortion. Deliberations on this bill should be undertaken in this light.

Amnesty International recognizes that Ireland will need to amend its constitution to fully comply with its international human rights obligations on the rights to life, health, non-discrimination, physical integrity, and equality under the law as they apply to access to abortion. In that connection, we remind the government that the UN Human Rights Committee has very clearly noted that, where constitutional provisions impede the full protection of human rights, international human rights obligations must be prioritized. For example, in its General Comment 31 on the general legal obligations of States Parties to the International Covenant on Civil and Political Rights, the Committee notes that "although [the Covenant] allows States Parties to give effect to Covenant rights in accordance with domestic constitutional processes, the same principle operates so as to prevent States Parties from invoking provisions of the constitutional law or other aspects of domestic law to justify a

43 See UN Committee on the Elimination of All Forms of Discrimination against Women, General recommendation No. 24: Article 12 of the Convention (women and health), paras. 14 and 31 (c).

44 Human Rights Committee, concluding observations on Ireland, 30 July 2008, U.N. Doc. CCPR/C/IRL/CO/3, para. 13

failure to perform or give effect to obligations under the treaty."45

OBLIGATIONS TOWARDS WOMEN AND GIRLS WHO ARE COMPELLED TO TRAVEL FOR CARE

Ireland cannot rely on the fact that some women seek and get access to needed care outside of Ireland to declare its human rights obligations discharged. Rather, Ireland's compliance with its human rights obligations must be assessed by the laws, policies and practices, which govern the lives of women in Ireland. Along that vein, the Committee on Economic Social and Cultural Rights has called for domestic measures to prevent women having to travel abroad in order to obtain abortion access.46

Where the law does not actively pose an obstacle for women to travel for the purposes of abortion access, other factors directly related to the need for international travel can pose insurmountable barriers for particular groups of women. Some women lack the financial means to travel or access to the information they would need in order to access abortion services abroad. Relying on travel creates de facto discrimination between those women who have the financial and informational resources to travel and those who do not. Some women are unable to travel because of their immigration status, their health status, their care responsibilities, because they are in state custody, because they live in a state institution or are a ward of court, or are otherwise prevented from travelling. The only real option open to these women is to continue a pregnancy that places their health at risk.

Relying on travel for women to exercise their rights creates inequity in access that the state has an obligation to overcome. The Committee on Economic, Social and Cultural Rights has stressed that "the Covenant [on Economic, Social and Cultural Rights] proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health."47 (italics added)

But even at the most basic level, abortions sought on health grounds are subject to severe sanctions if undertaken in Ireland. To meet its human rights obligations, Ireland cannot demand that women take actions abroad that – if taken in Ireland – would expose them to criminal investigation, prosecution and punishment.

45 UN Human Rights Committee, General Comment No. 31, The Nature of the General Legal Obligation Imposed on States Parties to the Covenant, 29 March 2004, para. 4.

46 "[…] the State party should adopt measures to assist women in avoiding unwanted pregnancies, so that they do not have to resort to potentially life-threatening illegal or unsafe abortions, or have abortions abroad." (CEDAW concluding observations on Nicaragua, UN Doc E/C.12/NIC/CO/4, para. 26)

47 CESCR, General Comment 14 (the right to the highest attainable standard of health (art. 12)), UN Doc E/C.12/2000/4, para. 18

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Subject
The new Maternity Bill

FAO: Paul Kelly

In response to the call for submissions on the above proposed bill, I would like to express my grave concerns regarding same and request that it be changed.

This bill will allow for the first time in Ireland the direct and intentional killing of the unborn baby, without any time limit. This is cruel, horrendous and unacceptable. This bill is ignoring the evidence that abortion does not hep women, it hurts them. The proposed legislation is profoundly wrong, in particular its provision on abortion in case of threatened suicide and it must be changed. There is no credible evidence that abortion is any kind of treatment for suicidal ideation in women. This bill is ignoring this medical evidence, the evidence heard at the Oireachtas Joint Committee on Health and Children hearings in January that decisively rejected the notion of abortion as evidence based treatment for suicide. It is also ignoring the grave concerns expressed and submitted to the Dail / Oireachtas over by 100 Irish Psychiatrists last week.

As an Irish citizen, I expect the Government to protect life, never to endanger it. I request that the Government pay heed to the medical evidence heard at the Oireachtas Joint Committee on Health and Children and the concerns of the Psychiatrists and of the majority of Pro life people in the country. I ask that this bill is changed to protect life at all stages.
Yours sincerely
Andrea Lawlor

Ann Lee <annleeknock@yahoo.ie>
08/05/2013 12:23 To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Re proposed bill.

Dear Paul,
I wish to express my deep concern at what this bill seeks to provide. As you have heard from the professionals abortion is not an antidote for suicide. As a counsellor I am aware of the deep and often secret pain carried by those who have had abortions. I feel unjustly represented by both the government and the media which seem to present any person who is anti abortion is a pathetic catholic. I speak not as a religious but one who working with the dying and my value on life. It is wrong to end life. I support and appreciate the need for structure and clarity in relation to medical intervention as with the Halapanavar case. But what the government is proposing is pathetic and lacking true guidance.
Ann Lee Walshe

Sent from my iPhone

Anne Dooley <anne.dooley@gmail.com>
08/05/2013 11:11 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Protection of Life and Pregnancy Bill

To : Paul Kelly,

Dear Paul,
As a citizen of this country I wish to make my views known on the proposed bill on abortion.
I object to any abortion legislation being introduced to this country. Twice we have had referenda
on this issue and on both occasions I have voted to ensure that we continue to value and protect the lives of both mothers and babies.

While I am fully in favour of any treatment to protect the life of any and every pregnant woman, I am utterly opposed to the deliberate targeting of the life of the unborn, which happens in an abortion.
I am particularly disturbed at the inclusion of suicidal ideation as grounds for abortion as the evidence to the recent Oireachtas Committee hearings on the subject would seem to be unanimous that abortion is never a solution to suicide. In fact there is a body of international evidence which indicates that abortion can adversely affect mental health.

I call on this government to have compassion for the vulnerable lives of innocent children which this
legislation is going to destroy as well as having compassion for vulnerable women.

I should appreciate if you would acknowledge receipt of my email.
Many thanks,
Anne Dooley
71, Raheny Park,
Raheny, Dublin 5.

Annette Mahon <annettemahonhere@hotmail.com>
08/05/2013 14:32 To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Human Life and Pregnancy Bill

Paul Kelly
Health and Children
Oireachtas
Human Life and Pregnancy Bill.

Dear Paul,

This bill is wrong for both the health of the mother and now definitely for the child in the womb.

This is of huge concern to me and those who do not want legislation for abortion under any circumstances enshrined in our laws.

I’m horrified at the governments proposed legislation for abortion.

The Government said the life of the unborn child would be safeguarded.

With no time limit on gestation period , this is appalling.

I’m asking my representatives to reject this bill.

I think it’s quite clear based on the psychiatrist’s reports that abortion is not a treatment for suicidality. In actual fact its in will be detrimental to the health of these women. What these women need is support to help them through the crises feeling. Post abortion women are silenced. Listen to Bernadette Goulding of Rachael's Vineyard "the pain and regret and immense loss, depression, panic attacks, loss of self esteem last for years and perhaps for life". There is no acknowledgement of this.
"These women are not grieving over a bunch of cells or a blob of tissue but over the loss of a baby". No mother ever looks at her baby and says I wish I had an abortion.
Destruction of the child in the womb is a tragedy of immeasurable proportions.

Ireland is the last bastion defending the life of the unborn child and we should be proud of it, everyone has a personal responsibility to maintain this.

The pro abortion side keep saying one life is too much to loose, well what about even one life of the unborn child? The consequences are unthinkable but we need to think about them. What effect is this going to have on our doctors, nurses anyone and everyone directly or indirectly affected by these proposals. Think of the health problems these babies who survive this untimely end of their gestation will have for their whole life.

Where are their rights in all this, will they be the future scandal of this present legislation? This is wrong on every count for our nation which upholds in its constitution the right to life of the unborn.

We do not need to legislate to satisfy clarity. We do not need to legislate for suicideality as it is not a treatment for suicideality.

According to Senator Ronan Mullins" some obstetricians were not afforded their viewpoints. Some speakers were not called; the balance of speakers was questionable. The whole thing is being rushed through very quickly. The outcome seems almost predetermined. There's a sense that government members are keeping to the government line with safe questions, no hard questions like "How can you justify this legislation?" Many Tds are concerned and the impression seems to be they are seeking to convince themselves that they have no choice but to follow through on this, buying into the idea that you can dispense with human life and that there is no alternative, fooling themselves and us".

It would appear there is a tight deadline from the labour side with no time to loose this golden opportunity. Why is this, such an important and Life Altering, Nation Altering decision?

What kind of country and society do we want to raise our children and grandchildren in? Look at Britain 200,000 abortions a year, they never envisioned that! 90%Down syndrome aborted and worst of all viable aborted babies left to die 80 in 2008. This is the difference between Abortion and the necessary termination of a pregnancy for the health of a mother, where everything possible is done to save the life of the child as well as the mother. This is the confusion that the media and pro-abortion interests don't want us to be clear about. Medical intervention is vastly different from abortion. Abortion is the deliberate killing of the unborn child. The child is not Allowed to survive.
This is totally against the pro-life intention of Article 40.3.3 of the Constitution.
The lives of unborn children now depend on your choices as TDs and as our bishops say “Every public representative is entitled to complete respect for the freedom of conscience. No one has the right to force or coerce someone to act against their conscience. Respect for this right is the very foundation of a free, civilised and democratic society"
Are they been given that right by having to vote with the party line in a public vote? Are they representing the people who voted for Article 40.3.3 of the constitution? They do not represent me or the 30,000 people who stood in the cold vigil in Merrion Square.

It is also clear that the pro abortion side is not content with this narrow interpretation of Abortion and hope to find the opportunity to expand to Abortion on Demand. At least they are honest about it. Don’t be

fooled into thinking you can hold back the floodgates once you open them, against abortion under any circumstances.
There is ample room in the guidelines to protect the life of the mother where there are physical complications, if not they can be added, but there is no need to legislate for Abortion to protect the right to life of the mother.

Savita Hanapalavar died from ecoli septs. and the treatment for this is introvenus antibiotics, not abortion. Ireppareable damage has been done to Irish medical practice by this story broken by The Irish Times and used by the pro abortion lobby to promote their Deadly Agenda.

Is it too late to salvage reason and good legislation and good practice which we already have and should do all in your power to keep safe.

What I would say to the women who are contemplating goig to England to have abortions.
"Don't go, don't do this, this will damage you and kill your baby. This may seem like the best solution at the moment but you will have to live with this for the rest of your lives. There is help. Please don't be pressurised by others to do this. Be aware that this may damage your health both physically and mentally."
I think women have the right to know this and that abortion is not the answer to a crisis pregnancy. That is why it's so wrong to legislate for the X case scenario in particular.
Please tell Enda Kenny that the inclusion of suicide as a ground for abortion is unacceptable to the majority of Irish people and medical practitioners and psychiatrists. Clarity must be made between legitimate life saving medical treatment and the intentional killing of a child through abortion which is contrary to the equal right to life of the unborn enshrined in our constitution.

I repeat the analogy I made at the meeting of the 30,000 people who turned up for the pro life vigil,if each one represents even 100 people that's 3,000,000 people !!

We voted for this government in good faith because Enda Kenny promised Fine Gael would not to bring abortion into Ireland.

Yours sincerely,

Annette Mahon, Edward Mahon. Amy Mahon. Darren Mahon.
St.kevin's Villa
Newlands Cross
Naas Road
Clondalkin Dublin 22

Anthony Kenny <emmanueltk@hotmail.com>
08/05/2013 12:35 To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc
bcc
Subject

Mr Paul Kelly
Principal Clerk
Joint Committee on Health and Children

As an Irish citizen and taxpayer I wish to submit my concerns about the proposed legislation contained in the Protection of Life During Pregnancy Bill 2013.

It is the Government's intention to introduce legislation to bring clarity to Ireland's laws and provide for the protection of pregnant women during pregnancy particularly in crisis situations and medical emergencies. The protection of life during pregnancy of both a mother and her child is naturally of the utmost concern to every rational person. Where there is a threat to one or both of these lives it is imperative that legal clarity be given to the medical personnel involved to intervene using best medical practise. Ireland already has a top-class record in this regard in that it has been internationally recognised as being one of the safest places in the world for maternal health.

It is of deep concern that threat of suicide is being included in the legislation as a possible ground for the termination of unborn life. This is in complete contradiction to the evidence given by expert phsychiatrists at the Oireachtas hearings in January where they said that abortion is not considered a treatment for the threat of suicide within the profession. In practise the threat of suicidal ideation would be extremely difficult to assess and judge even by the medical professionals. Because even if the doctors were reasonably convinced there was no real threat of suicide there would naturally be a degree of uncertainty that could in the final analysis affect their judgement. And even in cases where there could be considered a real threat of suicide does that justify the allowance of an abortion? If a man or woman threatened suicide unless the life of their newborn child was ended what would the rational response to such a crisis situation be? Also it should be obvious to anyone who has studied the issue internationally that whenever mental health reasons are legislated for as grounds for an abortion it becomes a widely used method of securing one. Such is the reality of human nature.

I urge the Committee to consider these matters wisely. Let us continue to ensure that our country is a secure place for a pregnant woman and her unborn child. And where there are situations when either life is under threat let us allow the medical profession the legal clarity and freedom to carry out treatment in accordance with best medical practise and experience.

Yours sincerely,

Tony Kenny
23 Whitechurch Heights
Dublin 16

Audrey Mitchell <audreyjmitchell@hotmail.com>
07/05/2013 22:02 To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Proposed Legislation on Maternity

Dear Paul,

In relation to the new Bill I would like to explain my objection.

As was clearly stated in today's Irish Independent Abortion is not a proper or effective treatment for the treatment of suicide. The proposed Bill ignores these facts. In the hearings earlier this year the government also heard this from all the psychiatrists.
I truly cannot believe the Government are proposing this Bill considering all the facts.

The Government continually blame Fianna Fáil for the dreadful economic situation we found ourselves in. However if Fine Gael and Labour introduce such Legislation which results in the introduction of Abortion to this Country - I believe this is much worse! Abortion is a matted of life or death!

Edna Kenny continually stated over the weekend that his duty was to legislate. However his duty is to legislate for the common good! Please read the article in today's Irish Independent and explain how this proposed bill is for the common good. There is no evidence to support the opinion that abortion can be the effective treatment for suicide (actually results in worse mental health issues) and there is a dead baby.

I believe there is no need for abortion legislation, but a need for Medical Guidlines in relation to areas where the Mother requires treatment.

Please include my opposition in your reports.

Yours sincerely,
Audrey Mitchell.

BARBARA HEWSON BL

Barbara Hewson

Barrister

Direct Line 020 7691 0117

Hardwicke Building, New Square, Lincoln's Inn, London WC2A 3SB

Telephone 020 7242 2523 Fax 020 7691 1234

www.hardwicke.co.uk

I wish to make a submission and to be considered as a legal expert and speaker at the Oireachtas Health Committee Meetings in relation to The Protection of Life during Pregnancy (Heads of Bill 2013)

Background

I am called to the Bar of England & Wales (1985), Ireland (1991) and Northern Ireland (2000).

I practise across a broad range of public, human rights and regulatory law. I defend healthcare professionals accused of misconduct before their professional bodies, and represent families in coroners' inquests.

I also act for vulnerable clients lacking mental capacity in the Court of Protection, and for local authorities defending judicial reviews of their decisions. In Ireland, I have acted as junior counsel for home birth midwife Ann Kelly, in a long-running fitness to practise enquiry and related High Court and Supreme Court proceedings; a number of women seeking home birth services, and a number of women claiming damages for unwanted Caesarean hysterectomies at Our Lady of Lourdes' Hospital, Drogheda.

In England, my work has included a number of successful cases in the European Court of Human Rights (P C & S v. U.K., 2002; Glass v. U.K., 2004). I also acted for the Pro-Life Alliance in its challenge to the court-ordered separation of conjoined twins in 2001. I am currently acting for the family of the late David Gray in a complaint against Germany in the European Court, arising out of death caused by a visiting locum GP;

I acted pro bono for Ms Conroy in the D v Ireland case.

THE HEADS OF THE BILL

I think the main concern about the Bill that I would have is:

It introduces a new criminal offence in blanket terms, but without acknowledging that the courts have the paramount role of interpreting constitutional rights and that following the D case and the stance which the State took in that case (supported by Dr Gerard Hogan's opinion which it called 'compelling') the constitutional courts must retain the power to interpret the scope of the woman's constitutional rights to life and to dignity and the limits of the unborn's right to life under Art. 40.3.3.

For example Dr Hogan advises that where a foetus realistically has no chance of being born alive, there is an argument that its right to life under Art. 40.3.3 is not even engaged. So if the bill is (as its supporters say) intended solely to legislate for the circumstances of the case of X, then it would be helpful if this could be spelt out.

Consideration could also usefully be given as to what, if any, provision the Oireachtas might wish to make to assist couples with wanted pregnancies diagnosed with lethal foetal anomaly, and those treating them.

Bernard Hayes <cfc.bhayes@gmail.com>
08/05/2013 14:40 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Submission objecting to the proposed abortion legislation

healthandchildren@oireachtas.ie

<Paul Kelly>

Submission on the Abortion Debate

1 This Government has so far not given fair, balanced, and objective hearing to those of us against abortion. It has followed the agenda of the blatantly pro-abortion national and international media and it has allowed the public broadcaster RTE to follow the same propaganda. The Pro-Life movement has little or no voice in this debate. Even the vocabulary of this discourse favours pro-abortionists who take offence at words like killing and murder! The facts against abortion are denied, suppressed or distorted to suit the pro-abortion agenda.

2 For me abortion means life is cheap. Life is no longer precious. Abortion diminishes life, abortion denies life and abortion destroys life.

3 The Universal Declaration of Human Rights and the European Convention on Human Rights do not include abortion as a human right because it would be a contradiction in terms. Abortion is against human life and the right to life.

4 No person, no institution, and no government has the right to issue any licence for abortion. The first duty of a State is to protect it’s citizens, not to give anyone a licence to murder them.

5 The threat to suicide is no basis for any type of law. Will the banks forgive the debt of a mortgage holder who threatens to commit suicide if they send him to prison for failing to pay his debts?
No civilized society could warrant the death of an unborn child on the basis of a threat to suicide by it’s mother. Is there one single proven case of suicide by a woman who failed to get an abortion?

6 The clear distinction between termination of pregnancy as a medical intervention to save the life of a mother, and of abortion as a deliberate choice to end the life of the unborn child has been glossed over in this critical debate.

7 If political representatives are not allowed to vote as their consciences tell them in this life/death debate, how can this political system claim to be accountable, transparent and democratic, let alone free? Does the party come before the welfare of the nation? Does party policy come before the welfare and lives of our most vulnerable citzens?

8 Legislation that denies the conscientious objection of medical practioners has no place in a free and fair society.

9 There is absolute denial by pro-abortionists in this country of the conseqeunces of abortion law based on suicidal ideation as evidenced in UK and California. An 'avalanche effect' operates in those and similar jurisdictions which in practice ends up as abortion on demand. The same will happen here.

Signed: Bernard Hayes

Tel 01 475 1292

1

SUBMISSION

Oireachtas Joint Committee on Health and

Children

Protection of Life during Pregnancy Bill 2013

Brendan O'Connor

8th May 2013

2

INTRODUCTION

I make this submission on my own behalf, as a concerned citizen. I have no political affiliation, nor am I a member of any lobby group. I am by profession originally an architect and more recently a Catholic priest. In addition to my qualifications as an architect, I hold a doctorate in Moral Theology.

During my 25 years in practice as an architect, I specialised in planning and development law and became familiar with the legal process. I also had a particular philosophical interest in natural and constitutional law and worked with the legal teams in a number of prominent constitutional cases in the area of human and civil rights.

The Main Submission, summarised below, addresses Head 4 & 8 of the Bill, the suicide issue. The Recommendations follow from the arguments adduced in this submission.

Brendan O'Connor

3

EXECUTIVE SUMMARY

Cardinal error

The proposal in Heads 4 & 8 to include suicide as a ground for a termination of pregnancy is based on a cardinal error of fact and of law made by the Supreme Court in the X case. A risk arising from a threat of self-destruction is not equivalent—legally, morally or practically—to a serious physical risk to the life of the mother. By agreeing to terminate the life of the unborn, precisely in order to end her life, the doctors are acting directly against her equal right to life. They are not excused in so doing by acting on the wishes of her mother. There is no constitutional right to deliberately take away the right to life of another.

Recent development in the law

In the recent case on suicide, the Supreme Court held that it would be contrary to the constitutional right to life to permit a husband to assist his wife to carry out her own suicidal wishes, as there is no constitutional right to suicide.1 If the mother of an unborn child has no constitutional right to wilfully end her own life, *a fortiori* she can have no such right to take away the life of her unborn child—who has an equal right to life—or to obtain assistance from others to that end. Because it implied the contrary, the decision in the X case cannot now be considered a binding interpretation of the constitutional right to life (Article 40.3) and should not be relied upon as the basis for legislation in this area.

The application of the 'test' in the X case

Suicide *per se* was not the ground for abortion in X, but a "substantial risk to the life of the mother ***which can only be avoided by a termination***". The evidential question—i.e. *whether or not a particular risk in a specific case can only be avoided by a termination*—can clearly be distinguished and severed from the test itself. If a particular risk *can* be avoided by any less drastic means—as we now

know to be the case with a threat of maternal suicide—it falls out of the loop and fails the constitutional test. Furthermore, termination of a pregnancy does not cure a real suicidal ideation; the woman could just as easily commit suicide following the termination as before it. The suicide question, therefore, does not form an essential part of the interpretation of Article 40.3.3° in X, nor does it bind the Oireachtas in its legislation.

1 Fleming v Ireland & Ors [2013] IESC 19, 29th April, 2013.

4

The right not to have one's life taken away

While the State may not always be able to positively protect or defend a right to life—it is a conditional guarantee—, the State ***must always*** abide by the unconditional guarantee to ***respect*** that right, i.e. by refraining from legislating (or acting judicially) to take away that right. This goes to the heart of the current legislative issue. Notwithstanding the X case, any legislation which authorised the taking away of the life of the unborn on the ground of a threat of maternal suicide would be a fundamental breach of the constitutional guarantee in Article 40.3.3° to respect equally the right to life of the unborn child and its mother. Legislators must form their own legal and moral judgement on this matter; they cannot plead that they are simply carrying out orders from the Supreme Court.

The perverse logic of wilful abortion

If an unborn child already has a constitutional right to life ***equal*** to that of her mother, she cannot acquire a greater right to life simply by being born. What is legally valid in one case must therefore be valid in the other. The supposed 'justification' for taking away a life in the pre-born case is that the mother might commit suicide unless the life of her child is ended. As a matter of legal

consistency, therefore, the same 'justification' for ending the child's life would have to be available to an equally distressed mother in respect of her recently born child. The moral madness of infanticide—which is surely self-evident to every member of the Oireachtas Committee—should make clear the dangerous irrationality and injustice of allowing a threat of maternal suicide as a ground for abortion, while purporting to uphold an equal right to life of mother and child.

5

RECOMMENDATIONS

Head 2 & Head 3:

1. Provide an immunity or statutory defence for doctors acting in good faith who refuse a termination. Without an express statutory defence, the legislation would create an inevitable bias in favour of termination. A doctor cannot be sued by an unborn child for wrongful termination, whereas a refusal of termination could lead to claims against the medical team.

2. Require clear evidence that no viable alternative exists by which the maternal and unborn lives can each be saved.

3. Provide an express requirement that, in each case in which a termination is decided on, the doctors must use what ever means are available to try to ensure the survival of the unborn child (whatever the wishes of the mother might be).

4. In particular, where the unborn child is approaching viability, due consideration must be given to the possibility of postponing treatment until the child can de delivered with some prospect of survival.

Head 4 & Head 8:

5. Delete Heads 4 & 8 entirely.

6. If deletion is not accepted by the Committee, at a minimum require clear evidence that no alternative exists by which the maternal and unborn lives can each be saved (which in the case of a suicidal intent must be presumed to be feasible), and that a termination would actually remove the risk to the mother's life (which in the case of a suicidal intent cannot be presumed).

Head 6:

7. Provide for medical and legal representation for the unborn, in the event that a decision is made to terminate its life, especially under Head 4.

Head 12:

8. Clarify whether the provision for conscientious objection in subhead (1) applies also to treatment under Head 4, as subhead (2) appears to cast doubt on this.

9. Provide that no institution, organisation or third party shall be obliged to provide a termination of pregnancy.

6

MAIN SUBMISSION

INTRODUCTION

Heads 4 & 8 — The suicide issue is based on a cardinal error

The proposal in Heads 4 & 8 to include suicide as a ground for a termination of pregnancy is based on a cardinal error of fact and of law by the Supreme Court in the X case. It is open to the Oireachtas to correct this error; indeed, it is constitutionally obliged to do so.

The error of fact consisted in equating a serious physical risk to the life of the mother with a risk arising from a threat of self-destruction. In the former case, a medical intervention may sometimes be required—which is *intrinsically necessary* to save the

mother's life and where possible that of her child—, even if a foreseen but unintended consequence is the death of her unborn child. In the latter case, a medical intervention as such is *never intrinsically necessary* to save the life of the mother or the child. The only perceived "necessity" arises, not from medical circumstances, but from the subjective desire of the mother to end the life of her unborn child, as an alternative to wilfully ending her own life. Furthermore, termination of a pregnancy does not resolve a real suicidal ideation; the woman could just as easily commit suicide following the termination as before it.

The error of law followed from this. The essence of a crime is *mens rea* (a guilty mind), a will to act in a way that deliberately injures another. In the case of the unwanted death of a child following an intervention necessary to save the life of the mother, there is no *mens rea* and no crime. The medical intervention is fully compatible with a due respect for the equal right to life of the mother and unborn child, and a will (*mens*) to save *both* lives where possible. In the case of a termination carried out to avoid a threat of selfdestruction, there is clearly a *mens rea* on the part at least of the doctors who carry out the abortion, if not also on the part of the mother who threatens suicide (who may not be fully responsible for her actions). By agreeing to terminate the life of the unborn, precisely in order to end its life, the doctors are acting directly against its equal right to life. They are not excused in doing so by acting on the wishes of the mother. There is in fact no constitutional right to deliberately take away the right to life of another. Since 2002, the Constitution has expressly prohibited the death penalty.2 In the recent case on suicide, the Supreme Court held that it would be contrary to the constitutional right to life to permit a husband to assist his wife to carry out her own suicidal wishes, as there is no constitutional right to suicide.3

The following discussion challenges the widespread assumption that the suicide element

of the X case is, nevertheless, cast in constitutional stone and that it must feature expressly in the proposed legislation in order for that legislation to comply with that Supreme Court ruling.

2 Article 15.5.2°

3 Fleming v Ireland & Ors [2013] IESC 19, 29th April, 2013.

7

The submission considers—

A. whether the X case is binding for the present legislation

B. the terms of X case decision itself, and

C. the underlying constitutional right to life which X sought to interpret.

A. IS THE X CASE A BINDING AUTHORITY?

The Constitution

The only legislative authority in the State is the Oireachtas.4 The primary responsibility of the Oireachtas is to legislate in accordance with the provisions of the Constitution and the decisions on national policy enacted by the people.5 In the present case, the first obligation of the legislator is to have regard to the plain meaning and intent of the text enacted by the people in Article 40.3.3°:

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 X case

The X case is a particular interpretation and application of that provision to a particular set of facts. The composite decision of the majority in the X case is given as follows in the Irish Reports head-note:

Held: *That the true interpretation of Article 40, s.3, sub-s.3 of the Constitution*

required that termination of pregnancy was permissible only when it was established as a matter of probability that there was a real and substantial risk to the life of the mother if such termination were not effected. To prevent termination except in circumstances where there was a risk of immediate or inevitable death of the mother did not sufficiently vindicate the right to life of the mother.6

This was the only substantive legal principle decided in the X case. The *application* of that principle to the particular facts of the case depended on the unchallenged evidence of the probability of a risk of suicide adduced in the High Court. The Supreme Court held:

"That the risks to the life of the mother which should be considered by the Court included a real and substantial risk that the mother might commit suicide."

Although a suicide risk was before the Court in the X case, it does not follow that a suicide risk, *per se*, must be formally recognised in legislation as a qualifying ground for a termination, in order that the legislation be compatible with the Constitution.

4 Article 15.2.1° *The sole and exclusive power of making laws for the State is hereby vested in the Oireachtas: no other legislative authority has power to make laws for the State.*

5 Article 6.1. *All powers of government, legislative, executive and judicial, derive, under God, from the people, whose right it is to designate the rulers of the State and, in final appeal, to decide all questions of national policy, according to the requirements of the common good.*

6 The Attorney General v. X. and Others, [1992] 1 I.R. 3

8

Article 15.4.1° *The Oireachtas shall not enact any law which is in any respect repugnant to this Constitution or any provision thereof*.

Legislation can only be considered repugnant to the Constitution when it has been so declared by the High Court or the Supreme Court.7

In the absence of legislation

The Supreme Court in the X case *has not declared repugnant*, in anticipation, any legislation which does not provide for suicide as a ground for abortion. It made its decision, in fact, in the complete *absence* of legislation by the Oireachtas.

Legislation in accordance with Article 40.3.3° clearly ought to have been enacted prior to the X case. McCarthy J. in his judgement in the X case said:

"*I think it reasonable, however, to hold that the People when enacting the Amendment were entitled to believe that legislation would be introduced so as to regulate the manner in which the right to life of the unborn and the right to life of the mother could be reconciled.*"

Various observations in the X case judgements left open the possibility that future legislation by the Oireachtas might take a *different approach* to that enunciated (21 years ago) by the Supreme Court.

O'Flaherty J.: "*The legislators when they come to enact legislation must have due regard to the mother's light to life—a right protected throughout the Constitution in any event.* ***Until legislation is enacted to provide otherwise,*** *I believe that the law in this State is that surgical intervention which has the effect of terminating pregnancy bona fide undertaken to save the life of the mother where she is in danger of death is permissible under the Constitution and the law.*"

McCarthy J.: *Since the Amendment contemplates lawful abortion, how may the State still, as far as practicable, vindicate the right to life of the unborn?* ***Legislation may be both negative and positive: negative, in prohibiting absolutely or at a given time, or without meeting stringent tests: positive by requiring positive action.*** *The State may fulfil its role by providing necessary agencies to help, to counsel, to encourage, to comfort, to plan for the pregnant*

*woman, the pregnant girl or her family****. It is not for the courts to programme society; that is partly, at least, the role of the legislature.*** *The courts are not equipped to regulate these procedures*.

These observations demonstrate that the X case decision of 1992 has not necessarily tied the hands of the Oireachtas.

The Fleming Case

The recent Supreme Court decision in *Fleming***8** held that there is no constitutional right to commit suicide or to arrange for the determination of one's life at a time of one's choosing. As noted above, the Court held that it would therefore be contrary to the right to life to permit a husband to assist his wife to carry out her own suicidal wishes.

7 Article 34.3.2°

8 Fleming v Ireland & Ors [2013] IESC 19; Judgment of the Court delivered on the 29th day of April, 2013, by Denham C.J.

9

If the mother of an unborn child has no constitutional right to wilfully end her own life—as confirmed in the Fleming case—, *a fortiori* she can have no constitutional right to take away the life of her unborn child—who has an equal right to life—or to obtain assistance from others to that end.

This decision follows from the constitutional obligation in Article 40.3 to respect life and to refrain from taking away the life of another. The Court also rejected the 'autonomy' argument to the contrary:

"*It is also possible to construct a libertarian argument that the State is not entitled to interfere with the decisions made by a person in respect of his or her own life up to and including a decision to terminate it. However, it is not possible to discern support for such a theory in the provisions of the Constitution, without*

imposing upon it a philosophy and values not detectable from it."

The State is not required or permitted to endanger or set aside the rights of others in order to facilitate the wishes of a person with suicidal intent. The Court in *Fleming* said:

"*It may well be, therefore, that as part of its obligation to vindicate the right to life, the State is required to seek to discourage suicide generally and to adopt measures designed to that end. It does not, however, necessarily follow that the State has an obligation to use all of the means at its disposal to seek to prevent a person in a position such as that of the appellant from bringing her own life to an end. The problem which the facts of this case throws up is that it may be impossible to consider the position of the appellant without also having regard to the position of other persons, not necessarily in exactly the same position as the appellant, whose right to life may also have to be taken into account."*

The Supreme Court appeal in *X* was evidently a 'hard case'—comparable to the facts in *Fleming*—in that it sought to establish a general right based on individual circumstances. The Court in *Fleming* rejected the idea that a general rule can be derived from such cases. It said:

"That reasoning reverses, however, the process of identification of the extent of rights of general application and risks converting the question of the identification of rights and correlative duties, into ***an ad hoc decision on the individual case***. ***It has not generally been the jurisprudence of the Irish Constitution that rights can be identified for a limited group of persons in particular circumstances no matter how tragic and heartrending they may be***. … *While it is clear that the appellant is in a most tragic situation,* ***the Court has to find constitutional rights anchored in the Constitution***. *The appellant has relied on her very distressing situation on a fact based argument that the blanket ban*

affects her adversely. ***That is not a basis upon which a constitutional right may be identified.***"

Because it implied something to the contrary, the decision in the X case cannot now be considered a binding interpretation of the constitutional right to life (Article 40.3) and should not be relied upon as the basis for legislation in this area.

10

B. WHAT DID THE X CASE ACTUALLY DECIDE?

A closer examination of the X case itself will also show that the suicide element in the decision is not as irreformable as is generally supposed.

Two elements in the decision

Finlay C.J. described his decision as follows:

"The conclusions which I have reached and which are shared by a majority of my colleagues on this Court ***as to the true test to be applied to the reconciliation of the right to life of the unborn and the right to life of the mother identified and guaranteed under Article 40, s. 3, sub-s. 3*** *of the Constitution* ***and on the facts which have been established by the defendants to satisfy that test*** *make it unnecessary for the purpose of deciding this appeal to reach any conclusion on these further issues which were raised."9*

The '**true test**' is further enunciated by Finlay as follows in his judgement:

"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."10*

There are thus two factors in this decision,

• one is the "**true test**" and

• the other, "**the facts which have been established by the defendants to satisfy that test.**"

It may be that the test itself —i.e. the choice between a 'real and substantial risk' and an 'immediate and inevitable risk'— will not be revised by the Supreme Court in the foreseeable future. It may well be persuaded, however, in the light of better medical and psychiatric evidence, that ***facts such as those adduced in X do not necessarily meet the "true test"***.

The inevitability test

The key to the prospect of a modification of the X case, on its own terms, may lie in the fact that the Finlay test stipulates a risk *"which **can only be avoided** by the termination of her pregnancy."*

The decision of the Chief Justice illustrates the relationship between the constitutional rule (applied in the absence of any expert medical or psychiatric evidence) and the particular facts in the X case:

"*I am satisfied that the only risk put forward in this case to the life of the mother is the risk of self-destruction. I agree with the conclusion reached by the learned trial judge in the High Court that **that was a risk which, as would be appropriate in any other form of risk to the life of the mother, must be taken into account** in reconciling the right of the unborn to life and the rights of the mother to life. …*

9 [1992] 1 I.R. 57.

10 [1992] 1 I.R. 53-4.

11

*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****.*"11

A risk arising from a threat of self-destruction is clearly not equivalent—legally, morally or practically—to a serious physical risk to the life of the mother.

The application of the test

The Supreme Court's error in the application of its own test appears to have been occasioned in part by the complete lack of expert medical evidence in the case.12 "*Common sense*" is no substitute for such evidence.

We know—and the hearings of the recent Oireachtas Committee amply demonstrate—that modern psychiatry does not accept that *it is almost impossible to prevent selfdestruction* or that a suicide risk can *only be avoided* by an abortion and indeed rejects as obsolete the notion of a termination an appropriate psychiatric procedure for a woman who is suicidal.13 In and of itself, a termination of pregnancy may be as likely

11 [1992] 1 I.R. 55.

12 "In the present case neither this Court nor the High Court has either heard or seen the mother of the unborn child. There has been no evidence whatever of an obstetrical or indeed of any other medical nature. There has been no evidence upon which the courts could conclude that there are any obstetrical

problems, much less serious threats to the life of the mother of a medical nature. What has been offered is the evidence of a psychologist based on his own encounter with the first defendant and on what he heard about her attitude and behaviour from other persons, namely the Garda Síochána, and her parents. This led him to the opinion that there is a serious threat to the life of the first defendant by an act of selfdestruction

by reason of the fact of being pregnant. This is a very extreme reaction to pregnancy, even to an unwanted pregnancy. But as was pointed out in this Court in *S.P.U.C. v. Coogan* [1989] I.R. 734 the fact that a pregnancy is unwanted was no justification for terminating it or attempting to terminate it."

Hederrman, J. in The Attorney General v. X [1992] 1 I.R. 75

13 Among many examples, the following are typical — (Dr John Sheehan): "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 of 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. … 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." (Hearings, 8th January 2013, pages 74-75). — Professor Patricia Casey, UCD: "In my work as a psychiatrist, I run the attempted suicide service in the Mater Hospital in which we see and assess more than 400 attempted suicides in women per year. I have never seen a pregnant women who was suicidal for whom an abortion was the only answer." (Hearings, 8th January 2013, page 56)

12

over time to increase as to decrease a risk of maternal suicide, while always involving the unjustified killing of the unborn child.

Even in the X case itself, the solitary evidence of the psychologist—cited by Hederman J.—was that the risk of suicide ***could have been avoided*** by proper care. "*In crossexamination the psychologist said:— "My recommendation would be she was not safe* ***unless under supervision****. I would have thought, given the state which I found her in,* ***in-patent treatment would be essential****. I don't think the parents can offer 24-hour supervision."*14

Distinguishing the test from its application

Within the limits of the legal principle established in the X case by the majority decision, the evidential question—i.e. ***whether or not a particular risk in a specific case can be avoided***—can clearly be distinguished and severed from that principle.

There must be a ***direct and necessary link*** between the risk to life and its inevitability.

If a particular risk can be avoided by any less drastic means—as is the case with a threat of maternal suicide—it falls out of the loop and fails the constitutional test.

The suicide question cannot therefore be considered a matter of constitutional law, but of expert medical opinion and of fact. It does not form part of the essential constitutional test, nor does it bind the Oireachtas in its legislation.

Legislation which conforms to the Supreme Court's 'true test'—including the ***'which can only be avoided'*** rule—must avoid conferring on suicide a statutory presumption of satisfying that test. The weight of evidence points to the contrary. Furthermore, termination of a pregnancy does not cure a real suicidal ideation; the woman could just as easily commit suicide following the termination as before it. Indeed, to specify *any* particular risks in legislation as satisfying the constitutional test would be to usurp the function of the medical profession and/or the Courts to decide on a case by case basis whether a particular set of facts are such that a real and substantial risk can only be avoided by a termination of pregnancy.

The suicide question, therefore, does not form an essential part of the interpretation of Article 40.3.3° in X, nor does it bind the Oireachtas in its legislation.

14 [1992] 1 I.R. 68.

Suicide *per se* was not established as a ground for abortion, but "***any risk to the life of the mother which can only be avoided by a termination.***"

This uncontested evidence clearly implies that X could have been kept safe if she had been taken into care. The glaring failure of the Supreme Court to address or hear further evidence on alternative remedies renders a crucial aspect of the judgement particularly open to criticism and review. In any case, it fully justifies the Oireachtas in declining to follow it slavishly in that respect.

13

C. THE MEANING OF AN EQUAL RIGHT TO LIFE

A risk to one's life is not the same as a threat to one's *right* to life

The Supreme Court's error in the application of its stated principle to the facts of the X case appears to stem from a failure to properly construe the question in terms of the distinct natural and constitutional rights of the mother and her child. Even before the Eight Amendment, the Court had held that—

*"The child's natural right to life and all that flows from that right are independent of any right of the parent as such."*15

The root of the problem is that the Court accepted, without argument, that a threat of maternal suicide carried the same order of inevitability and objectivity as a physical threat to maternal life from a medical emergency.

It thus failed to distinguish a threat to the ***right to life*** of a mother or child (which would be a matter of law) from a threat to the ***life*** of either mother or child. A risk to ***life*** is clearly a medical matter. It only involves the patient's ***right*** to life (and thus becomes a

legal matter) if some third party *causes* that risk to life (by an unjust attack) or *denies* the patient the legitimate and proportionate means to remove that risk.

"Not only has the child born out of lawful wedlock the natural right to have its welfare and health guarded no less well than that of a child born in lawful wedlock, but a fortiori ***it has the right to life itself and the right to be guarded against all threats directed to its existence whether before or after birth****."*16

The Chief Justice in X referred to the suicide risk to the life of the mother as a risk which *"must be taken into account in reconciling the* ***right*** *of the unborn to life and the* ***right*** *of the mother to life"*.17 This proposition involves a serious logical fallacy.

A risk of maternal suicide is radically different in character—as a matter of practical reality and of law—from a physical risk to the life of the mother of an unborn child. In the case of a physical illness, there is ***no threat to the constitutional rights of either mother or child***; there is a medical threat to each of their lives, which must be resolved by medical care, so far as practical, having due regard to both lives (but recognising the inherent dependency of one life on the other). In the case of a risk of maternal suicide, there is a threat—which the State must try to avert—to the ***life*** of the mother (but clearly not to her ***right to life***) and ***also a direct threat to the constitutional right to life of the unborn child.***

The only prospective attack on a ***right*** to life in the X case was by the mother on her unborn child. The Supreme Court did not act to protect the right to life of the unborn child, as it was unconditionally obliged to do by the Constitution.18 Instead, it became complicit in that attack, in the mistaken belief that the unborn life could not be defended.

The phrase "*in reconciling the right of the unborn to life and the right of the mother to life"* points to the conceptual source of the error. The Court believed that the ***right*** to the

15 Walsh, J. in G. v. An Bord Uchtála [1980] I.R. 32

16 Walsh, J. in G. v. An Bord Uchtála [1980] I.R. 32

17 Finlay, C.J. in The Attorney General v. X [1992] 1 I.R. 55

18 Article 40.3.1°, 2° and 3°.

14

life of the mother and her unborn child were in conflict and thus in need of reconciliation. A closer examination of the constitutional right to life will show that this was not the case.

The primary right not to have one's life taken away

The Constitution "guarantees in its laws to respect" the ***right*** to life, without qualification.19 That means that the State, at a minimum, may ***never pass a law*** which under any circumstances would have the effect of nullifying that right.

In this primary sense, the right to life is **a universal, equal and absolute right**. It imposes a duty on others—"thou shall not kill"—; it is a right ***not to have one's life unjustly attacked or taken away by another.*** An unjust attack is any deliberate threat to one's life by another, other than in proportionate self-defence. Being a negative or restraining right, it is fully capable of being enjoyed equally by all, at all times and in all circumstances. It does not involve any *reconciling* of rights, since there are no conflicting or superior positive rights in question—***no one has a positive right to unjustly attack the life of another***, even to save his or her own life.

The secondary right to have one's life protected

The second component of the right to life is the right to protection or defence, and the corresponding duty of others to provide that protection.

"The right to life necessarily implies the right to be born, the right to preserve and defend (and to have preserved and defended) that life" 20

This is necessarily a limited and qualified right, as it depends in part on the prevailing circumstances. Thus, the Constitution provides that the State shall "by its laws protect ***as best it may*** from unjust attack … the life … of every citizen"21 and guarantees "***as far as practicable***, by its laws to defend and vindicate that right."22 The State undertakes to protect a person against a threat to life (from unjust attack), insofar as may be feasible in the circumstances, but may never do so by itself authorising or initiating an unjust attack, e.g. by depriving another of the primary right to life.

The constitutional duty of the State

In the case of a medical emergency, in which a mother's life is at risk, the only function of the law is to ensure—through the State medical services—that both lives are protected and defended "*as far as practicable*". In such cases, there is no threat to the constitutional *right to life* of either mother or child; no third party is unjustly threatening or attacking the lives in question. There is a *medical* threat to each of their *lives*, which must be resolved by medical care, so far as practicable, having due regard to both lives (while recognising the inherent dependency of one life on the other).

Where there is a threat to a ***right*** to life, however, the State must "*by its laws protect as best it may from unjust attack"* the innocent victim. The State may not refuse to prevent an unjust attack on life when it is within its power to do so.

19 Article 40.3.1° and 3°.

20 Walsh, J. in G. v. An Bord Uchtála [1980] I.R. 32

21 Article 40.3.2°

22 Article 40.3.3°

15

The parents of an unborn child—and the mother in particular—have a unique moral and constitutional duty to defend and vindicate the right to life of the unborn child whom

they have conceived. A maternal suicide threat is obviously contrary to this responsibility.

"It lies not in the power of parent who has the primary natural rights and duties in respect of the child to exercise them in such a way as intentionally or by neglect to endanger the health or life of the child or to terminate its existence."23

Where the parents fail thus in their constitutional duty, the State is obliged to supplement or substitute them as far as practicable.

The situation of the young mother-to-be in the X case was that her life was at risk from her own extreme reluctance to continue with her pregnancy. This also posed a threat to the life of her child. The clear obligation of the Supreme Court in that case was to prohibit the wilful termination of her pregnancy and to order the medical protection of mother and child by whatever form of supervision or treatment might be appropriate.24

The responsibility of the Oireachtas

To legislate in accordance with the Article 40.3 of the Constitution in this matter—which is the first responsibility of the Oireachtas—, it is essential to consider carefully the constitutional guarantees and undertakings concerning the right to life.

While the State may not always be able to positively ***protect*** or ***defend*** or ***vindicate*** a right—it is a *conditional* guarantee—, the State ***can always*** abide by the unconditional guarantee to ***respect*** a right, i.e. by refraining from legislating (or acting judicially) to take away that right. This goes to the heart of the current legislative issue.

Subject to this constraint, the Oireachtas may legislate or produce guidelines to positively protect both lives equally in the case of a threat to each life arising from a grave risk to the life of the mother. Such protection may properly recognise the dependence of the life of the unborn on the life of its mother until viability, but it may

not render one life of less value in the eyes of the law than the other.

23 Walsh, J. in G. v. An Bord Uchtála [1980] I.R. 32

24 “If there is a suicidal tendency then this is something which has to be guarded against. If this young person without being pregnant had suicidal tendencies due to some other cause then nobody would doubt that the proper course would be to put her in such care and under such supervision as would counteract such tendency and do everything possible to prevent suicide.” Hederrman, J. in The Attorney General v. X [1992] 1 I.R. 76.

The first responsibility of the Oireachtas, in the present matter, is to refrain from enacting any legislation which would breach the constitutional guarantee to ***respect the equal right of the mother and the unborn child*** not to have their lives wilfully taken away by the actions of another.

16

Notwithstanding the X case, therefore, the conclusion is inescapable that any legislation which authorises the taking away of the life of the unborn on the ground of a threat of maternal suicide would be a fundamental breach of the constitutional guarantee in Article 40.3.3° to respect equally the right to life of the unborn child and its mother

The invisible victim

In much of the public discourse on this issue, the right to life of the unborn child has been largely invisible. The debate has largely focussed on the mother and on the medical personnel involved. The precise words of Article 40.3.3° acknowledging an equal right to life of mother and child are thus emptied of their meaning.

In order to illustrate where this blindness might lead, consider the recent controversy generated by Alberto Giubilini and Francesca Minerva's article in the UK-based Journal of Medical Ethics, entitled "*After-birth abortion: why should the baby live?*"

It wasn't a very original argument for the morality of infanticide—Peter Singer and

Michael Tooley had made the same point decades ago—but the arresting title re-ignited the controversy. That article was merely an infanticide thought-experiment. A subsequent special issue of the Journal of Medical Ethics included a contribution from a paediatrician who actually has done it. Dr Eduard Verhagen, a paediatrician at University Medical Centre Groningen in the Netherlands, says that, in his experience, infanticide is sometimes preferable to second-trimestre abortion. The so-called Groningen Protocol in the Netherlands allows euthanasia of newborns under strict conditions if there is "hopeless and unbearable suffering" and both parents give "informed consent".

Why is this relevant to the current debate in this country? Anyone who will calmly consider the proposition that it is legally and morally permissible to take the life of an unborn child—at say 29 weeks (the heads of the Bill mention no gestational time limit)—could find no valid moral or legal objection to taking the life of the same child some minutes later, if it survived an attempted abortion or a spontaneous delivery and drew breath as a new-born child.

If the unborn child already has a constitutional right to life ***equal*** to that of her mother, she does not acquire a greater right to life simply by being born. What is valid in one case must be valid in the other. The supposed 'justification' in the pre-born case is that the mother might commit suicide unless the life of her child is ended. As a matter of legal consistency, therefore, the same 'justification' for ending the child's life would have to be available to an equally distressed mother in respect of a recently born child.

The moral madness of infanticide—which is surely self-evident to every member of the Oireachtas Committee—should make clear the dangerous irrationality and grave injustice of allowing a threat of maternal suicide as a ground for abortion, while purporting to uphold an equal right to life of mother and child.

Submission from Brendan O'Regan, Arklow.

I have a few short points to make on the proposed ***Protection of Life During Pregnancy Bill 2013.*** This is a personal submission.

1. Re Head 2
' 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'

The bill as proposed allows for the direct termination of the life of an innocent person, the unborn child. This is self-evidently unjust and runs completely counter to the ethos of child protection that I thought the State was committed to. No other law allows for the killing of the innocent. Also, I thought this was ruled out when we voted to end the death penalty in a referendum, so the bill may be unconstitutional.

2. Re Head 4:
' Risk of loss of life from self-destruction '
The suicide element is the most objectionable element of the bill. In no other area of life would you give in to a threat of suicide like this e.g. student would not be given extra high grades in Leaving Cert if she was at risk of suicide because of exam pressure, or a person in debt would not have their debts cancelled just because of a threat of suicide. Still less should a person's life be ended because another person threatens suicide. As shown in your previous hearings on this matter, there is no medical evidence that abortion would help a woman suicidal in pregnancy, and some evidence that it might do harm. Intuitively a suicidal person needs the best of medical and emotional care and attention, not something that may leave a legacy of guilt, which in itself could just as easily lead to suicidal feelings.

3. Re Head 6

'Formal Medical Review Procedures '

The Constitution gives equal right to life to mother and baby. Yet the mother can appeal if the abortion is denied, but if her request is not denied there's no facility for anyone to appeal on behalf of the baby, not even the father, who seems to have been airbrushed out of the situation. This is not equality.

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Brendan O'Regan 8/5/13

BRENDAN.A.OROURKE@nuim.ie
08/05/2013 16:28 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
proposed bill on abortion

Attention Paul Kelly,

I wish to express my disapproval of the proposed abortion bill which is being put forward by the coalition government under the guise of allegedly helping those females who are suicidal or are rapped. The grounds for granting such abortions are clearly not sustainable or adequate as expressed by the Irish Psychiatric association and the Irish doctors IMO. The terrible effects of such a bill is clearly evidence by the wide abuse of the so called limited grounds for abortion (i.e. mental health) in the UK which has resulted in over 200,000 babies being killed each year. Pregnant mothers who seek an abortion admit that they have lied to the doctors and authorities by faking suicide tendencies in order to get their abortion and such a bill is open for abuse. The life of the unborn must be respected in all cases irrespective of whether or not the pregnant mother is suicidal or rapped. All life is sacred and this includes the voiceless unborn which are our future Irish citizens.

I would ask that you please respect our pro-life heritage and our Irish constitution by rejecting this draft limited abortion bill.

Brendan O'Rourke

Brendan Tarrant <brendansemail@yahoo.com>
08/05/2013 15:34
Please respond to
Brendan Tarrant <brendansemail@yahoo.com> To

Subject
Submission on proposed abortion legislation

Mr Paul Kelly
healthandchildren@oireachtas.ie

Submission on proposed abortion legislation

Dear Mr Kelly,

The 'Protection of Life during Pregnancy Bill' is completely misleading. The title is a misnomer as it is designed precisely to facilitate the direct and deliberate ending of life during pregnancy.

The very proposal of such a bill is a shocking development as it flies in the face of the expert medical evidence given at the Oireachtas hearings.

Some established FACTS need to be restated:

1) Abortion is NOT a treatment for suicidal ideation.

2) The Government is NOT compelled to legislate for the X-case - the clarity desired by some members of the medical profession can be provided by better and more detailed guidelines as per the recent coroners inquest in Galway.

2) The so called "Protection of Life during Pregnancy Bill" does NOT as Enda Kenny says 'simply clarify existing law'. The Government is proposing to create a new statuary right to kill and unborn child on grounds of threatened suicide by the child's mother.

4) The Government says it will ensure that the process takes full account of the 'equal right to life of the unborn child' but the so called "Protection of Life During Pregnancy Bill" is based on the idea that the unborn child does NOThave an equal right to life. In no other area of law does one persons threat of self-destruction nullify another persons right to life.

The Government has descended to a shocking level of inhumanity in even contemplating evil of such magnitude despite all the expert medical evidence of the Oireachtas hearings.

This genocidal Bill must be retracted immediately as it promotes the killing of our most innocent and vulnerable citizens.

Yours sincerely,

Brendan Tarrant
29 Vale View Close
Cabinteely
Dublin 18

Subject
Abortion Debate

Richmond

Templemore

Co Tipperary

8th May 2013

Mr Paul Kelly
c/o Health and Children @ Oireachtas.ie
Dáil Eireann
Kildare St
Dublin 2

RE: Protection of Life during Pregnancy Bill 2013

Dear Mr Kelly,

Vis a Vis the Government's proposal to legislate for abortion, I wish to say that this is the most retrograde proposal this Government, or indeed any Government of Ireland to date, has ever pursued. Why? because there are enough clear-headed 'experts' (medical) who have stated time and time again, that abortion is NOT necessary to save the life of a mother . Furthermore, in the region of 120 psychiatrists, including the eminent Professor Patricia Casey, have clearly stated that there is no credible evidence that abortion is any kind of treatment for suicidal ideation in women.

There will always be those within any profession who will argue to the contrary. Where does that leave us?

1- Those 'experts' arguing in favour of abortion are in the minority
2- Hard cases make bad law
3- Abortion is MORALLY EVIL
4- Abortion will undermine all our human rights - if my right to be born is taken from me, well what else will be taken from people in the future?
5- Abortion is murder of the defenceless, and I don't want innocent human lives being taken deliberately in this country.

I could add many many more points, I won't.

It is clear already that the Taoiseach and his Government are proposing a dangerous and destructive thing - the legalization of abortion on the ground of threatened suicide. We know what the consequences for the

unborn child would be. And we know what this kind of legislation has started elsewhere.
I did not elect this Government to legalise the murder of unborn human life. The wilfull destruction of human life is an abomination and must NOT be allowed to happen here.

We can continue to be a shining light to other countries, or we can open the floodgates. May God preserve us from making a terrible mistake.

Yours sincerely

Caitríona & Peggy Connolly

PROTECTION OF LIFE DURING PREGNANCY BILL 2013

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

- Legislation for abortion is not required by the European Court judgement.
- Legislation for abortion on the suicide ground is not required by the X-case.
- The Oireachtas has the prerogative of not legislating for a Supreme Court decision if it believes it would be harmful to do so.

Based on the above it is difficult to understand why The Taoiseach is so determined to introduce abortion to Ireland. Two years ago he said he would NEVER introduce abortion to Ireland. We believed him then. Therefore it is impossible to believe him now. Nothing has changed. Abortion is essentially the same today as it was yesterday. To kill one baby is an immoral act. It is not possible to solve the abortion issue by turning it into a political issue, because it is NOT a political issue. It is a human rights issue. It has to be studied on the basis of the truth. It is time the politicians abandoned their pride and their arrogance and faced up to the truth. Posterity will thank them for doing the right thing.

Signed: Carmel O'Sullivan

Address: 12 Roebuck Lawn, Clonskeagh, Dublin 14.

Dated: 7th May 2013.

"Caveatemptor" <caveatemptor@eircom.net>
08/05/2013 16:12 To
"Health & Children Oir Comm" <healthandchildren@oireachtas.ie>

Subject
Protection of Life during Pregnancy Bill 2013

Protection of Life during Pregnancy Bill 2013

Head 4 Risk of loss of life from self-destruction should be removed from the legislation
Abortion on the suicide ground is tantamount to abortion on demand. It has been clearly demonstrated and statistically proven that the risk of suicide in pregnancy is 1 in 500,000 and also that it is not possible to detect the improbable occurrence of such an event thus making abortion on such grounds a mere lottery or to be more precise Russian Roulette. I say this because head 4 only sets down minimalist criteria which can be interpreted subject to the reasonable opinion held in good faith that the woman might commit suicide not immediately but at an unspecified future time ("It is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate") and that the baby's survival should not be considered until the actual medical procedure (abortion) is about to take place ("preserving unborn human life as far as practicable governs the actual medical procedure – the termination of pregnancy only")

Information in the public domain would suggest that there are psychiatrists for whom a termination of pregnancy for a woman with suicidal ideation would be a simple reasonable opinion made in good faith. In support of this I will quote child psychiatrist Dr Peadar O'Grady, who has made it widely known that he Dr O'Grady said. "If certification is needed to facilitate an abortion, it can be done by one doctor," he said. "I have done it for teenagers in case where the social workers were afraid to accompany them to Britain without back-up. "That was one child psychiatrist certifying the need and nobody challenged it……?"

Another issue is that if the diagnosis disallows abortion for suicide ideation then the mother or her advocate can request a second opinion by way of appeal. This seems at odds with the child's constitutional right to life as voted by the people in Article 40.3.3. There is no appeal process to vindicate the child's rights under article 40.3.3 or the fathers right to protect the child and the mother.
This proposed law allows the state two chances to abort the child but does not allow the child any right to defend him/her self either on the first or second occasion.

Head 4 also erases the rights and ethos of healthcare institutions not to get involved in abortion
Healthcare workers also have their conscientious rights limited by this law as they are debarred from complete self-exemption from involvement in abortion activities. In effect if a doctor does not want to kill a child he is obliged by this law to appoint another doctor who will kill the

child, this is not an opt out, it is a subcontract. This also applies to Head 2 of this proposed Bill.

Catherine Cummins Kilcolman Ballaghaderreen Co Roscommon

"Catherine Donohoe" <cldonohoe1@gmail.com>
08/05/2013 02:16 To
healthandchildren@oireachtas.ie
cc
Paul Kelly
bcc

Subject
Proposed abortion legislation

Dear Sir,

I consider that the proposed legislation to introduce legalised abortion into this country is unfortunate and wrong as it means legalising the killing of children who have a right to be born and a right to life - as much a right as I have had or as the Taoiseach , Tanaiste and any other living person has had to be born and to live. To deprive any person of that sacred right ,the first and most basic of all human rights is in my opinion barbarous .

I understand that the Taoiseach and Tanaiste maintain that this proposed legislation is necessitated by a judgment made by the Supreme Court fifteen years ago. That judgment seems now to be out of date and in need of review in the light of present day knowledge as expressed by the many psychiatrists and medical experts that we have been hearing.. In my opinion the Government should not proceed on basis of that Supreme Court judgment.

If this legislation is passed it will mean that hospitals and professional surgical, medical and nursing staff will be obliged to perform or assist in the performance of abortions, against their conscience, in any case of a pregnant woman claiming to be suicidal and requesting abortion on that account. We have only to look at the scale of such abortions in England to foresee what is likely to happen in this country if legalised here.
Moreover the availability of abortion in other countries has lead to its acceptance as a means of restricting the number of children to one ,two or three according to preference and also to abortion of children on gender or other grounds according to whim .
.
We are being assured that there will be strict regulation. The present Government - even if their intentions in this respect are genuine - will not be there forever to regulate; our nation's future will be in other hands. As for guarantees of regulation how can we the people of this country believe in or trust such regulations when we have experienced the complete failure to regulate the Banks with the result that the people are suffering horribly and have to live with the prospect of continued suffering for themselves and their children long into the future

I respectfully implore this Government not to bring the evil of abortion upon us.

- Catherine Donohoe

Submission by Dr Catherine Bates and Mr Patrick Flynn.

1. **Experience:**

   We have extensive experience of working with young adults, with almost 30 years' experience between us of lecturing in Higher Education Institutions within Ireland. In addition, I (Catherine) worked for two years in a women's drug rehabilitation project in inner-city Dublin, during which time I worked with women who experienced unplanned pregnancies. I also have a PhD in Sociology.

2. **Executive summary:**

While we welcome the government's decision to legislate for the X-case after 21 years, we would like to express the following strong reservations about the proposed draft legislation:

a. The number of doctors involved, particularly where there is a risk of suicide.

A suicidal woman should not be submitted to the stress of examination by a panel of doctors – she is not on trial. One doctor is capable of diagnosing a woman as suicidal, in the same way that one doctor can diagnose a life-threatening physical condition. Only a mental health specialist, not an obstetrician, is qualified to diagnose the risk of suicide. An obstetrician should be consulted following the diagnosis of a need for a termination, whether due to a physical or mental health risk, but should not be required to make the diagnosis, unless the pregnancy is causing the physical risk to the life of the woman.

b. The omissions of many relevant circumstances.

The legislation does not refer to cases of rape, cases where the foetus cannot survive, and cases where there is a threat to the woman's health (such as would cover the Savita Halappanavar case). While the government is acting on the requirement to legislate for X, the opportunity to legislate for other harrowing cases that have come to light in the meantime should also be seized.

c. Right to Choose

The legislation should allow women to choose to have an abortion if they require regardless of circumstance – 'abortion on request' as referred to by the WHO. We accept that this will require a repeal of the Eighth Amendment and urge the government to act on this.

Until these situations are all legislated for, women in Ireland will continue to be denied their human rights.

3. **List of recommendations and main body:**

Head 2: one medical practitioner should be able to certify in good faith that a medical procedure is needed, as with any other medical procedure which does not involve a pregnancy. There is no need for further practitioners to be involved. If the risk is due to

an obstetric condition, an obstetrician should be able to certify the need for the procedure. If the risk is from another condition, a specialist in that area should be able to certify it. There is no need for an obstetrician to be involved otherwise, in order to preserve the woman's life. If a woman feels that her doctor's decision is prejudiced by her/his beliefs on abortion, she should be entitled to a consultation with another doctor.

Subhead 3: recommendations as to the number of doctors as per above. Regarding the need to include the obstetrician to ensure the care of the mother and foetus, the obstetrician should be consulted regarding the health implications of terminating the pregnancy on the life of the mother, but should not be required to certify the need for the procedure if the risk to the mother's life is from a non-pregnancy related condition.

Head 3: This is very clearly worded, with a simple procedure easing the ordeal for the pregnant woman. This head should be the model for Heads 2 and 4, with a decision to certify the termination in each case made by one relevant doctor (but heads 2 and 4 should continue to refer to the woman's right to choose whether she wants to proceed with the termination).

Head 4: The current requirement for 3 doctors is excessive. As with a physical condition, one psychiatrist is all that is required to diagnose a mental health condition. The current wording discriminates between mentally and physically ill women, and between mental and physical health professionals. *'There is no medical basis for differentiating between a medical emergency and a psychiatric emergency. All psychiatric emergencies are medical emergencies.'* (http://doctorsforchoiceireland.wordpress.com/campaigning/ Accessed 07/05/13)

Examination by three separate doctors would be an unnecessary ordeal for a potentially suicidal pregnant woman. As with our recommendation on head 2 above, the obstetrician could be consulted on the health implications of terminating the pregnancy on the life of the mother, but should not be required to certify the need for the procedure.

We strongly request a new Head (or an addition to heads 2 or 4) that would cover the right to a termination where a doctor certifies that the foetus will not survive. A further addition should cover the right to a termination in cases of incest or rape.

Head 12: We agree strongly with subhead 3 – to ensure that women have the right to access life-saving terminations as outlined above.

Head 19: We believe that the termination of pregnancy should be decriminalised, provided that it is at the request of the pregnant woman, and that ultimately a woman has the right to choose whether she wants a termination in this country, for her own good reasons. The inclusion of the 14 year prison sentence is criminalising women who may elect to have terminations in this country as opposed to those women who elect to have a termination abroad and are currently (and rightly) immune from prosecution in this country.

gned: Catherine Boyle Date: 07/05/13

07/05/13

Celia Foley <celfoley@eircom.net>
07/05/2013 15:29 To
healthandchildren@oireachtas.ie

Subject
submission on proposed abortion legislation

To Paul Kelly

Dear Sir,

I wish to make a submission on the proposed abortion legislation.

There is no human right to abortion, whatever the circumstances.
The intentional killing of another life is not the answer to a suicidal pregnant woman. It has been shown by the psychiatrists that there is no evidence for this assumption and more evidence to show that abortion, for whatever reason, can cause mental health problems to the woman.
Evidence from other countries where abortion was allowed on mental health problems has shown a vast increase in the number of abortions carried out, in spite of a wish by legislators to curtail availability.

Clarification of the guidelines for doctors on the termination of pregnancies within the existing legislation is needed.

I have serious reservations about other aspects of this proposed legislation.

That doctors and medical staff and hospitals will not be allowed to opt out on conscientious objection. Basically it is bullying of someone`s human right to freedom of religious/ethical view.
That an abortion can be carried out up to full-term in the case of a suicidal woman is monstrous - ??? Have you read the accounts of full-term abortions in the US? Legalised murder.
Once a decision to accept abortion for whatever reason is allowed legally it will open the floodgates to more easily available abortions. Examination of other countries records will prove this.
Once abortion is legalised what other intentional killings in time will be allowed? Euthanasia? Killing babies after birth with abnormalities ? (already proposed in Australia by ethicists)
The "abortion mentality" increases in practise.
As the parent of a child with Down Syndrome I am very conscious of the pressure exerted on pregnant mothers in the UK to abort such children. Recent statistics show that around 90% babies diagnosed in the womb as having DS are aborted in the UK and USA. Abortions in the UK are being performed because the babies have cleft palate and other treatable conditions.
It seems to be if the baby is wanted it will continue and if not wanted it will be aborted.
Abortions will escalate no matter the desire to contain the availabilty.

Please consider my deeply held views that abortion should never be

allowed, but every support and help given to women to continue with their pregnancy.
There are many women who would love to adopt.

Yours Sincerely

Celia Foley

Celia Lopez-Jurado

Document I

Protection of life during pregnancy Bill 2013

Submission

1. I am a doctor and I believe on the right of the mother and the unborn baby to life. I am very proud of the Irish Constitution to protect the life of the unborn.
2. Executive summary of the submission.
   *--There are medical guidelines to treat any medical condition in pregnancy. They may need to be clarified and make sure that all hospitals etc follow the guidelines.
   *--Legislation for abortion on the suicide grounds is profoundly wrong and goes against the Constitution.
   *--There is no evidence-based medicine that abortion is a solution for the mental health of the mother.
   *--The pregnancy bill 2013 gives very limited conscientious objection rights for doctors and none for healthcare institutions with a pro life ethos.

3. List of recommendations

   a) Head 2: Risk of loss of life from physical illness

   To ensure that all the medical establishment have appropriate guidelines (also in case of emergency) to treat any medical condition in a pregnant women. Also that there are procedures of who and how are these guidelines are followed through.

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

   To consider that legislating for abortion on the suicide ground is not required by the European Court judgment. The Oireachtas has the prerogative of not legislating for a Supreme Court decision if it believes it would be harmful to do so.

   c) Head 12: Conscientious Objection

   To respect the fundamental natural right of the human person: the right to religious liberty and as a consequence **to act accordingly to their conscience**. This natural right ought to be acknowledged in the juridical order of society in such a way that it constitutes a civil right.

4. Body of Submission

   Head 2: Risk of loss of life from physical illness
   The Medical Council and relevant Bodies could provide the necessary clarity by introducing guidelines which would protect women in pregnancy by re-affirming that they receive all

necessary life saving treatments in pregnancy and requiring that we also exercise a duty of care towards the unborn.
It may happen that as a consequence of the treatment, the life of the unborn is in danger or even may die but this is not intentional directed towards a directed termination of the pregnancy which is wrong (fundamental right to life of the unborn).

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

Legislation for abortion on the suicide ground is not required by the X-case. When he was Taoiseach, John Bruton said he would not introduce legislation in line with the X- case because that would have the effect of bringing abortion into Ireland. As I said before the Oireachtas has the prerogative of not legislating for a Supreme Court decision if it believes it would be harmful to do so.
This legislation will not be about `life-saving´ treatment but, in fact, the opposite. The Government has produced no evidence to show that abortion is ever beneficial in the treatment of the mental health of women. We know from the latest review of the evidence (Fergusson et al.) that abortion is not associated with any mental health benefit for women. In fact, it is associated with a low to moderate increased risk for women´s mental health. And, of course, if the mother dies we know the baby always dies. So it is dishonest to pretend that this proposal is about saving life.
That is why over 100 psychiatrists last week signaled their opposition to being involved in certifying women as needing abortion to save their lives because this is not evidence-based medicine. International experience shows that provision for abortion on the mental health ground will be abused. It is hard to see how things could be different in Ireland, given the nature of what is proposed on the Abortion Legislation.

Head 12: Conscientious Objection

Man has the right to act in conscience and in freedom so as to personally to make responsible moral decisions. He must not be forced to act contrary to his conscience. Nor must he be prevented from acting according to his conscience, especially in religious matters.

Authority is exercise legitimately only when it seeks the common good and respects the fundamental rights of persons and individuals (including the unborn child). The common good presupposes respect for the person as such. In the name of the common good, public authorities are bond to respect the fundamental and inalienable right of the human person.

If rulers were to enact unjust laws or take measures contrary to the moral order, such arrangements would not be binding in conscience. Nobody should be forced to act against his convictions, nor is anyone to be restrained from acting in accordance with his conscience in religious matters in private or in public, alone or in association with others within due limits. **This right is based on the very nature of the human person.** For this reason it continues to exist even in those who do not live up to their obligation of seeking the truth and adhering to it.

Celia Lopez-Jurado

Submission
to The Oireachtas Joint Committee on Health and Children
in respect of its consideration of the Outline Heads of the
"Protection of Life During Pregnancy" Bill 2013
By Charles Byrne

1. Introduction

I am a 35 year old Catholic from Drogheda who has been involved in the pro-life movement for 15 years.

2. Summary of submission

This legislation is opening the door to abortion on demand. It accepts the erroneous principle that innocent life can be justly ended. This legislation is treasonous, since it undermines the integrity of the State. This proposed legislation defies the law of our Creator and so invites upon us His wrath.

3. Recommendations

The process of enactment of this legislation must be suspended immediately.

4. Main body of Submission

The declaration that "it is not an offence" to kill an innocent human being in the womb when his mother is deemed suicidal undermines our most fundamental notions of justice. The life of that innocent unborn child does not belong to the mother or to the State. The State has no jurisdiction to take away the life of an innocent person. The State, by declaring its indifference to such an action, is collaborating with this evil. This "law" is nothing less than state sanctioned murder. This legislation will lead to abortion on demand since it makes the protection or ending of the life of the unborn subject to the subjective opinion of fallible men. Every other country that has enacted such ambiguities has seen widespread abortion follow as a matter of course. Those responsible for even suggesting this legislation are guilty of conspiracy to murder, and so, are criminals.

This legislation is treasonous, because it undermines the very legitimacy of the State. When the State starts to toy with important principles of justice, becoming in effect the executioner of the innocent, it loses its integrity. The State cannot pretend to be the protector of the common good when she upholds evil principles.

Most importantly, this legislation is gravely offensive to Almighty God. He alone is the sovereign giver and taker of life. It is His domain, not ours. When we enshrine the violation of the Fifth Commandment, "thou shalt not kill", into our laws we set up a false law in opposition to the law of God. We will, by so doing, bring down the wrath of God upon this nation. All those responsible for the instigation of this legislation are on its implementation *de facto* excommunicated from the Catholic Church. That means that they will not be entitled to receive any of the Sacraments until such time as they repent and make a public reparation for their crimes. In the future, those responsible for this scandalous legislation will be held accountable, be it in this life or in the next.

In Christ the King,

Charles Byrne, 7 College Rise, Drogheda, Co. Louth. Tel: 086 353 2636

"Charles Campbell" <jkoleary@eircom.net>
08/05/2013 14:13 To
<healthandchildren@oireachtas.ie>
cc

bcc

Subject
Human life and pregnancy bill submission

Dear Paul,
Re: Human life in Pregnancy bill
For a civilized and just society, best practice in moral, ethical, medical and psychological guidelines should be supported legally and promoted. Laws based on flawed and outdated ideologies should be overturned or avoided.
1. The law of Ireland already adequately protects both mother and unborn child therefore further laws are not required for their protection. Evidence: UN consistently ranks Ireland as one of the safest places in the world for pregnant women.
2. Given the Savita case, medical guidelines are required, not legislation. Evidence: Report and review recommendations commissioned by the Government.
3. Given the X case, the flawed and now outdated ideology supporting the idea that there is a judicial recommendation for abortion in the case of suicidality, should be reviewed in the light of current moral, ethical, medical and psychological evidence. The current law should be supported by a change in ideology rather than legislation to continue to uphold the best practice already found in Ireland. Evidence Professor David Ferguson who recommends at the end of his interview that legislation for abortion in the case of suicide not be enacted.
http://www.rte.ie/news/morningireland/player.html?20130507,20198517,20198517,flash,232

Please consider our submission for the above bill. We hope that Ireland will remain a sane and safe place for pregnant women rather than descend into the mad and unsafe place exhibited by other western countries which do not have our pro-life laws.
Many thanks
Yours sincerely,
Charles and Jane Campbell

Choice Ireland

Legislating for the X case; A Submission on the *Protection of Life During Pregnancy Bill 2013* to the Oireachtas Joint Committee on Health and Children

8 May 2013

Contents of Submission

Executive Summary

Choice Ireland is a Dublin based feminist pro-choice group which has been active since January 2007. We see reproductive freedom and justice as a critical element of women's liberation and gender equality. We recognise that reproductive freedom is multi-faceted and on this basis we seek to ensure a woman's freedom to pursue all reproductive choice and promote education to empower women to take charge of their fertility and the right to bodily integrity.

The criteria under which abortion is allowed under the terms of the X Case are strictly limited and would likely only affect a tiny proportion of the thousands of Irish women who terminate pregnancies every year. These terminations take place for a wide variety of reasons, including terminations due to the foetus being unable to live outside the womb due to a fatal foetal abnormality. Choice Ireland accepts that this Heads of Bill represents the beginning of the Government attempting to legislate for abortion on the grounds of the X Case, however in order to be compliant with the European Court of Human Rights Judgment in the ABC case, any legal framework introduced must be effective and accessible. This legislation would provide strictly limited access to abortion and Ireland will remain one of the most restrictive regimes in the world.

Recommendations

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

 Choice Ireland further recommends that this head be expanded to ensure that all risks to a woman's life are dealt with in the same section, including where the threat to a woman's life is as a result of being suicidal in order to decrease the risk of stigmatising women through differential treatment of physical and psychiatric threats to life.

 Choice Ireland is further concerned that there is no provision under this Head to ensure speedy access to medical treatment where a physical threat to a woman's life has been established

 Choice Ireland recommends inclusion of a legislative provision that mandates treatment in an appropriate timeframe in order to comply with the provisions of the ABC judgment.

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

 Choice Ireland recommends that in such cases two opinions should be deemed sufficient.

 Choice Ireland is further concerned about whether vulnerable and severely ill pregnant women would be liable for medical fees for consultant psychiatrists

4

or obstetricians if she is seeking treatment and recommends the inclusion of a provision that will preclude this.

 Choice Ireland also recommends that these provisions be amended to ensure that women have access to treatment in a speedy manner.

Head 6 Formal Medical Review Procedures and Head 8 Review in case of risk of loss of life through self-destruction

 The review group should consist of no more than two doctors.
 It is questionable whether under its current construction this Head complies with the ABC judgment.

Head 19 Offence
 Choice Ireland recommends that no provision for criminalising women for having abortions is included in the Bill.

Conclusion
In conclusion, Choice Ireland must reiterate how X Case legislation will only assist a very small number of women seeking abortions in Ireland.
The proposed Heads maintains an arbitrary distinction between physical and mental health as if they are different. There is no clinical basis for this, and legislating for this distinction would be a regressive move for a state which has made strides in how mental health has been treated in recent times. Women deserve better than this.
Choice Ireland supports a referendum to repeal the 8th Amendment to the Constitution in order to ensure that all women have the right to choose including, where there is a risk to health or they have been victims of rape. 5

Who are Choice Ireland?
Choice Ireland is a Dublin based feminist pro-choice group which has been active since January 2007. We are a voluntary organisation and are dependent on small fundraising initiatives and donations from supporters and members. We are registered with SIPO and are fully compliant with SIPO regulations.
Choice Ireland is a feminist organisation and we see reproductive freedom and justice as a critical element of women's liberation and gender equality. We recognise that reproductive freedom is multi-faceted and on this basis we seek to ensure a woman's freedom to pursue all reproductive choice and promote education to empower women to take charge of their fertility and the right to bodily integrity.
Choice Ireland is not affiliated to any political parties; however we work with other pro-choice groups and feminist organisations. We have campaigned extensively on the following issues:
• Free Access to Accurate Information on All Crisis Pregnancy Options
• Legislation Regulating Information Provided by Crisis-Pregnancy Centres
• Immediate Legislation for the X and C Cases
• Proper Sex-Education
• Free Access to Multiple Forms of Contraception including the Emergency Contraception
• Free, Safe and Legal Abortion
• High-Quality Post-Abortion Care
• End to Stigma Surrounding Abortion
• Practical Support for Women Seeking Abortion
• End to Stigma Surrounding Sexual Health and Contraceptive Needs
• Increased Support for Single and Low-Income Parents
• Increased Protection for Working Mothers
• Free Access to Quality Childcare
• End to Stigma Surrounding Single Parenthood
• Choice in the Method of Childbirth
• Creation of More Feminist Health Centres 6

Introduction
UK Department of Health statistics suggest that 4,149 women provided Irish addresses to UK clinics providing abortion services in 2012. In addition Statistics compiled by the Crisis Pregnancy Programme indicate that some 1,470 women travelled from Ireland to the Netherlands from 2005-2009 to terminate their pregnancies. In addition, seizures made by the Irish Medicines Board suggest that many Irish women terminate pregnancies within the state by ordering medications over the Internet. Anecdotal evidence suggests migrant women from some Eastern European states who have the financial means to travel, return to their home countries for abortion services. Currently abortion is illegal in Ireland save in cases where there is a real and substantial threat a pregnant woman's

life which may only be addressed though the termination of her pregnancy. This right was established following the 1992 Supreme Court ruling "X v Attorney General" however no legislation has been provided in order to give effect to this right.
In 2010 the European Court of Human Rights ruled that Ireland was in violation of the European Convention on Human Rights as women had no mechanism allowing them to establish whether they had a right to an abortion in the state under the terms of the X case.
The criteria under which abortion is allowed under the terms of the X Case are strictly limited and would likely only affect a tiny proportion of the thousands of Irish women who terminate pregnancies every year. These terminations take place for a wide variety of reasons, including terminations due to the foetus being unable to live outside the womb due to a fatal foetal abnormality. Choice Ireland accepts that this Heads of Bill represents the beginning of the Government attempting to legislate for abortion on the grounds of the X Case, however in order to be compliant with the European Court of Human Rights Judgment in the ABC case, any legal framework introduced must be effective and accessible. This leglisation would provide strictly limited access to abortion and Ireland will remain one of the most restrictive regimes in the world 7

Recommendations

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

The Expert Group Report on Abortion offered a number of doctors involved in the process.
The X Case ruling allows abortion in cases where a woman's life is at risk. Choice Ireland recommends that no more than two doctors should be involved in the decision making process. As many Doctors work as part of a medical team, limiting the number of Doctors to two increases the likelihood that the determination can be made by the woman's own medical team and reduces the associated pressures on the woman. In addition this option avoids limiting access to terminations for women in areas where a wider pool of experts is unavailable. On this basis, the mandatory consultation with a GP should be removed, unless heads are amended so that the decision can be made by one doctor subsequent to consultation with a GP.
Choice Ireland further recommends that this head be expanded to ensure that all risks to a woman's life are dealt with in the same section, including where the threat to a woman's life is as a result of being suicidal in order to decrease the risk of stigmatising women through differential treatment of physical and psychiatric threats to life.
Choice Ireland is further concerned that there is no provision under this Head to ensure speedy access to medical treatment where a physical threat to a woman's life has been established. Given the current workings of the public hospital system – including the maternity structures this is very worrying. Choice Ireland recommends inclusion of a legislative provision that mandates treatment in an appropriate timeframe in order to comply with the provisions of the ABC judgment.

Head 4 Risk of loss of life from self-destruction

This Head proposes that in cases where a woman's life is at risk due to a threat of suicide that three opinions be sought, that of an obstetrician in addition to two psychiatrists. Choice Ireland recommends that in such cases two opinions should be deemed sufficient. This avoids the risk of stigmatising women through the differential treatment of physical and psychiatric threats to life.
While the provision may provide legal clarity it appears that it may be so onerous as to be inaccessible for women and thus not actually comply with the terms of the ABC judgment.
Choice Ireland wishes to point out The Expert Group stated the following disadvantages with regard to the possibility of involving three doctors in their Report; 8

• This proposal would put an extra burden on a patient and her treating doctor(s), meaning that three doctors would be required for the final decision in certain cases.
• The diagnosis of expressed suicide intent is a routine process for psychiatrists and it would therefore be hard to justify formally requiring a second psychiatrist when this does not occur when a pregnancy is not involved.
• Access to a necessary medical treatment could be curtailed due to geographical and service delivery issues.
• This option also risks stigmatising mental health conditions and making them a 'separate case'.

Choice Ireland acknowledges that this is intended to protect the life of the "unborn" however it may fall short of compliance with the ABC judgment due to the fact that access to necessary medical treatment could be curtailed due to geographical and service delivery issues.
Choice Ireland is further concerned about whether vulnerable and severely ill pregnant women would be liable for medical fees for consultant psychiatrists or obstetricians if she is seeking treatment and recommends the inclusion of a provision that will preclude this.
Choice Ireland also recommends that these provisions be amended to ensure that women have access to treatment in a speedy manner. Currently not all of the 19 maternity units have psychiatric facilities. For example, the Lourdes Hospital in Drogheda would refer people off-site to St. Bridgid's Hospital in Ardee, Co. Louth for psychiatric assessment. Furthermore the bill is drafted in a way that specifically excludes child psychiatrists who suicidal teenagers would be referred to and it is essential that this is amended.

Head 6 Formal Medical Review Procedures and Head 8 Review in case of risk of loss of life through self-destruction

It is Choice Ireland's view that the review group should consist of no more than two doctors.
It is questionable whether under its current construction this Head complies with the ABC judgment.

Head 9 General provisions for the Committee

This section contains a provision for making a person who fails to attend before the committee reviewing a decision (including a pregnant woman) of being guilty of an offence and subject to a fine of up to €2,500. 9

It is quite feasible that women who seek terminations and are refused may initiate a review and then travel overseas for treatment and not come to a hearing or women who are suicidal may not be in any state to attend a hearing.
Choice Ireland recommends that the state does not introduce a mechanism that has the potential of criminalising women in this manner. This is not compliant with the terms of the ECHR. A woman who has a life-threatening condition whether it is physical or mental should not be subject to a fine if her circumstances dictate she cannot attend a hearing.
Choice Ireland recommends this provision be deleted.

Head 19 Offence

The ECHR stated in the ABC judgment that the criminal penalties for women for having an unlawful abortion created a significant "chilling factor". This legislation retains a criminal offence and a significant penalty of a 14 year prison sentence should a person be found guilty of having an unlawful abortion or assisting in one and thus will not be compatible with the ECHR. This in effect brands women as criminals if they do within this jurisdiction what is legal in Northern Ireland where a person could lawfully obtain an abortion if there is a risk to their health as distinct from life.
Choice Ireland recommends that no provision for criminalising women for having abortions is included in the Bill. 10

Conclusion

In conclusion, Choice Ireland must reiterate how X Case legislation will only assist a very small number of women seeking abortions in Ireland.

The proposed Heads maintains an arbitrary distinction between physical and mental health as if they are different.

There is no clinical basis for this, and legislating for this distinction would be a regressive move for a state which has made strides in how mental health has been treated in recent times. Women deserve better than this.

The proposed Heads also maintains the artificial distinction between life and health. While Choice Ireland accepts that the Supreme Court decision in the X Case stated that a woman was entitled to an abortion where there is a real and substantial risk to her life, as distinct from health, it still places medical practitioners in a difficult area where they must wait for the exact moment a risk to health becomes a threat to life and as the inquest of Savita Halappanavar demonstrated, this is clearly not an optimum level of medical treatment for women.

Choice Ireland supports a referendum to repeal the 8th Amendment to the Constitution in order to ensure that all women have the right to choose including, where there is a risk to health or they have been victims of rape.

WRITTEN SUBMISSION IN RESPECT OF THE OIREACHTAS JOINT COMMITTEE ON HEALTH AND CHILDREN'S CONSIDERATION OF THE OUTLINE HEADS OF THE PROTECTION OF LIFE DURING PREGNANCY BILL 2013

INTRODUCTION

- I am “Pro-Life” meaning that I believe in the equal right to life of Mothers and Babies. I am a practicisng Catholic.

- Ever since the Irish Government announced in April of 2012 that it was going to legislate for the X case, I have attended marches and vigils for life.

- I have been in frequent contact with TDs and Senators regarding the proposed legislation and I was a member of a pro-life delegation that met with County Councillors at the Civic Offices in

Nenagh, Co. Tipperary.

- I have also begun to support Irish and international pro-life organisations via donations.

- I often post on pro-life issues on my blog http://cloversoldier.wordpress.com/.

- I am also a member of a group of pro-life people that meets outside the Civic Offices in Nenagh every Friday to pray a rosary for the unborn.

EXECUTIVE SUMMARY

1) This written submission outlines the reasoning for **not** providing legislation for abortion on "mental health grounds."

2) The main body contains factual information which details how mistakes have been made in Britain where abortion has been legalized on "mental health grounds" since 1967.

3) It also contains details from t*he latest World Health Organisation report on Trends in Mortality, the judgement from the European Court of Human Rights regarding* A, B and C v. Ireland *and facts from the recent Oireachtas Committee on Health and Children*

4) ***Recommendations****:*

    1) ***Clarity for women in pregnancy:***

Instead of introducing abortion legislation, the Government should provide clarity for women in pregnancy, in order to ensure that the best medical care possible will be provided for both mother and baby during pregnancy.

    2) ***Medical guidelines***

Medical guidelines should be drawn up in consultation with the appropriate bodies of expertise within the medical profession and this should be done on the basis of best medical practice. The Government should make

a commitment to the Committee of Ministers of the Council of Europe, that these actions will be carried out. These guidelines should take into consideration, the lives of both the mother and the baby.

3) ***The X case***

The Government should also commit to the examination of the difficulties linked with the X case, the options for the clarification of these difficulties should be identified and the government should report to the Committee of Ministers any progress that has been made.

THE IMPACT OF ABORTION ON "MENTAL HEALTH GROUNDS" IN BRITAIN:

1) The experiences of other countries show us that abortion legalised on "mental health grounds" eventually leads to "abortion on demand". Abortion was legalised in Britain in 1967 on "mental health grounds". Yet in 2012 there were 200,000 abortions carried out in Britain and 98% of these abortions were carried out on "mental health grounds". http://www.lifenews.com/2013/02/12/200000-uk-abortions-98-done-on-mental-health-grounds/

2) Lord David Steel, the man responsible for the 1967 abortion law in Britain, said that for Ireland to introduce abortion on "mental health grounds", would be a mistake. He "never envisaged there would be so many abortions in Britain" as a result of that law.

HOW IRELAND'S PRO-LIFE LAWS ARE VIEWED INTERNATIONALLY:

3) *The latest World Health Organisation report on Trends in Mortality 1990 to 2010, shows that, without abortion, Ireland ranks in the top 5 in safety for women in pregnancy.*

4) *According to the European Court of Human Rights judgment in* A, B and C v. Ireland*, Ireland is* ***not obliged*** *to legalise abortion via the way of any legislation, regulation or any other way.*

EVIDENCE FROM MEDICAL EXPERTS:

5) *Expert evidence from the Oireachtas Committee on Health and Children tells us that abortion* ***is not a medical treatment*** *for a pregnant woman with suicidal thoughts. Medical experts in this committee agreed that abortion is* ***not*** *a treatment for suicide.*
http://www.thelifeinstitute.net/am_cms_media/life-institute-expert-hearings-briefing-doc.pdf

6) *Here is what Dr John Sheehan said, at the committee hearings:*

7) "*The notion of carrying out an emergency termination is completely obsolete in respect of a person who is extremely suicidal...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."*

Dr. John Sheehan,

Perinatal Psychiatrist

CONCLUSION:

8) *These are some of the many facts available, which clearly state many reasons, as to why Ireland should not introduce abortion of any kind.*

9) If Ireland, keeps its pro-life laws, then it will remain one of the best countries in the world for maternal healthcare. Pregnant women living abroad will know that Ireland will still remain an ideal country for women to give birth to a healthy baby.

Signed: *Ciarán Butler* ***Date:*** *7/5/2013*

Submission to the Joint Oireachtas Committee on Health and Children on the Scheme of the Protection of Life during Pregnancy Bill 2013

8th May 2013

Dr. Claire Murray, Lecturer in Law, University College Cork

Introduction

The provisions contained in the scheme of the Protection of Life during Pregnancy Bill 2013 are the absolute minimum that are required to comply with the Supreme Court decision in the case of Attorney General v X [1992] 2 IR 1. This legislation will affect only a very small number of women in Ireland. Those women who have been the victim of rape or incest, who are carrying a foetus with a fatal abnormality incompatible with life outside the womb, and those women whose health will be seriously affected by carrying a pregnancy to term will continue to be forced to travel outside the jurisdiction to obtain abortion services, provided that they are well enough and can afford to do so. In order to fully respect the autonomy rights of women living in Ireland it is necessary to repeal the 8th Amendment to the Constitution as this constitutional provision limits the scope of any legislation that can be introduced.

This submission is primarily concerned with the inclusion in the draft scheme of a separate process to "assess the risk of loss of life from self-destruction." This is set out in Head 4. This is the issue on which much of the debate focused prior to the publication of the draft scheme. The inclusion of a separate and more onerous process to assess risk to life by suicide is questionable and I argue derives from a belief that women in this vulnerable position are inherently untrustworthy.

The inclusion in the draft legislation of a separate process where the risk to life is from self-destruction

The inclusion of a separate process for assessing risk to life by self-destruction involving three medical practitioners (an obstetrician and two psychiatrists) is in line with Option 3 set out in the Report of the Expert Group.[14] According to the explanatory notes under Head 4 this provision arises "from the recognised clinical challenges in accurately assessing suicidal intent, and the absence of objective clinical markers." This proposal to involve three medical practitioners is now being characterised as a reasonable compromise in light of earlier suggestions that five or six practitioners

[14] Report of the Expert Group, p. 35.

would be involved in the assessment process. It is, however, unduly onerous and unnecessary. The Expert Group itself identified difficulties with including a separate process for assessing risk to life by suicide in the legislation. First, it is inherently discriminatory to have a different procedure in place for women who are experiencing mental health difficulties or suicidal ideation and wish to avail of a lawful abortion. Second, these "safeguards," as they are termed, serve to reinforce the stigma surrounding mental health conditions in Ireland by treating it as a case apart and by inferring that women in this position cannot be trusted. Furthermore, the Expert Group stated that "access to a necessary medical treatment could be curtailed due to geographical and service delivery issues."[15] Finally this proposal places an extra burden on women in this category by requiring three doctors to make the final decision in cases involving suicide, rather than two medical practitioners in cases where the risk to life is from a physical illness or condition. This may result in additional delays in decisions being reached.

It is important to note that in circumstances where a woman is experiencing suicidal ideation or intent but is not pregnant and seeking an abortion, there is no requirement to have a second psychiatrist verify the medical decision of the first psychiatrist that the woman does in fact pose a threat to her own life. As stated by the Expert Group[16] and many of the consultant clinical psychiatrists who have contributed to the debate on this issue, both before the initial hearings of the Joint Oireachtas Committee and on the airwaves, diagnosing expressed suicidal intent is a routine process for psychiatrists. The only reason for including additional hurdles in this particular legislation is because of a fear that the process will be "abused" – the suggestion being that women will fabricate suicidal ideation or, that women and psychiatrists will conspire to certify that an abortion is appropriate in circumstances where the legal test has not been satisfied. This is deeply disrespectful towards both pregnant women and the psychiatric profession.

Specific issues relating to the process contained in Head 4

The requirement set out in the draft Scheme that the decision of the three doctors assessing the risk to life by self-destruction be unanimous, doctors are required to "jointly certify", may create practical difficulties. It allows for the possibility that one medical practitioner could veto the decision in circumstances where the other two doctors are willing to certify that the legal test has been satisfied. Given the recent statement issued on behalf of 113 consultant psychiatrists in Ireland to the effect 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" it is clear that there is a difference of opinion within the psychiatric profession on this issue.[17] There are, therefore, legitimate reasons for

[15] Report of the Expert Group at p. 35.
[16] Report of the Expert Group at p. 35.
[17] Eilish O'Regan, "More than 100 psychiatrists disagree with abortion proposal" (2013) *Irish Independent,* 25th April.

fearing that this situation will arise. It is also odd that the obstetrician/gynaecologist should be in a position to veto the decision of two consultant psychiatrists that there is a real and substantial risk of loss of the pregnant woman's life by suicide. Obstetricians have no training or expertise in assessing suicidal ideation or risk to life by self-destruction and so it is unclear what they will add to the panel in making this decision. There is an appeals process included in the draft scheme, details are contained in Head 8, but a similar joint certification process is in place and so the same issue could potentially arise.

The recognition in the explanatory notes under Head 4 of the contribution that could be made by the woman's GP is welcome. However, under the existing scheme the GP will have no direct input into the decision-making process. Arguably it would make more sense, given the valuable insight into the woman's clinical history that can be offered by the GP, for the GP to be included on the panel making the decision in relation to the risk to life. I wish to be very clear that this is not a suggestion that a fourth doctor should be formally added to the panel. Rather, if the general position is that two doctors are required to assess the risk to the life of the woman then where that risk is of self-destruction a GP and a consultant psychiatrist would seem to be a reasonable combination. In the context of involuntary admission under the Mental Health Act 2001 the process requires a GP to provide a recommendation for admission and the final admission order is made by a consultant psychiatrist.

Finally, the draft legislation does not provide that the woman must be examined by all three medical practitioners at the same time. While this approach may have been adopted to avoid the process being characterised as an inquisition, and in that respect it is welcome, it may have other negative consequences. Allowing for the possibility that a woman in distress, who states that she is suicidal, might be required to attend at three different appointments to meet with three different medical practitioners and to recount her story three times is questionable. It has the potential to draw out the process and it gives the appearance of a series of obstacles being placed in the way of the woman. It is likely that the repeated recounting of her story by the woman may operate to compound her distress. There is also the risk that any slight variations in the story told by the woman over multiple examinations could be seen as evidence that she is not being entirely truthful. This is an issue that requires further consideration.

Author Profile: This submission is made by Dr. Claire Murray, Lecturer in the Department and Faculty of Law, University College Cork. Dr. Murray is a graduate of UCC (BCL, PGCTLHE, PGDTLHE, PhD) and Kings Inns (BL). She researches in the areas of mental health law, feminist theories of rights and family law. She lectures in welfare law, family law and tort law and is a coordinator of the Gender, Law and

Sexuality research initiative within the Law Department in UCC. Dr. Murray holds a pro-choice position on abortion.

Erich Clara <erclar@googlemail.com>
08/05/2013 14:28 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
submission - Protection of Life During Pregnancy Bill 2013

To whom it may concern,
I have encountered more women, who are extremely distressed after having had an abortion and their decision is haunting them.

- It is stated from a noticeable amount of psychiatrist that abortion is not a treatment for women who are suicidal (even psychiatrists who are pro-choice agree about this)
- and evidences brought forward in discussions are stating that women who had an abortion are more susceptible for suicide. Also it is to be recognised that in countries which introduced abortion and carry out abortions on the grounds of mental health (i.e. 98% of all abortions in the UK) have still women dieing from suicide, as recent maternal mortality statistics from Britain show.

It is in my view a complete contradiction to want to keep a woman from taking her own life by misleading her into having an abortion.

- It is evident that the death of Savita Halappanavar is used in order to introduce (on the long term) abortion on demand into Ireland, although her death was a result of medical misconduct and not a lack of clarity in the life-saving treatment for a pregnant woman.

- The state has the responsibility to care for all its members, burn and unborn, and not to allow wealthy/powerful lobbies to dictate their morality to the whole of society and also not to allow sick ideologies to creep into the minds of leaders (i.e. that some lives are less worth than others or that not all the human beings have the same state of personhood and other similar).

With Regards

Erich Clara

Clare O'Callaghan <claremaryocallaghan@yahoo.com>
08/05/2013 16:11
Please respond to
Clare O'Callaghan <claremaryocallaghan@yahoo.com>

To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Submission on the Protection of Life in Pregnancy Bill 2013

Dear Mr. Kelly,

I wish to make a submission regarding the Protection of Life in Pregnancy Bill 2013.

Clarity is to be welcomed on the issue of termination of pregnancies however I wish to state my strong objection to the inclusion of suicide as grounds for a legal termination - 'Head 4 Risk of loss of life from self-destruction'. As the recent Oireachtas hearings were told; termination is not a resolution to suicidal tendencies and in fact a termination itself can lead to suicidal thoughts. In my opinion it does not make sense to be introducing legislation that is against current medical knowledge and especially not to implement legislation based on the now outdated opinion of judges who had no expert medical knowledge.

I note also that there is no time limit to when terminations may take place. This means that a woman could potentially decide eight months into her pregnancy that she feels suicidal and is thus granted a termination. This is not a correct situation in my view.

I welcome the fact that individuals are not obliged to carry out terminations however I do object to the fact that "No institution, organisation or third party shall refuse to provide a lawful termination of pregnancy to a woman on grounds of conscientious objection" as this would force hospitals who have an ethos of life being forced to provide services that are morally objectionable. The right to life is a fundamental right for all and forcing institutions to abandon this ethos is highly questionable.

I welcome the fact that under Explanatory Notes: 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. I believe that if a woman's life is in danger then the best medical care should be provided for her. If this results in the unintentional or inevitable or unavoidable death of the child then that is not morally objectionable. What is objectionable is the direct targeting and intentional destruction of the child in the womb.

I note that under Head 2 'Explanatory Notes': 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. This means that if a doctor suspects that there might possibly be a risk to the life of the mother in the future then (s)he can terminate a pregnancy. This will lead to the situation where a doctor may perform a termination just in case there might be a risk to the life of the mother in the future as if (s)he does not do so (s)he may be prosecuted. This is a very precarious situation.

I trust that these opinions from a concerned citizen will be taken into account when revising this Bill.

Kind regards,

Clare O'Callaghan

Colin Dunne <colinpdunne@yahoo.ie>
08/05/2013 14:44
Please respond to
colinpdunne@yahoo.ie

To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Proposed Abortion bill

Dear Mr Kelly
I am writing to appeal that the government remove from this bill the section allowing for an abortion where a woman presents with suicidal ideation. There is no evidence that abortion is a medical treatment for suicidal ideation and some research suggests it can make a woman's mental health worse.
Regards
Colin Dunne
34 The Lawn
Woodbrook Glen
Bray
Co. Wicklow

Con McGrath <conhallows@gmail.com>
08/05/2013 14:50 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Pregnancy bill

Dear Mr. Paul Kelly,
We wish to state our opposition to this Human Life in Pregnancy Bill. In light of all the evidence shown that Ireland continues to be one of the safest places in the world for pregnant mothers and their unborn babies and in view that many psychiatrists have pointed out abortion is not a treatment for suicidal ideation.
Why then is the Enda Kenny Government persisting with this bill against the vast majority of views by the very people they are supposed to represent!
Thanking you,
Con McGrath

Dan OCinneide <danocinneide@yahoo.com>
08/05/2013 17:06
Please respond to
Dan OCinneide <danocinneide@yahoo.com> To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Fw: Abortion submission/question

Paul,
Please see email below...
Dan Kennedy

----- Forwarded Message -----
From: Dan OCinneide <danocinneide@yahoo.com>
To: "Paul.Kelly@oireachtas.ie" <Paul.Kelly@oireachtas.ie>
Sent: Wednesday, May 8, 2013 4:56 PM
Subject: Abortion submission/question

Paul,
Please put the following submission/question before the relevant members:
After a suicidal woman is granted permission for a "termination" (under the requirements of the legislation), and assuming her unborn child is around 30 weeks gestation (for example), must this "termination" always result in the child's death? Or, could the legislation be interpreted such that the pregnancy is terminated, but the child's life could be saved - the child could be delivered (say, a section) and removed to an incubator?
And secondly:
How many, and what exactly are, the methods to be used in ending an unborn child's life?
Many thanks in advance.
Best wishes,
Dan O'Cinnéide
61 St Patricks Road
Drumcondra
Dublin 9
087 7912911

David Binchy pdf

Cover Note

Name Deirdre Conroy Address 113 The Maples, Clonskeagh, Dublin 14 email deirdre@deirdreconroy.com 086 280 5413 I am making this submission order to contribute and clarify certain aspects of the Bill where the State is remiss in honouring its undertaking to allow termination in exceptional circumstances, based on: a) My personal experience relating to a termination which I brought to public attention in 2002 via a letter to the Irish Times, foregrounding exceptional circumstances and which triggered a national debate.
b) My case taken to the European Court of Human Rights, represented by barrister, Barbara Hewson, which challenged my right to have had a termination within my own jurisdiction.
c) The State's defence in that case. I am prepared to appear and discuss my submission with the Committee in Public Session.
Signed:
Deirdre Conroy 8 May 2013

Submission to Joint Committee on Health and Children in relation to
Protection of Life during Pregnancy Bill 2013

Introduction Relevant Experience:

I am a woman with the experience of having to terminate at 18 weeks, a foetus doubly confirmed as having a fatal abnormality incompatible with life (Trisomy 18). I suffered life threatening after effects because, I believe, I was not treated in my chosen Dublin hospital where a complete delivery of a second already dead twin would have been carried out at the time. When I was operated on 10 days after the termination the surgeon told me 'we got you just in time'. I am an Irish national, mother of two university student sons and I have taken the first violation of Human Rights case against the State in respect of the medical treatment that was unavailable in this jurisdiction. My experience from denial of medical intervention through to the findings of the ECHR lasted over four and a half years. The aftermath until recent weeks has been a long and concealed burden of secrecy to protect my identity and that of my children. Until I could no longer retain my privacy and felt obliged to speak in public about the findings in my case, after the outcome of the inquest into the death of Savita Hallapanavar revealed that her death had come about due to privileging the life of an unviable foetus, with medical staff quoting Irish law and religion as the reason for non-intervention. It proved to me that my four and half years taking that case were to no avail and it appears the State has no intention of honouring its undertaking in defence of my case.

In the absence of any express provision in these Heads of Bill for pregnant woman with traumatic diagnoses of lethal foetal abnormality, I wish to ascertain whether it is intended to foreclose any development by the courts of the law in X, in the way Dr Hogan envisaged and advised the State and the European Court eight years ago, in D v Ireland.

I now request an opportunity to present my observations and recommendations and to be called to speak in Public at Committee. Deirdre Conroy Submission to the Health Committee in relation to Protection of Life during Pregnancy Bill. Contact Details 086 2805413 deirdre@deirdreconroy.com

Executive Summary My recommendations are based on my personal experience and the Expert Opinion put forward by the State's counsel, Dr Gerard Hogan, in July 2005 in D v Ireland, and endorsed by the Government in a separate document, Supplemental Observations. My case was declared inadmissible at an oral hearing in Strasbourg on the grounds that I had not exhausted the judicial remedies open to me in this State (I was advised by a barrister not to make my case public while pregnant in the event that I would be prevented from travelling). I make this submission on my own behalf for the purpose of bringing to the attention of the State, its defence and undertaking in D v Ireland and I recommend that a pregnant woman have the right to be informed and choose in conjunction with her medical practitioners, a medical intervention where a foetus is diagnosed with a lethal abnormality, incompatible with life. I do not represent any lobby group, organisation or political party. The scope of my submission refers to Head 1 Interpretation 'unborn' Head 2 Risk of loss of life from physical illness, not being a risk of self destruction (slow onset of sepsis) - real and substantial risk of the pregnant woman's life Head 3 As above in a medical emergency

Head 4 Risk of life from self-destruction Head 6 Formal Medical Review Procedures - Establishment of a formal framework providing for an accessible, effective and timely medical review mechanism under this judgement. Head 14 'Regulations', whereby the Minister may make regulation under this head that may contain such consequential supplementary and ancillary provision as the Minister considers necessary or expedient. **Supplementary Documents:** 1. Expert Opinion of Dr Gerard Hogan in Council of Europe European Court of Human Rights Application No. 26499/02 D v Ireland. 27 June 2005

2. Supplemental Observations of Ireland submitted to the court pursuant to Rule 54 of the Rules of Court. 1 July 2005

3. ECHR Decision D v Ireland. 28 June 2006

Reference is made to: The Green Paper on Abortion Sept 1999 Deirdre Conroy Submission to the Health Committee in relation to Protection of Life during Pregnancy Bill. Contact Details 086 2805413 deirdre@deirdreconroy.com

4

Recommendations **Head 1 - Interpretation** Quote from Heads: '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. I refer to State's Counsel Opinion in D v Ireland Point 22. 'Thus, in the present context, the argument that 'unborn' presupposes that the foetus could in fact be born alive could certainly have been advanced by the Applicant (D) and, if advanced would have received serious consideration by an Irish court. If, factually, it had been established that the foetus here had no realistic prospect of being born alive, then at least a tenable argument could have been made to the effect that this foetus was not an 'unborn' for the purposes of Article 40.3.3. Indeed, even if the foetus in that instance was an 'unborn' for the purpose of Article 40.3.3, its right to life might not have actually been engaged in this case, given that it had no realistic prospect of life outside of the womb.'
The foetus I carried had no prospect of life, nor obviously had the already dead foetus. **Head 2 and Head 3 Risk of loss of life** In my case, the real and substantial risk to the woman's life was not anticipated. Had I attempted to exhaust the court remedy as upheld in State's defence, based on the X case and the timing from X's injunction on 7 Feb 92 to decision on 5 March 92, I would have been 27 weeks pregnant, with one dead foetus and one unviable twin. There was a real and substantial risk to my life post delivery as I had to be admitted for emergency medical treatment to evacuate dead twin tissue; this was overlooked in the State's defence of my case.
The real and substantial risk to the woman's life was not applied in the case of Savita Hallapanavar (Oct 2012)
I recommend under Head 2 and 3 that the Supplemental Observations of Ireland in D v Ireland be addressed and a judicial framework be developed for similar cases, I quote from the State's evidence:
A Trisomy 18 or Edward's Syndrome
2.2 As is clear from the applicant's supplemental observations, she accepts that Edward's syndrome is a lethal genetic condition. Neither the applicant nor the applicant's constitutional expert addresses the consequences of the fact that Edward's syndrome is a condition from which those affected will die for the purposes of any analysis of Article 40.3.3 of the Irish Constitution. In this regard, the Court is respectfully referred to the expert

opinion of Dr Gerard Hogan, Senior Counsel, an Irish expert in Constitutional law who has been asked to address the issues arising in the instant application and, in particular, the opinion of Dr Michael Forde SC dealing with the question of exhaustion of domestic remedies (Document Appended). Insofar as Dr Forde states that the applicant had no prospect of success before the Irish Courts, the Government wish to draw the court's attention to the expert view of Dr Gerard Hogan to the effect that:
(i) No issue remotely comparable to the present case has ever been considered by the Irish Courts, and
(ii) The issue of what constitutes 'unborn' for the purposes of Article 40.3.3 has not received any real judicial consideration.
2.3 In this context, Dr Hogan asserts that the argument that the protection afforded to the unborn attaches to the viable foetus is a matter that would have received serious consideration by an Irish Court. It is respectfully submitted that Dr Hogan's opinion is persuasive and indeed compelling.
End of Quote
I draw the Committee's attention to the Miss D case of 2007, in which the young woman carrying an unviable foetus with anencephaly was represented by Dr Gerard Hogan, advocating that she should have the right to travel to the UK for an abortion. I trust the anomaly is obvious. It would have been the first time a case such as mine was tested in the Irish courts and the decision was to send the young woman away.
At that time, I brought the findings of my case to Dr Gerard Hogan's attention in order to demonstrate that a legal opinion existed to accommodate Miss D in Ireland (I telephoned him, not realising he was the State Counsel in my case). I believe Dr Hogan resigned as Miss D's legal representative.
Following is an example of what I anticipated if I took a case to the Irish courts while 18 weeks pregnant, bearing in mind I was not a seventeen-year-old and had two children to protect.
The Sunday Tribune's editorial of 6 May 2007 described Miss D's hardship as follows: "Miss D has had to summon a legal team, prepare an affidavit, talk to psychiatrists. She has had to sit in a courtroom packed with five sets of legal teams and journalists, her every move watched and reported on, her relationship with her boyfriend described, her relationship with her mother analysed. She has had to leave the courtroom while detailed textbook descriptions of the medical condition the foetus she is carrying suffers from are described in terms no doctor would ever use when talking to a patient". Deirdre Conroy Submission to the Health Committee in relation to Protection of Life during Pregnancy Bill. Contact Details 086 2805413 deirdre@deirdreconroy.com
6

Head 4 Risk of Loss of Life from Self-Destruction

The debate on suicide ideation has raged between pro-life and pro-choice groups, between obstetricians and psychiatrists and the State and the Church. In my opinion, the suicide issue is a diversion from the real and substantive requirement of humane intervention in traumatic pregnancies, diagnosed unviable. The proposed legislation, based on a teenage rape case in the 1990's predicates a flood of deceitful women demanding abortion on demand. It is a very unsafe and undesirable basis on which to establish such an important constitutional right.

I recommend a review of the Heads of Bill under Head 14, Regulations, to expand the provisions to lethal foetal abnormality, based on my experience as a woman receiving that diagnosis and the mental trauma caused by (a) having to leave the jurisdiction and (b) being expected to carry to full term an unviable and dead foetus,, with other children to look after. A woman should not have to be suicidal to be offered humane medical intervention. **Head 6 Formal Medical Review Procedures** One of Ireland's obligations under the judgement in A, B and C v Ireland, is the establishment of a formal framework providing for an accessible, effective and timely medical review mechanism I recommend a specialist group be established to counsel and advise pregnant women carrying a foetus or foetuses incompatible with life, based on the Antenatal Results and Choices organisation in Northern Ireland.

The explanatory notes of Head 6 quote from the ECHR judgement on Tysiqc v Poland 2007, and sets out its relevance to the detailed procedural safeguards envisaged by the Court.

However, it overlooks the anomaly in that judgement, where even within the European Court of Human Rights, there is dissent among judges in relation to recourse in national court systems.

The following commentary is written by Judge Borrego of the ECHR, also one of the judges in D v Ireland. He complains that after the ECHR had 9 months before, decided that I should have exhausted the Irish Courts; and was now departing from what it had found in my case.

Judge Borrego on Tysiqc v Poland:

4. Eight months ago, the same Section of the Court gave a decision concerning the application *D. v. Ireland* ((dec.), no. 26499/02, 28 June 2006). I do not understand why the Court's decision is so different today in the present case.

5. There is no unanimous position among the member States of the Council of Europe with regard to abortion. Some of them are quite restrictive, others are very permissive, but nevertheless the majority adopt an intermediate position.
Ireland is one of the most restrictive countries. As stated in Article 40 § 3 (3) of its Constitution, "the State acknowledges the right to life of the unborn ...". Only in the case of a "real and substantial risk" to the mother's life is there a possibility of a constitutional action, involving proceedings which are in principle non-confidential and of an unknown length, to obtain authorisation for a legal abortion.
Poland adopts an intermediate position: the Contracting Party's legislation provides for a "relatively simple procedure for obtaining a lawful abortion based on medical considerations ... Such a procedure allows for taking relevant measures promptly and does not differ substantially from solutions adopted in certain other member States" (see paragraphs 34 and 121 of the judgment).
6. As to the debate on abortion, in *D. v. Ireland* (cited above, § 97) the Court also noted "the sensitive, heated and often polarised nature of the debate in Ireland".
In the present case, the Court neglects the debate concerning abortion in Poland.
7. Concerning the applicant in *D. v. Ireland*, there was a real risk to the life of the mother. The applicant was a woman who was eighteen weeks pregnant with twin sons when she was informed that one foetus had "stopped developing" by that stage and the second had a severe chromosomal abnormality ("a lethal genetic condition"). Some days later, she had an abortion in the United Kingdom. As a result of the strain, she and her partner ended their relationship, she stopped working, and so on.
8. The Court's approach with regard to abortion is different in both cases. I should say it is quite respectful in *D. v. Ireland*: "This is particularly the case when the central issue is a novel one, requiring a complex and sensitive balancing of equal rights to life and demanding a delicate analysis of country-specific values and morals. Moreover, it is precisely the interplay of the equal right to life of the mother and the 'unborn' ..." (ibid., § 90).
On the contrary, in the Polish case all the debate is focused on the State's positive obligation of "effective respect" for private life in protecting the individual against arbitrary interference by the public authorities (see paragraphs 109 and 110 of the judgment). No reference is made to "the complex and sensitive balancing of equal rights to life ... of the mother and the unborn" mentioned in *D. v. Ireland*. In the present case, the balance is one of a very different nature: "the fair balance that has to be struck between the competing interests of the individual and of the community as a whole" (see paragraph 111).
9. In *D. v. Ireland*, everything must be objective. In the present case, everything is subjective.

Concerning the Irish woman, the Court's decision states: "It is undoubtedly the case that the applicant was deeply distressed by,*inter alia*, the diagnosis and its consequences. However, such distress cannot, of itself, exempt an applicant from the obligation to exhaust domestic remedies" (see *D. v. Ireland*, cited above, § 101).
In the eighteenth week of pregnancy, with a real risk to her life and facing a non-confidential procedure of unknown length, the Irish woman was obliged to exhaust domestic remedies. She "sought advice, informally, from a friend who was a lawyer who had told her that if she wrote to the authorities to protest, the State might try and prevent her travelling abroad for a termination and ... she was not prepared to take this risk". But, in her case, the Court did not consider "that informally consulting a friend amount[ed] to instructing a solicitor or barrister and obtaining a formal opinion" (ibid., § 102).
It is very interesting to compare this statement with the one in the Polish case, in which the applicant "feared that the pregnancy and delivery might further endanger her eyesight". In this case the Court considers this fear "sufficient" and "is of the view that her fears cannot be said to have been irrational" (see paragraph 119 of the judgment).
10. The majority have based their decision that there has been a violation of Article 8 on the fact that the Contracting Party has not fulfilled its positive obligation to respect the applicant's private life.
End of Quote.

Head 14 Regulations

Whereby the Minister may make regulation under this head that may contain such consequential supplementary and ancillary provision as the Minister considers necessary or expedient. I refer to State's Counsel Opinion in D v Ireland Point 19. 'In other words, the actual decision in the X case graphically demonstrated the potential for judicial development in this area.'
And to
Point 20. 'Thus, in the light of the decision in X, one would be hard pressed to exclude on an a priori basis most arguments in this area, particularly in a case such as the present one where the facts are compelling. To put it another way, while Article 40.3.3 plainly excludes a liberal abortion regime, the courts are nonetheless unlikely to interpret this provision with remorseless logic, regardless of the personal circumstances of the woman seeking a termination in Ireland. The X case clearly holds out the possibility of the further development of the law in this area where, for example, the continuation of the pregnancy

seems pointless or is not medically advised or where to do so would be oppressive and at odds with humanitarian considerations.' I refer again to the Miss D case in 2007, where the seventeen-year old applicant sought a termination due to foetal anencephaly, the Irish court did not direct that she should be treated in her own jurisdiction, but despatched her to the United Kingdom, which was a total contradiction of the State Counsel's Opinion in my case, Dr Gerard Hogan. I continue to maintain there was no prospect of a successful remedy open to me as, based on the X case, a termination would not have been constitutionally admissible. In conclusion, these Heads of Bill ignore the State's Counsel Opinion in D v Ireland and neglect to provide any possibility of further development of the law in this area. I call on the Minister to consider my recommendations and, under Head 14, to honour its defence in D v Ireland and regulate for medical intervention in such cases as are diagnosed with fatal foetal abnormality.

Signed: Deirdre Conroy Dated: 8 May 2013

Dermot Dowdall <dermotdowdall@gmail.com>
08/05/2013 13:21 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Attention Paul Kelly

Sir,

I wish to make known my most strenuous objection to the Government proposal to legislate for abortion where a threat of suicide is involved.

The state has no grounds on which to sustain this movement given that our legal institutions have concluded this after a deep investigation with our medical institutions. Furthermore the people have repeatedly made it clear in the polling stations that abortion is not wanted here. Overthrowing the clear will of the people and its institutions is an act of treachery. It serves a will other that of the people.

The consequences of this action by the state are so profound as to far exceed the errors of a financial nature made by other governments to date. Not only will it be the rock that the governing parties perish on, but, when this current fashion fad expires, the names of the individuals who sign it will eventually live in Irish infamy, for they do this while criticising child sexual abuse, yet opting to end the children's lives instead.

No civil war here please, no Irish killing Irish. We have no right to kill anyone at any stage of life.Sometimes this cannot be helped and that is the nature of things, the circumstances are well enough described but suicideation clearly does not qualify.

This is not only an attack on the unborn but also upon those under counted thousands who have repeatedly shown their views in polling stations, protests, and communications.

DEEP DEEP SHAME ON THOSE PARTICIPANTS OF THIS TREACHEROUS PUTSCH.

Dermot Dowdall

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,

Dr. Peadar O'Grady
Dr. Mark Murphy
Dr. Mary Favier

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Dr Peadar O'Grady is a Consultant Child and Adolescent Psychiatrist and is a founding member of Doctors for Choice

Dr Mark Murphy is a GP Registrar in Sligo Town and member of Doctors For Choice. He has published research in the European Journal of General Practice in 2012 on the attitudes and clinical experiences of Irish GPs on abortion.

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).

Submission to the Joint Oireachtais Committee on Health and Children
PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013 –
Date: 8th May 2013
Prepared by: Doctors for Life
c/o 3 Sycamore House, Millennium Park, Osberstown, Naas, Co Kildare,
Tel: 045 854022 Fax: 045 854218 email: deirdregleeson@medwise.ie Doctors 4 Life submission: Protection of Life During Pregnancy Bill (Heads of) 2013
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1. Introduction

Doctors for Life represents a broad spectrum of specialties in medicine and is making this submission because of our concerns for the impact of this Bill on our patients including mothers and unborn babies and because of the potential impact on the professional practice of doctors.

While welcoming the clarity which the proposed legislation gives to management of emergencies and life threatening illness in pregnancy, the group believes that some elements of the proposed legislation will seriously undermine the efforts of doctors and nurses to care for both mother and baby. We refer specifically to the proposal to allow for termination of pregnancy in the case of threatened suicide on the part of the mother, for which there is no objective test and no evidence-based reason to believe that termination would resolve the problem.

Twenty years have passed since the X case judgement, which did not hear any medical evidence. Medical research and expert medical opinion since that time confirms that abortion is not a treatment for suicide. The government is not obliged to legislate for a flawed judgement that does not have the backing of evidence based medical care.

Constitutional democracy is based on the equal and inherent value of every human life and the equality of all before the law. Abortion denies the inherent dignity and worth of the unborn child and treats that child as someone who is unequal before the law.

Once a decision is made that some unborn children (i.e. those targeted for abortion) do not have the same dignity, worth and rights as other unborn children and once the principle is conceded that some human lives can be directly ended, what is to stop the targeting of other children? For e.g. those with life-limiting illnesses or palliative care needs. We believe that this legislation once introduced will inevitably lead to abortions for a wide range of reasons.

We are further concerned about implications for healthcare professionals who wish to exercise their right to conscientious objection. We do not believe this is sufficiently protected in this Bill. Doctors 4 Life submission: Protection of Life During Pregnancy Bill (Heads of) 2013

We believe this Bill if passed into legislation will have an adverse effect on patient care and the professional practice of medicine in Ireland. Doctors 4 Life submission: Protection of Life During Pregnancy Bill (Heads of) 2013
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2. Response to head 2 of Bill: Risk of loss of life from physical illness, not being a risk of self destruction.

This head is almost identical to the current medical council guidelines. The only difference is that they ask that two doctors, one being an obstetrician /gynaecologist working in that location and the other on the specialist medical register who agree in good faith that "terminating the pregnancy is necessary to save the life of the mother". It also states that if the unborn baby is viable outside the womb "doctors must make all efforts to sustain its life after delivery". Therefore there is nothing new in this Head.

This Head outlines the current practice in all maternity units in the country, most commonly in the management of severe pre-eclampsia where it may be necessary to deliver the baby early in order to cure the condition. Obstetricians are always weighing up the balance between maximising the potential for both patients- the pregnant woman and her unborn baby. For example if a pregnant women presents at 24 weeks with severe pre-eclampsia. The ultimate treatment is to deliver the baby. But initially treatment entails controlling her blood pressure and monitoring clinical symptoms and biochemical parameters to assess the severity and progression of the disease whilst simultaneously monitoring the unborn baby and giving the mother steroids in an effort to mature the baby's lungs to improve the baby's chance of survival once delivered.

On occasions delivery may have to be induced at a gestation where the baby is unlikely to survive. In practice on these occasions most doctors would consult another colleague when making these difficult decisions.

Recommendation:

We agree that professional guidance should be developed by the relevant professional bodies. This is not abortion but appropriate medical treatment where the intention is to preserve the life of both if possible. Therefore the current situation does not require a change in the law merely clarification on what constitutes a real and substantial risk to the life of the pregnant women. Doctors 4 Life submission: Protection of Life During Pregnancy Bill (Heads of) 2013

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3. Response to Head 3: Risk of loss of life from physical illness in a medical emergency

Usually these situations in clinical practice are obvious, e.g. bleeding from a placental abruption or placenta praevia where the pregnant women presents with life threatening haemorrhage and immediate delivery is required to save the life of the mother primarily, but that every effort would be made to save the baby as well. Obviously in these situations quick decisions are necessary and it would not be pragmatic to have to wait the approval of another doctor. This head affirms what already happens in Ireland.

Recommendation:

We welcome the requirement in the Bill for the treating doctors consult with the woman's General Practitioner. However, it may not be practical to consult the patient's GP in a situation of imminent threat to the mother's life arising from physical illness during pregnancy. We recommend that where there is likely to be a significant time lapse between diagnosis and emergency delivery of the foetus, the GP must be informed. Doctors 4 Life submission: Protection of Life During Pregnancy Bill (Heads of) 2013

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4. Response to Head 4: Risk of loss of life from self destruction.

It is striking that this head proposes that a threat of suicide would make something legal that would otherwise be illegal i.e. the taking of innocent human life. Furthermore it proposes that the medical profession would be complicit in the direct and intentional taking of innocent human life. As far as we can ascertain there is no other situation in law or medicine where a threat of suicide would be deemed a justification for an attack on the life of human being.

In proposing this the government claims they have no choice but to implement the Supreme Court decision in X. We reject this claim. The Supreme Court in that case did not hear any medical or psychiatric evidence, and the young girl at the centre of the case was not referred for, or offered, any treatment or counselling. A bad or mistaken judgement is not a sound basis for a good law.

There is insufficient reliable scientific evidence to justify abortion as an effective treatment for pregnant women. We believe that Psychiatrists should be supported by the government and the Minister for Health in using only treatments which are based on sound scientific evidence in Irish hospitals. A recently conducted survey found that 113 of Ireland's Consultant Psychiatrists believe any 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.

As the evidence given by the majority of Psychiatrists to the Oireachtas committee indicated that there is no clear evidence from international research that abortion provides any overall benefit to women's mental health, and there is no evidence indicating abortion is an appropriate treatment for pregnant women with suicidal ideation.

It should be further noted that that although psychiatrists are very good at identifying and managing patients at high risk of suicide that because suicide in pregnancy is so rare it is not possible to predict which high risk patients will complete suicide . Furthermore the reliable research evidence that concern for dependents including dependent children is protective against suicide should be emphasised. In order to manage the risk that one in an estimated 250,000 to 500,000 thousand pregnant Doctors 4 Life submission: Protection of Life During Pregnancy Bill (Heads of) 2013

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women may complete suicide in Ireland, it is proposed to introduce legislation here which will in time I have no doubt lead to the abortion of up to one in five live births. Currently in the UK there are an average of 190,000 abortions per year, one in five live births.

If this law is passed then any psychiatrist any refusing an abortion to a woman who sought one, could expect there to be a very critical public outcry in the media if that woman went on to complete suicide. The Psychiatrist and team would likely be subject of a statutory enquiry which would receive extensive media coverage usually negative. This would add to the natural personal grief which all Psychiatrists experience when a patient for whom they have cared, completes suicide. Being acutely aware of the terrible burden of pain a suicide inflicts on a family is naturally an additional pressure for the treating Psychiatrist. In summary, it is essential to point out that abortion is not an evidence based treatment of suicide risk in pregnancy.

Psychiatrists themselves are the first to admit they cannot accurately predict suicide. Consequently there would be a very large number of terminations in order to potentially get it right. Review of the evidence shows the risk of suicide is significantly less in pregnant females, one third to one half of the risk of non-pregnant females of similar age. However, the risk of suicides increases significantly after an abortion. Pregnancy appears to confer a protective role against suicide. This has been shown in studies published by the British Medical Journal (1996)[1] and the American Journal of Psychiatry (1997)[2]. Indeed the Finnish studies looked at all their registers between 1987 and 1994 and found no cases of suicide in pregnancy but a 3 fold increase in suicide in the first year after abortion.

1 Suicides after pregnancy in Finland, 1987–94: register linkage study. BMJ 1996;313:1431

2 Lower risk of suicide during pregnancy. Am J Psychiatry 1997;154:122-123

Recommendation:

Doctors should seek only to care and to cure and to provide the best possible care for all their patients, born or unborn. They should not be complicit in the direct and intentional taking of human life. All doctors, including psychiatrists must practice evidence-based medicine and refuse to act as ‘social police’. There is no evidence that Doctors 4 Life submission: Protection of Life During Pregnancy Bill (Heads of) 2013
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abortion (the direct and intentional killing of the unborn baby's life) is a treatment for suicide ideation. *There is a real and substantial risk of loss of the pregnant's woman's life by way of self destruction.* It is unclear and potentially possible that the present wording of the proposed Act could allow for the direct intentional killing of the child where a doctor construes Head 4 subhead (1) (b) (i) to allow them to carry out a procedure that involves the direct intentional killing of the child rather than simply terminating the pregnancy because the existence of a living child could still result in the loss of life of the mother from self-destruction.

The wording of the proposed Act does not definitively protect the unborn child from direct intentional killing in the event that a woman threatens suicide because of the existence of the child. Although the explanatory notes (on page 8, 2nd last paragraph and page 11 last paragraph) imply that the life of the child must be protected if at all possible, because the Act does not contain wording that specifically states this, that protection will not exist in law. We, furthermore. maintain that no specific wording could possibly fully prevent such a thing from happening with the continued inclusion of Head 4 and we therefore move that they strike it out.

Recommendation:

The government has not adequately protected the right to life of the unborn with its present wording and, a the very least, should makes its assumption of protecting unborn life (as expressed in its explanatory notes mentioned above) by including wording that confers that protection (in as far as that is possible) if it insists on the continued inclusion of head 4. Doctors 4 Life submission: Protection of Life During Pregnancy Bill (Heads of) 2013

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5. Response to Head 11: Notifications

We take issue with the following: *It is not intended that the Freedom of Information Act 1997 will apply to these records.*

Without the benefit of the Freedom of Information Act it will be impossible to compile statistics on terminations carried out under this legislation. It is in the public interest that details on the numbers of terminations carried out under this legislation are accessible and subject to scrutiny.

In addition, it is essential for the development of evidence based medical practice and continuous improvement of medical care that details of the indications for the terminations and the outcomes are available to medical researchers.

We believe that the information re any abortions sanctioned, could be accessible under the freedom of information Act in a form that protects the identity of individual patients.

Recommendation:

We strongly recommend the Freedom of Information Act 1997 should apply to these records, which concern the life and death of patients and the care given by clinicians and nursing staff. Doctors 4 Life submission: Protection of Life During Pregnancy Bill (Heads of) 2013

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6. Response to 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) 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.

Recommendation:

Doctors for Life makes the following Recommendations:

1. The right to individual conscientious objection must be extended to medical and nursing students.

2. The restriction of the right conscientious objection to individuals, as distinct to institutions, cannot be justified. Institutions have a right to protect their ethos under Parliamentary Assembly of the Council of Europe, Resolution 1763 (2010)[3] and Resolution 1928 (2013), adopted April 24th, 2013[4], which calls on member states to (*inter alia*):

[3] *Assembly debate* on 7 October 2010 (35th Sitting) (see Doc. 12347, report of the Social, Health and Family Affairs Committee, rapporteur: Mrs McCafferty; and Doc. 12389, opinion of the Committee on Equal Opportunities for Women and Men, rapporteur: Mrs Circene). *Text adopted by the Assembly* on 7 October 2010 (35th Sitting).

[4] *Assembly debate* on 24 April 2013 (14th Sitting) (see Doc. 13157, report of the Committee on Political Affairs and Democracy, rapporteur: Mr Volontè; and Doc. 13178, opinion of the Committee on Migration, Refugees and Displaced Persons, rapporteur: Mr Türkeş). *Text adopted by the Assembly* on 24 April 2013 (14th Sitting).

9.8. ensure that the religious beliefs and traditions of individuals and communities of the society are respected, while guaranteeing that a due balance is struck with the rights of others in accordance with the case law of the European Court of Human Rights;

9.9. accommodate religious beliefs in the public sphere by guaranteeing freedom of thought in relation to health care, education and the civil service provided that the rights of others to be free from discrimination are respected and that the access to lawful services is guaranteed; Doctors 4 Life submission: Protection of Life During Pregnancy Bill (Heads of) 2013

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9.10. ensure the right to well-defined conscientious objection in relation to morally sensitive matters, such as military service or other services related to health-care and education, in line also with various recommendations already adopted by the Assembly, provided that the rights of others to be free from discrimination are respected and that the access to lawful services is guaranteed;
9.12. change their legal regulations whenever these go against the freedom of association for groups (including churches) defined by their religion or beliefs;
9.13. ensure the full respect of Article 9 of the European Convention on Human Rights and relevant jurisprudence by the European Court of Human Rights since 1949 and that the freedom of communities and individuals defined by religion or belief is respected and exercised within the limits of the law.

3. A doctor who exercises the right to conscientious objection should not be obliged to refer the patient for the very procedure to which he/she conscientiously objects. The British GMC[5] guidelines on conscientious objection are more nuanced than those of the Irish Medical Council and state:

5 GMC Guidelines 2013.

 52 *You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.*

The current wording in Head 12 (1), although it protects a doctor refusing to terminate a pregnancy on the grounds of conscientious objection from legal prosecution under headings 2 and 3, it does not protect them from being discriminated against by employers or other bodies, such as academic bodies conferring qualifications or awards (amongst others). Doctors 4 Life submission: Protection of Life During Pregnancy Bill (Heads of) 2013
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It requires specific wording to protect them from such discrimination; for example
" No person, institution or other body may discriminate against any doctor on the grounds that they will not carry out a termination under the concientious objection clause"
The present wording of Head 12 subhead (2) is wholly unclear and the meaning of it cannot be understood clearly; it is even consceivable that it could be construed to mean that a doctor does not have the right to refuse to carry out a termination in any situation covered by Head 4. As this would be contrary to the ECHR rulings (Article 9) amongst others. it cannot remain as it is but must beclarified. If the government are inteding to force all doctors to carry out or assist in the carrying out of termination where there is risk of loss of life of the mother from self-destruction as outlined in Head 4, then they must come out and clearly say so. Doctors 4 Life submission: Protection of Life During Pregnancy Bill (Heads of) 2013
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7. Conclusions:

Ireland is one of the safest places in the world for pregnant women. The 2005 report on Maternal Health produced by the WHO, UNICEF and the World Bank[6] confirms Ireland as having the lowest maternal mortality rate in the world. Introducing abortion even on restrictive grounds is not necessary to protect the life of pregnant women in Ireland. Rather what is needed is the Medical Council to produce clinical guidelines on the management of high risk pregnancies that keep up to date with current medical evidence and support good obstetric practice.

6 Maternal Mortality in 2005 Estimates developed by WHO, UNICEF, UNFPA and The World Bank WHO 2007

We firmly believe that introducing abortion on restrictive grounds will inevitably lead to abortion on demand as has happened in other countries. This is not in the best interests of our patients and will have a negative effect on good obstetric practice.

We the Doctors for Life have grave concerns about The Protection of Life During Pregnancy (Heads of Bill) 2013. We would like to attend the public hearing of the Oireachtais Committee to discuss our submission further.

Finally, the notice of five days to make submission to the Oireachtais Committee as a result of government decision is totally inadequate and undemocratic. We request an extension to the deadline to facilitate further consideration of the complex medical issues and a more complete submission.

Tel. 022-21652

Email:dbnunan@eircom.net

Lisieux,

Cork Rd.,

Mallow,

Co. Cork.

8th May 2013

To Paul Kelly, Principal Clerk, Joint Committee on Health and Children

RE: Hearings on Protection of Life during Pregnancy Bill 2013.

SUBMISSION

HEAD 1 Interpretation.

1. In this section, there is no definition of the term **'Abortion'**, even though the Bill introduces the right to an abortion in the case of a pregnancy where the mother is threatening suicide.

   I would like the Committee to ask one of the expert medical witnesses to describe to its members, and to the wider audience, the different methods by which abortions are carried out, so that the Committee is not discussing in the abstract, and under euphemistic cover, the lethal fate that is proposed under this Bill for some future children, however few or many, whose lives may become forfeit as a result of the intention behind this proposed legislation.

2. Significantly, there is **no definition of 'mother' or 'child' in this section**. Does this mean that these terms are not mentioned in any part of the Bill, which is vitally concerned with the relationship between mother and child? I want this question asked of the Minister for Health, Dr. O'Reilly. (Does it reflect a fear of the image of the mother and child which represents fertility, nurture, caring for life etc? The child in this image represents life, joy, hope. All these positive images are opposite to those represented by abortion: death of the innocent, regret, despair, darkness etc.)

3. The **definition of "unborn"** given in this section is a controversial one. It relies on the High Court Judgement in the *Roche v. Roche & Others* which deemed that human embryos acquired legal protection under the Constitution only from the moment of implantation. This judgement is questionable, as it was the intention of the electorate in the 1983 Referendum to protect life all the way from conception, which would follow the logic of human life being a continuum from conception until death. This judgement was not tested in the Supreme Court.

The 2002 referendum, based on the Twenty-fifth Amendment of the Constitution (Protection of Human Life in Pregnancy) Bill, 2001, included a clause that provided for the right to life of the unborn to be protected only 'after implantation in the womb of a woman.' Since this referendum was rejected, is it not obligatory on the Government to respect the outcome for this part of the Referendum of 2002 and to conclude that the proposal contained therein to restrict the right to life of the unborn was rejected and should not be used in the proposed legislation under the Protection of Life During Pregnancy Bill 2013?

Please put this question to the Minister for Health, Dr. O'Reilly.

Submitted by Donal Nunan

<imr@indigo.ie>
08/05/2013 16:59 To
<healthandchildren@oireachtas.ie>, <paul.kelly@oireachtas.ie>
cc

bcc

Subject
Submission on the taking of unborn human life

To Mr Paul Kelly
From Donal O'Driscoll,
Blackrock, Co Dublin
Date: 8 May 2013
Submission
on the taking of unborn human life
1. My experience:
I have no direct experience of the taking of unborn human life.
2. Executive summary:
1. This is an appalling document, and reflects no credit on those supporting it.
2. Inadequate time has been allowed to the public.
3. "Heads" of the Bill give a false impression.
1. Who has control over selection of medical practitioners?
2. The title of the Bill is also deceptive. It is not correct to say that it is about protecting life, when it's real purpose is to end life.
3. My recommendations:
3.1 The ECHR was established with the best of motives. As is clear from the decision in the ABC case, and the recent visit of Mr Jagland, of the CoE, these objectives no longer obtain. This body is now promoting murder, not endeavoring to stop it.
At the least, we should cease to be associated with this body and withdraw from it with immediate effect.
2. In a referendum of the Irish people, the right to life was established as a cardinal principle. This should be fully observed.
3. The 1992 ruling of the Supreme Court was erroneous, and this should be corrected.
4. The proposals are based on deception and lies.
The proposals bear some resemblance to what was tried in Sweden, and subsequently replace by abortion on demand.
The present proposals look like Stage 1. When this has been discredited, it is to be followed by Stage 2, abortion on demand.
There is no right to take the life of another.

4. Main submission:
1. Totally inadequate time is being given for analysis by the public.
I have not been able to examine the Bill properly.
4.2 As far as I can see much of what is contained in the Bill has been considered and rejected in referendums by the public.

4.3 "Heads" of the Bill give a false impression.
This gives the impression that principles only are being discussed. What is being considered is 33 pages of the substantive Bill.
4. The title of the Bill is also deceptive. It is called the "Protection of Life during Pregnancy Bill".
The protection of life during pregnancy is already covered under existing medial regulations. If anything these regulations need to be enforced, not abandoned.
The Bill is not about protecting life, it’s about ending it.
Protection of life is only the cover: the real purposes is to facilitate social abortions, in particular those arising from sexual pleasure.
4.5 Head 2: Who has control over the selection of medical practitioners? The woman, the spouse, the profession, a judge, the state, etc
4.6 Head 4: There is now every evidence that abortion, far from being a cure for psychiatric illness, has the opposite effect.
4.7 Head 12: This appears to give a right to conscientious objection, but his immediately contradicted.
4.8 Head 18 calls for the repeal of relevant sections of the Offences against the Person Act. This has already been rejected by the people. The Act should remain in force.

Donal O'Driscoll

_____

Donal Smyth <donalsmyth@yahoo.com>
08/05/2013 16:41 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Submission

Dear Sirs,

I wish to object in the strongest terms to the proposal by the Irish Goverment to introduce Abortion into Ireland on any grounds. Abortion is murder. Nothing less.

The Goverment propose to legislate for the X case in which there was no medical evidence introduced in the hearing of the case.

The Government has failed to date to produce any medical evidence to show that Abortion prevents Suicidality in women and is misleading the public.

Abortion is not a solution to any problem medical or otherwise.

I am totally opposed to Abortion in Ireland in my name.

Please acknowledge receipt of my email.

Donal Smyth
30, Droim na Coille,
Dromin Road,
Nenagh,
Co. Tipperary

May 8, 2013. 4.39pm

Donncha O'Cathail

Head 1

"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.

Comment: The treatment of ectopic pregnancies is ethically non-controversial. However, it is quite unclear as to how this definition of implantation, "implantation in the womb of a woman", can be used to exclude "emergency contraception" as the latter is capable of acting as an abortifacient.

"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.

'Unborn' The definition suggested above is based on the Supreme Court judgment in *Roche v Roche & Others*[18] which deemed that embryos acquire legal protection under Article 40.3.3 of the Constitution only from the moment of implantation.

Comment: I believe that the *Roche v Roche & Others* case does not provide a good basis for a definition of the unborn. It seems to me that there is an illogicality within the reasoning behind that definition in that it contained a narrow notion of what 'capable of being born' might mean. Substantially, one can see that the location of an embryo for example, outside the womb and frozen, does not render it incapable of being born since all that is required is "implantation in the womb of a woman".

Head 2

"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". (This latter phrase occurs repeatedly in several heads)

Comment: I suggest an amendment by the insertion of the words **"indirectly and unavoidably"** before the word **"ended".**

Continued on next page

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 –

……

(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".

Comment: The last part, (ii) immediately above, is problematic in the extreme. It is no exaggeration to say that the idea of "reasonable opinion" and the decision to Terminate the pregnancy to avert the "loss of the pregnant woman's life by way of self-destruction" are in fact incompatible and mutually exclusive. The dogs in the streets know that when a person is suicidal they need to be minded, to be accompanied, to be professionally medicated, and so on. Obviously, in so far as the rest of Head 4 is predicated on this false premise / supposition, and, since the principle of proportionality is entirely missing from the proposal, then it must needs be deleted from the legislative proposal.

"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".

Comment: There is within the above, a false dichotomy established. The two-patient model is entirely absent, regrettably.

Dr. Bridget O'Brien

M.B. B.Ch. B.A.O. D.C.H

Surgery: 066 7124744 ***59 Boherbee,***

Home: 066 7137351 **Tralee, Co. Kerry.**

07.05.2013

Attn: Mr. B. Kelliher,

Chair of The Health Committee On Abortion,

Dear Mr Kelliher,

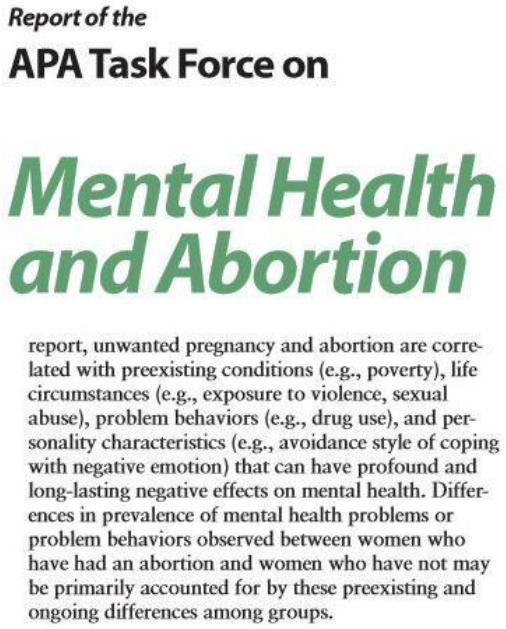
I am writing to you in relation to the Protection of life during pregnancy bill 2013. There are a number of reasons to exercise caution . I would like to highlight the following reasons for concern;

Our maternity service is principally focused on health of the mother and baby. There was a very proactive approach to maternal health. All efforts were made to ensure a good outcome for the mother. This resulted in a zero maternal mortality. Recent maternal mortality figures give rise for great concern. There is a dramatic increase in maternal mortality, most remarkable from 2008.
The maternal mortality of 3/100,000 in 2008 has now emerged at 8/100,000 for 2012. The unfortunate death of Savita Halappinaver must be viewed against this background. The focus must revert to overall maternal wellbeing, rather than the current narrow focus on abortion to explain this increase.

Abortion particularly partial birth abortion has profound impact on mother and doctor alike. This method of family planning is not favourably received in any jurisdiction where it has been introduced. It is now no longer legal in most jurisdictions. Clarification on what medical indications are required for abortion later in pregnancy is sought.

The United Kingdom operates a limited abortion. The Reprostat numbers indicate that the abortion rate is actually higher when a restrictive abortion regime is in place as against controlled abortion on demand. The recently released statistics also indicate that maternal and foetal outcomes in the United Kingdom are less advantageous to both than is currently the case in Ireland.

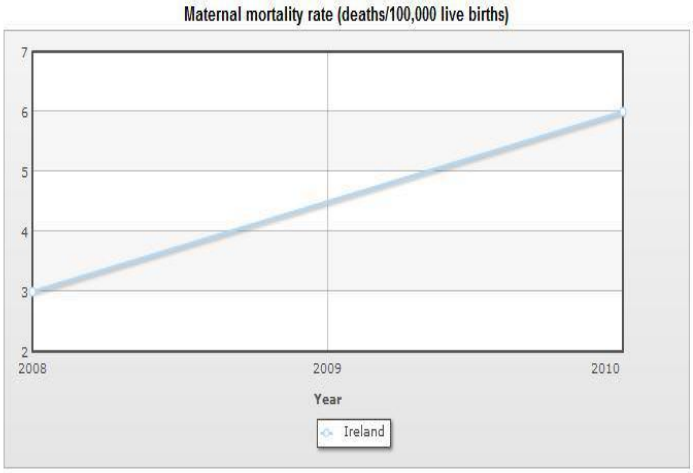
~Meta-analysis of all data would indicate that pre-existing poor mental health is predictive of a poor outcome for subsequent mental health following abortion. Is there then logic in including this as a reason for providing for abortion?



Demographics: Birth rate
Demographics: Death rate
Demographics: Net migration rate
Demographics: Infant mortality rate
Demographics: Maternal mortality rate

Indian Ocean
Indonesia
Iran
Iraq
Ireland

Submit



Terminations of pregnancy in the European Union.

Gissler M, Fronteira I, Jahn A, Karro H, Moreau C, Oliveira da Silva M, Olsen J, Savona-Ventura C, Temmerman M, Hemminki E; REPROSTAT group.

⊕ **Collaborators (32)**

Information Department, THL National Institute for Health and Welfare, Helsinki, Finland. mika.gissler@thl.fi

Erratum in
BJOG. 2012 Mar;119(4):516.

Abstract

OBJECTIVE: To study the current legislation and trends in terminations of pregnancy in the European Union (EU).

DESIGN: Data were collected on legislation and statistics for terminations of pregnancy.

SETTING: Population-based statistics from the EU member states.

POPULATION: Women in reproductive age in the 27 EU member states.

METHODS: Information on legislation was collected for all 27 EU member states. Statistical information until 2008 was compiled from international (n = 24) and national sources (n = 17). Statistical data were not available for Austria, Cyprus and Luxembourg.

MAIN OUTCOMES MEASURES: Terminations of pregnancy per 1000 women aged 15-49 years.

RESULTS: Ireland, Malta and Poland have restrictive legislation. Luxembourg permits termination of pregnancy on physical and mental health indications; Cyprus, Finland, and the UK further include socio-economic indications. In all other EU member states termination of pregnancy can be performed in early pregnancy on a women's request. In general, the rates of termination of pregnancy have declined in recent years. In total, 10.3 terminations were reported per 1000 women aged 15-49 years in the EU in 2008. The rate was 12.3/1000 for countries requiring a legal indication for termination, and 11.0/1000 for countries allowing termination on request. Northern Europe (10.9/1000) and Central and Eastern Europe (10.8/1000) had higher rates than Southern Europe (8.9/1000). Northern Europe, however, had substantially higher rates of termination of pregnancy among teenagers.

CONCLUSION: A more consistent and coherent reporting of terminations of pregnancy is needed in the EU. The large variation of termination rates between countries suggests that termination of pregnancy rates may be reduced in some countries without restricting women's access to termination. Sexual education and provision of access to reliable and affordable contraception are essential to achieve low rates of termination of pregnancy.

Yours Sincerely,

Dr. Bridget O'Brien

Medical Council No: 017890

"Dr. Ciaran Clarke" <dr.csclarke@gmail.com>
Sent by: ciaransclarke@gmail.com
07/05/2013 21:00 To
Paul Kelly <healthandchildren@oireachtas.ie>
cc

bcc

Subject
submission re: abortion legislation

Dear Mr. Kelly,

I write as a practicing psychiatrist, very concerned at the the revolutionary change which this draft legislation involves.

It is unacceptable for doctors to be asked to become directly involved in the taking of innocent life. Doctors are to be misused in a way that demeans us as people and as professionals.

There is no evidence supporting the use of abortion as an effective intervention to prevent suicide in pregnancy (a contrary answer in an under-graduate exam would lead to a summary failure of the candidate). We psychiatrists know better than anyone how difficult suicidal risk is to assess, and we also know well the principle that, in times of such crisis, we counsel against such life-changing decisions.

If enacted, this law will result in the more widespread misunderstanding of suicidal behaviour as something concrete, and will therefore render courts more likely to find psychiatrists guilty of malpractice should a girl or woman suffer adverse consequences as a result of a suicide which the psychiatrist has abetted.

The bill is unworkable and inhumane, as it compels distraught women to go through procedural wrangles, rather than enabling provision of the help they need.

I am not a constitutional lawyer, but I think that, in it's efforts to activate the X-case judgement, it must of necessity limit the scope of that judgement. It will therefore very probably be found to be unconstitutional.

I hope you will be able to represent these views to the committee.

Kind regards.
Dr. Ciaran Clarke
Barringtons Hospital Limerick
M.C.R.N.: 000482

Evelyn Hannon <evhannon@gmail.com>
07/05/2013 22:33 To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject

195B North Circular Rd.,
Dublin 7
6 May 2013

Sirs/Madams
I did not appoint the judges to the Supreme Court who later gave a majority verdict in the "x" case. The Labour Party did. Kathleen Lynch is wrong when she says "the people of Ireland spoke in the x-case ruling". I personally have never voted Labour. So why have their appointees in the past dictated policy to the people of Ireland?
As Enda Kenny says himself "The people are the constitution". Then have another referendum with one question. " Do you think suicide is a ground for allowing abortion?". The people of Ireland would say "No". Yesterday Enda Kenny said "we must pass this legislation to SAVE LIVES!! Was that a joke? The doctors of Ireland are well able to look after the health and life of pregnant women. They know when they have to terminate a pregnancy and when they can save both lives. Furthermore, not allowing a doctor to make a conscientious objection would be to deny them their right to the hippocratic oath.
Only in communist countries can politicians dictate how doctors perform their work.
My daughter Alva O'Dalaigh, in practice in England, was allowed opt out of referrals for abortion.
I brought my children up to respect life and even bees and wasps were put out the window - not stood on.
I would hate to be the T.D. who votes to terminate even ONE life.
Beannacht,
Dr Nuala O'Neill

Félim Donnelly <f.t.donnelly@gmail.com>
08/05/2013 15:17 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Abortion

Dear Committee,

I am a doctor of 25 years standing working as a General Practitioner. I am angry that politicians are dictating how to treat a woman with serious mental health problems during pregnancy. Their treatment based on little or no medical evidence goes against best medical practice and all common sense. I have seen women who years after their abortion under the mental health indication, were in great distress recounting years of mental suffering. If something is not a treatment how can politicians put it into legislation. This would be detrimental to medical practice in Ireland. In my experience the analogy would be like a a man who is a prescription drug addict who says to the doctor, "I will kill myself if you don't give me the drugs". If the doctor yields to that manipulation against best medical practice the next week there will be 3 or more doing the same thing.
As a doctor i ask you not to include suicide or self destruction in this bill.

Dr Felim Donnelly
Salthill
Galway

The Turretts,

Charleville,

Co. Cork.

Mr. Paul Kelly,

Principal Clerk,

Joint Committee on Health and Children.

I wish to make the following points in relation to the Protection of Life during Pregnancy Bill 2013.

This Bill will make a direct attack on unborn children for the first time in this jurisdiction. Up to now the principle of the double effect applied where necessary treatment to save the life of the mother resulted sometimes in the death of the unborn child. This was a secondary effect and did not always result in the death of the unborn child.

I object to the use of the word implantation in the womb of women because human life begins at conception i.e. the fertilisation of the ovum. The Hippocratic Oath for Doctors states clearly "I will have the utmost respect for human life from the first moment of conception to its natural end". This is something that is accepted and believed by the majority of people in Ireland. Under this Bill there will no protection for the baby between conception and implantation. This opens the door wide for embryo experimentation which is an abhorrent practice. It also means that certain types of the morning after pill can be used and some of these work by causing an early abortion.

In Head 2, it states "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". This paragraph is quite ambiguous, one could envisage a scenario where a woman was having an abortion late in pregnancy and the baby turned out to be disabled, there could be a temptation here to leave the baby die or worse, as practiced in other countries, this in my book would be an appalling crime.

The fact that there is no time limit on the securing of an abortion in this Bill, gives rise to very serious concerns. It could become confused with present medical practise where from approximately 23 weeks on the baby would be viable outside the womb, and there would be circumstances where, legitimately, labour could be induced in the interests of the mother and sometimes in the interest of the baby. Calling these late situations abortion, in my view, is totally confusing the issue and could interfere with best medical practise.

In Head 4:

In the explanatory notes it states "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 gives a lot of scope to practitioners and could be abused.

In Head 4 it also states:

"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 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". This statement is very ambiguous, as I have stated already and should be clarified. There is a suggestion here that the child's life after birth maybe at risk.

In Head 6: it states that:

"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". This section again is unclear and does it mean, for instance, that the woman can decide herself that she requires an abortion?

Head 12 is going to place doctors in a very difficult situation as it could run counter to their conscience. The requirement that a doctor should refer a patient to another doctor who he/she knows is in favour of abortion could involve the doctor in the procuring of an abortion. "Conscientious objection does not absolve you from responsibility to a patient in emergency circumstances". What does this mean? Doctors will always give treatment in emergency circumstances and if it means procuring an abortion, which is already inevitable, this would be good medical practice but I cannot see what situation would arise where an emergency abortion was necessary otherwise.

Head 18:

This provides for the repeal of Sections 58 and 59 of the Offences against the Person Act 18-61. To me the Bill does not seem to be strong enough to replace Sections 58 and 59 which are very important.

Having studied the Bill in detail I am fully convinced that this Bill will lead to an opening of the floodgates and will lead to abortion on demand. I state this for the following reasons:

- Using the word implantation instead of fertilisation or conception as we know it leaves the baby exposed at the very early stages.

- Allowing abortion as a cure for threatened suicide is never necessary and this is the opinion of the majority of Psychiatrists in this country, those who gave evidence at the Oireachtas, at the Health Committee and those who have spoken since, and indeed, the majority of Obstetricians have stated likewise. Any country that legalised abortion for mental health reasons saw a huge escalation in the number of abortions carried out for this reason. This is widely open to abuse as it is difficult for a Psychiatrist, by their own admission, to decide when a woman is in danger of committing suicide and this could be used by women to easily procure an abortion.

- The fact that there is no time limit would lead to an extraordinarily complicated situation and would be wide open to abuse for the reasons I have stated that from approximately 23 weeks gestation the baby is viable and this from then on is not an abortion and every effort must be made to save the baby's life.

I believe that human life is sacred from the first moment of conception, namely fertilisation of the ovum. From then on the baby's DNA is decided and the baby's heart can be heard beating at 5-6 weeks. I believe it is a crime against humanity to end the life of the weakest section of the community by cutting off the baby's life at any time between conception and birth. We should be an example to the whole world to proclaim that we in Ireland protect human life at all stages of development regardless of whether the baby is disabled or fully

healthy. I hope the government will have a change of heart and abandon this Bill. Abandoning this Bill can only bring great blessings on the country.

Many thanks for accepting this submission.

Dr. Martin B. O'Donnell.

8-5-2013.

Protection of Life During Pregnancy Bill 2013

I am opposed to this legislation due mainly to Head 4: Risk of loss of life from self-destruction and Head 8: Review in case of risk of loss of life through self-destruction

Introduction:
In 1983 the Irish people voted to support an equal right to life for women and their unborn babies thus enshrining in our constitution the two patient model of care. In 1992 the Supreme Court in its judgement on the X Case interpreted Article 40:3:3 as allowing abortion where a mother's life was under threat by suicide. Our Government is now proposing to legislate for this ruling. The following submission sets out my reasons for opposing legislation for abortion on grounds of suicide. In 1992 the issues of abortion and suicidal intent during pregnancy made news headlines due to the X Case. In an attempt to educate myself on the subject I attended both Pro-Life and Pro-Choice meetings. I was left in no doubt that the Pro-Choice lobby saw the X Case as the beginning of widespread abortion on demand and while I continued to educate myself from both sides of the divide, I have decided to align myself to the Pro-Life stance on this most fundamental issue of human rights.

Summary:
Summary of Weaknesses inherent in Head 4 and Head 8

1. The X Case ruling is unsafe.
2. To legislate for abortion on grounds of suicidal intent is medically out of date and ignores the clear evidence of modern psychiatry.
3. Legislation will force a change to the current 2-patient model of care in Irish hospitals.
4. Psychiatrists will be Compromised
5. This legislation will be open to abuse

Recommendations:

1. I recommend medical guidelines instead of legislation to provide clarity for the medical profession and legal support for what is going on in every hospital. Guidelines also have the added benefit of being far easier than legislation to up-date and amend.
2. Adequate and appropriate recognition and treatment of mental illness during pregnancy.
3. Constitutional referendum to allow the Irish people decide whether they wish to accept or reject the Supreme Court's interpretation of Article 40:3:3.

Main Body of Submission:
Head 4: Risk of Loss of Life from Self-Destruction &
Head 8: Review in Case of Risk of Loss of Life through Self-Destruction

1. The X Case Ruling is Unsafe

- During the Supreme Court deliberations in 1992 no medical evidence was heard thus rendering their subsequent judgement as deeply flawed.
- In no other area of law does the threat of suicide make legal that which is otherwise illegal.

  To legislate for X would be to enshrine in law a most unsafe judgement.

2. To Legislate for Abortion on Grounds of Suicidal Intent is Medically out of date and Ignores the Clear Evidence of Modern Psychiatry

- Pregnant women at risk of suicide are entitled to have treatment which is appropriate, safe and effective. Pregnancy is not a contraindication to effective psychological or pharmacological treatment.

- 21 years have passed since the Supreme Court ruling. Given that we have more information on mental illness and suicidality now than we had in 1992 the Supreme Court ruling is medically out of date. Central to the X Case ruling is that abortion is a treatment to avert suicide. Inherent in this is the belief that those who are likely to take their lives can be identified by psychiatrists and that this can be averted by abortion. Studies show that suicide cannot be predicted even in very high risk groups. A letter recently sent to members of the Oireachtas signed by 11 consultant psychiatrists detailed how none of the co-signatories had ever seen a suicidal woman in pregnancy where abortion was necessary to save her life. This shows that a body of psychiatric opinion based on 200 years of experience in adult and adolescent psychiatry finds no evidence that abortion is a necessary intervention to prevent suicide. The requirement that treatments must be evidence-based is not met.

- Evidence of modern psychiatry is clear that suicide is more likely after an abortion than because of a pregnancy. Fergusson, a pro-choice researcher, has found in his work that mental health problems do occur post abortion even in those with no previous mental illness history and that abortion increases the risk by 30%. He also writes that there is no evidence of benefit to mental health from abortion. But for those with a history of mental health problems, having an abortion places women at heightened risk of mental health problems after the abortion.

3. Legislation will force a Change to the Current 2-Patient Model of Care in Irish Hospitals

The 2-patient model of care has served us well in Ireland making us one of the safest places in the world in which to be pregnant. Legislation will require a change to current practice in hospitals. Post legislation medical personnel will be dealing not with two patients but rather with one patient with a right to an abortion.

4. Psychiatrists will be Compromised

If this legislation is enacted psychiatrists will be expected to propose an unproven intervention (abortion) for a rare outcome (suicide) that is more often incorrectly rather than correctly predicted. In the event of a woman insisting she is suicidal against the opinion of her examining psychiatrists they may be tempted to "err on the side of caution" and accede to her wishes.

5. This Legislation will be Open to Abuse

In other jurisdictions abortion introduced even on restrictive mental health grounds has led to very liberal abortion regimes. The British Pregnancy Advisory Service as the biggest independent abortion provider in Britain is worth a mention here:

"It is not the case that the majority of women seeking abortion are necessarily at risk of damaging their health if they continue their pregnancy. But it is significant that , because of the law, women and their doctors have to indicate that this is the case." (BPAS Newsletter May 2012)This proves beyond doubt that there is manipulation of the law to procure abortion and shows that concern about abuse of our proposed abortion law is indeed valid.

When a woman insists she is suicidal and doctors disagree, they may acquiesce in granting an abortion so as to "err on the side of caution". It is naive to believe that the government's decision to legislate will lead to the introduction of an "exceptionally low level" of abortion in Ireland.

Edel Crosbie, 60, Old Golf Links, Coast Road, Malahide, Co. Dublin.
edelcrosbie@eircom.net
086 8296675

Dear

In response to your request for submissions re the "Protection of Life during Pregnancy Bill 2013" please see the attached and note its contents.

Head 1 Interpretation

The definition of unborn should commence at conception not implantation. How could an abortion be for the common good when the basic right to life is to be violated?

Why exclude emergency conception from the scope of the bill when in fact this also means (morning after pill abortofacient) which is abortion also.

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

This is not a direct killing (abortion) but indirect loss of the baby's life due to medical intervention to save the Mother.

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

Similar to Head 2 i.e. indirect killing of baby.

Head 4 Risk of loss of life from self-destruction

In other jurisdictions such as Britain and California where legalised abortion on medical health grounds was allowed abortion on demand followed and now stands at thousands every year.

All the medical evidence inclusion from most psychiatrists stated that the risk of suicide in pregnancy is extremely rare so could not be considered in any circumstances a reason for direct killing of the baby. The reasonable medical intervention would treat the person's thoughts on depression in an appropriate medical way.

To bring this suicide ideation to its rational conclusion would a pregnant woman or other person have a right to end the life of an other person who might have upset them so badly as to cause them to be suicidal?? !

Why should a Doctor or anyone have to decide if a pregnant is suicidal or not, and even if she is medical intervention is the appropriate treatment and not the killing of an innocent Baby. Even if they have 6 Medics in agreement they still are not justified in recommending killing of an innocent Human Being.

Subhead (1)(b)(ii)

In the event of a mid to a late term abortion where the unborn baby may be viable outside of the womb, obviously Drs must make every effort to sustain its life but we all know that the health of this baby is being seriously compromised. **In fact it could be considered a serious act of child abuse.**

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

Are we more concerned about the documentation than the life of the baby ??

Head 6 Formal Medical Review Procedures

We would ask the European Court of Human Rights what rights have the unborn child when the most basic right of a person is the right to life can be violated ?. Who will defend the life of the unborn from abortion (**direct killing**)?.

Head 12 Conscientious Objection

The provisions in this Head are very ambiguous. If a Nurse or medic has a conscienctous objection to an abortion i.e. direct killing, how could she/he be possibly obliged to ensure that another colleague take over to do this direct killing?

Head 18 Repeal and Consequential Amendments

If they want to make amendments to the constitution we the people of Ireland want to be consulted via a referendum as of our democratic rights.

Head 19 Offence

Brings us to mind where the abortionist Dr Gosnell in Philadelphia is on trial for murder of babies born alive and also a Mother. Apparently no inspection was carried out in that clinic which was in a deplorable state.

To finish we would feel very let down and disappointed by Enda Kenny who gave a pre election promise that he would not introduce abortion in Ireland. There is still time to keep that promise. We hope this will be the case when he comes looking for votes next time round, and that we will be able to say he kept his promise.

Currently Ireland's Maternal Mortality rate is one of the lowest in the world. Do we want to reverse this? Mothers are known to die during or after abortion apart from a higher inclination to suicide in the aftermath of an abortion.

Expert evidence shows that abortion is not a treatment for suicide.

The so called "**restrictive"** legislation will allow for the deliberate killing on an unborn child which has never happened in Ireland before.

We sincerely hope you will listen to the voice of the majority of the Irish people who do not want abortion i.e. direct killing of babies for suicidal ideation introduced in Ireland.

Yours faithfully,

Eileen O'Connor

Sec. to pro life group Killarney

34 Delbrook Park, Dublin 16

To raise my objection to Head 4: Risk of loss of life from self-destruction in Protection of Life during Pregnancy Bill 2013

7th May 2013

Dear Sir/Madam,

My name is Eileen Shortiss and I would like to voice my objection to the 'Protection of Life during Pregnancy Bill 2013'. I am a qualified midwife and am very concerned about the systematic ignoring all of the expert psychiatric evidence presented at the recent Oireachtas hearings on abortion.

I would particularly would like to raise my objection to Head 4: Risk of loss of life from self-destruction. There is no evidence that abortion ever helps women's mental health and in fact it may damage women. I cannot understand why ideology is given more importance than evidence. The recent paper by Professor Coleman in the British Journal of Psychiatry 2011 found that women who had undergone an abortion experienced an 81% increased risk of mental health problems, and nearly 10% of the incidence of mental health problems was shown to be attributable to abortion.

I also note that Sr Consilio Fitzgerald, Cuan Mhuire has stated in her letter of the Saturday 4th May 2013 that many of the distressed women that came to Cuan Mhuire over the past 50 years, came because they were suffering distress having undergone an abortion. (http://www.irishexaminer.com/opinion/letters/politicians-must-protect-the-rights-of-the-unborn-230274.html)

I would also like an explanation as to why the Government is ignoring the statement agreed by 113 psychiatrists, saying the Government should not include a suicide provision in its legislation. As a midwife I am particularly concerned that the bill will also force hospitals with maternity wards to carry out abortions.

Recommendation:
I would like to recommend that Head 4: Risk of loss of life from self-destruction be removed completely from the Protection of Life during Pregnancy Bill 2013.

I hope you will take on my board my concerns.

Kind Regards

Eileen Shortiss

Eileen Tiernan <eileen_tiernan@yahoo.com>
08/05/2013 16:41
Please respond to
Eileen Tiernan <eileen_tiernan@yahoo.com>

To
"paul.kelly@oireachtas.ie" <paul.kelly@oireachtas.ie>,
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>

cc

bcc

Subject
Fw: A dreadful proposal by Government See email address

Submission to the oireactas committee regarding proposed abortion 'Protection of Life in Pregnancy bill"

Eileen Tiernan
No 21 Riverside Drive
Churchfield, Clarmorris, Co Mayo

1. Legislating for abortion on the suicide ground is not required by the European Court judgment. We could provide the necessary clarity by introducing guidelines which would protect women in pregnancy by re-affirming that they receive all necessary life saving treatments in pregnancy and requiring that we also exercise a duty of care towards the unborn.

2. Legislation for abortion on the suicide ground is not required by the X-case. When he was Taoiseach, John Bruton said he would not introduce legislation in line with the X-case because that would have the effect of bringing abortion into Ireland. The Oireachtas has the prerogative of not legislating for a Supreme Court decision if it believes it would be harmful to do so.

3. This legislation will not be about 'life-saving' treatment but, in fact, the opposite. The Government has produced no evidence to show that abortion is ever beneficial in the treatment of the mental health of women. We know from the latest review of the evidence (Fergusson et al.) that abortion is not associated with any mental health benefit for women. In fact, it is associated with a low to moderate increased risk to women's mental health. And, of course, we know a child always dies. So it is dishonest to pretend that this proposal is about saving life.

4. That is why over 100 psychiatrists last week signaled their opposition to being involved in certifying women as needing abortion because this is not evidence-based medicine. International experience shows that provision for abortion on the mental health ground will be abused. It is hard to see how things could be different in Ireland, given the nature of what is proposed today.

Obvious bad features of this legislation:
- Abortion on the suicide ground
- No apparent time limits
- No appeal process on behalf of unborn child
- Limited conscientious objection rights for doctors and none for healthcare institutions with a pro life ethos.

"Elizabeth Hogan" <elizabeththogan@eircom.net>
07/05/2013 23:18

To
<healthandchildren@oireachtas.ie>
cc

bcc

Subject
Proposed Abortion Legislation

Attention: Paul Kelly

I wish to lodge an objection to the Oireachtas Committee for Health to the proposed legislation of abortion for the following reasons:

Ø Any legislation based on the X case ruling would mean that for the first time an Irish Government would be sanctioning and legitimising the taking of innocent human life. Once the principle is conceded that some human lives can be directly targeted, there is no going back – the door to liberal abortion will be opened – just like in all other countries that have been down this road.

Ø The European Court of Human Rights judgment in A, B and C v Ireland does not oblige Ireland to introduce abortion by way of X case legislation or regulation. It merely requires clarification of our laws on the issue which can be done by way of Medical Council clear guidelines.

Ø The unique relationship between a mother and the child conceived within her (another human being) is extremely special & if this child is taken, by whatever means from her womb, the effects on the mother are horrendous and will be felt, in time, if not immediately after the abortion.

Ø Research shows that women who have undergone an abortion experienced an 81% increased risk of mental health problems and nearly 10% of the increase of mental health problems was shown to be attributable to abortion (Priscilla K Coleman. the British Journal of Psychiatry (2011) 199: 180 – 186.

Ø At the Oireachtas Hearings in January last, all the Psychiatrists agreed that abortion was not a remedy for suicide. Surely we cannot turn our Government cannot ignore expert advice from those qualified & experienced in Psychiatry.

I would plead that we do not go down the road of legalisation of abortion which is the direct targeting & killing of innocent human life.

Thank you.

Elizabeth Hogan
Co Wexford Pro Life Campaign
30 Carricklawn
Wexford.

Family Crowley

gillian crowley <gilliancrowley@yahoo.co.uk>
08/05/2013 13:22
Please respond to
gillian crowley <gilliancrowley@yahoo.co.uk> To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Mothers and Unborn Children

To whom it may concern,

As parents of a newborn baby we implore the government not to accept the legislation of abortion in this country.
The psychiatric evidence presented at the Oireachtas hearings in January was unanimous that abortion is not a treatment for suicidal ideation.The argument for abortion in the case of threatened suicide was totally demolished at these hearings.The motions at the IMO conference which called for the provision of abortion in Ireland were defeated. Over 100 Consultant Psychiatrists have given their backing to a statement taking issue with the Government's abortion proposals, making clear again that abortion is not a treatment for suicidal ideation. Our Government cannot ignore the facts.

The Government does not have to legislate. Clearer medical guidelines to protect mothers and babies can be introduced. Ireland, without abortion, is the safest country for pregnant women. We know this from recent experience. This country has a much better record of safeguarding the lives of pregnant women than any of the six countries that recently challenged our abortion laws before the UN.

Please listen to the views of the electorate and do not allow the introduction of the wilful murder of the unborn in our hospitals. These days are of the utmost importance for us in Ireland.

We implore you do not allow us to embrace the culture of death.

Yours sincerely,

Gillian, John and Baby Jack Fitz - Gerald.

Dear Mr Kelly,

I am writing to you to outline my concerns with the "Protection of life during Pregnancy bill". The whole premise of this bill is to bring clarity to current medical practise. However I have identified a number of flaws with its intent.

Head 4.

Point 2 maintains that the risk of self destruction be averted by the termination of a womans pregnancy.

1. The Government is not 'required' to legalise abortion because of the European Court ruling in the ABC case. The Court simply said that Ireland needed to provide clarity in its abortion laws.

2. The evidence given by medical experts at the recent Oireachtas Committee hearings on abortion, has demolished the Government's case for legalising abortion on suicide grounds.
3. In particular, experts agreed that abortion is NOT a treatment for suicide.
4. They also confirmed that they had NEVER come across a case where abortion was the only treatment for a woman who was suicidal.
5. Doctors agreed that not one woman has died in this country because of our ban onabortion or the provisions of the 1861 Act.
6. The 1861 Act criminalises abortionists, not doctors - and it can protect women.
7. Under the X case ruling, abortion will be made available on grounds of suicide through all nine months of pregnancy.
8. That's because psychiatrists, dealing with pregnant clients who claim to be suicidal, will be forced to practise defensive medicine for the first time. If a legal right to abortion for claims of suicidality exists, psychiatrists will need to protect themselves in making decisions. One expert said it would "potentially compromise the therapeutic alliance between psychiatrist and patient."
9. Dr Justin Brophy, has also said that legislation based on the X case would create a 'logistical nightmare' for psychiatrists.
10. Doctors reaffirmed that terminology is hugely important, and that it is of enormous psychological importance to a woman who is having her pregnancy interrupted for life-saving procedure whether we call that an abortion or a termination of pregnancy.

Point 3 p10 of the Bill. Three doctors are required to form an opinion and jointly certify that a termination is required.

1. This is an ultimately flawed procedure as an abortion can be an emotive and more often divisive issue amongst clinicians. Therefore some clinicians may be more partial to an abortion procedure than others. Therefore will there be judicial balance in the decisions being made on behalf of the unborn child.

2. There exists little or no advocacy or appeal procedure on behalf of the unborn child. This therefore is impinging on the Human rights of the unborn child and runs contrary to our constitution.

Point 4 It States “G.Ps often have a long term relationship with their patients.” This is supposition and assumption that this would be the case. It is not often the case that a woman would have a long term relationship with their G.P. A woman may have a regular and contientious relationship with her G.P if she regular attends Smear test and regular checkups. However this may not always be the case. If an abortion procedure is required a G.P may find themselves encountering the patient for the first time. This would lead to quick referrals that would run contrary to proper medical procedure.

Head 6. Point 2 p14

A third party may represent the patient if suicide is seen as reasonable intent. This is ultimately flawed as it may lead to misrepresentation on behalf of the patient. As recently demonstrated in the “C Case” the exigencies of a third party misrepresented the patient. This is a serious flaw in the bill and needs to be addressed. This could lead to open advocacy by those who are ideologically motivated to introduce abortion in this country on demand.

Thank you for considering the points that I have outlined and I look forward to hearing from you.

Kind regards,

Anne O’ Dea

frag murry <frag333@gmail.com>
08/05/2013 12:41 To
healthandchildren@oireachtas.ie

Subject
PROTECTION OF MATERNAL LIFE BILL 2013.

PROTECTION OF MATERNAL LIFE BILL 2013.

Dear Mr Kelly

I wish to register my complete opposition to the proposed legislation

PROTECTION OF MATERNAL LIFE BILL 2013. This Bill's title, which is preoccupied with the protection of the mother's life over that of her child, is at variance with the Constitutional provision of equality of the right to life of both mother and child. Indeed, the Supreme Court's verdict in the 'X' case on the basis of suicide merely served to confuse and compound the issue, leaving a veritable mess for the Government to resolve, without discriminating against the right to life of either mother or child.

This is the first time in our history that any legislation ever permitted the deliberate destruction of human life in instances where pregnant women claim to be suicidal.

No evidence has yet been produced to indicate that abortion is an appropriate treatment for pregnant women with suicidal tendencies.

This legislation also proposes to deny medical personnel the right of conscientious objection in refusing 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 fetus

or embryo for any reason, in direct contravention of resolution 1763 of the Parliamentary Assembly of the Council of Europe which reaffirms the right of medical personnel to refuse such procedures on conscience grounds.

From also a personal view point as a young Man who works in the Area of Sex Education the Impact Abortion has on a Persons Mindset after the procedure is very devastating , it leads to more Problems for the Person instead of Actually giving them the Peace of Mind they first sought . Our responsibility as a Country is for 2 People not 1, Mother and Child, and Science itself has Proved this with out a shadow of Doubt .So as a Nation we have a Chance to Protect Life but also Future Generations and not fall into the Trap that so many Nations have in the past it brings nothing but grief to young Mother and wider Family .
.

Yours sincerely,

Ferghal Mc Grath

Fiona Hodge <hodgef@ncad.ie>
08/05/2013 11:47 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
FAO Paul Kelly, re: Protection of Life During Pregnancy Bill 2013

Hi Paul,

I am writing to you to say that I feel very strongly that the 'Protection of Life During Pregnancy Bill 2013' is not necessary in this country for the following reasons:

1. Legislating for abortion on the suicide ground is not required by the European Court judgment. We could provide the necessary clarity by introducing guidelines which would protect women in pregnancy by re-affirming that they receive all necessary life saving treatments in pregnancy and requiring that we also exercise a duty of care towards the unborn.

2. Legislation for abortion on the suicide ground is not required by the X-case. When he was Taoiseach, John Bruton said he would not introduce legislation in line with the X-case because that would have the effect of bringing abortion into Ireland. The Oireachtas has the prerogative of not legislating for a Supreme Court decision if it believes it would be harmful to do so.

3. This legislation will not be about 'life-saving' treatment but, in fact, the opposite. The Government has produced no evidence to show that abortion is ever beneficial in the treatment of the mental health of women. We know from thelatest review of the evidence (Fergusson et al.) that abortion is not associated with any mental health benefit for women. In fact, it is associated with a low to moderate increased risk for women's mental health. And, of course, we know a child always dies. So it is dishonest to pretend that this proposal is about saving life.

4. That is why over 100 psychiatrists last week signaled their opposition to being involved in certifying women as needing abortion to save their lives because this is not evidence-based medicine. International experience shows that provision for abortion on the mental health ground will be abused. It is hard to see how things could be different in Ireland, given the nature of what is proposed.

Obvious bad features of this legislation:?- Abortion on the suicide ground?- No apparent time limits?- No appeal process on behalf of unborn child?- Limited conscientious objection rights for doctors and none for healthcare institutions with a pro life ethos.

Kind regards,

Fiona Hodge

Fiona Hodge
Department of Visual Communication
National College of Art and Design
100 Thomas Street
Dublin 8

Phone: +353 1 6364281
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"Fiona O'Connor" <fionaoconnor1@gmail.com>
08/05/2013 14:59 To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>, paul.kelly@oireachtas.ie
cc

bcc

Subject
URGENT¦Draft Legislation; Maternal Bill

Hi Paul,

I'd very much like to immediately raise my overwhelming concerns with you around the proposed Maternal Bill legislation. I ask that Oireachtas please carefully consider the legislation under discussion, and assess further the heavy societal implications of enforcing such legislation into Irish Law.
As an Irish woman I understand the trepedation many women face upon the discovery of an unplanned pregnancy. I do however insist on the infallible statement that given the chance,a pregnancy will most certainly evolve into a human being, and a great kid thereafter,think of your son/daughter,nieces/nephews.
As a woman living in today's liberal society I understand the pressures many women may face with the prospect of an unplanned pregnancy,I do not however see any causal link between suicide and babies. I have no doubt that the long term mental damage an abortion may inflict upon a woman would far outweigh the short term difficulty of deciding to continue with one's pregnancy. Ultimately the happiness which any baby can bring to the lives of others would hands down win, every time.
The Irish Government should aim to retain their reputation of valuing the sacrecy of all persons. The Government should not conform to the movement of other states,regardless of any pressures felt.
Would not a referendum be a more democratic push forward for Ireland? As an Irish woman petrified of the abortion floodgates, I beg of the Irish Government to at the very least hold referndii before any laws are enforced.
Please acknowledge this mail, and advise of your response on this urgent matter as soon as you can.

Kind Regards,
Fiona

Fiona B. de Londras

SUBMISSION ON THE GENERAL SCHEME OF THE PROTECTION OF LIFE DURING PREGNANCY BILL 2013

Professor Fiona de Londras, Durham Law School

As I am unable to attend pursuant to the Committee's invitation due to a prior commitment, I submit this analysis of the Heads of the Bill for the attention of the Committee members. I consent to it being placed in the public domain.

Head 1

1.1 I propose revision of the interpretation of "reasonable opinion" to read: "'reasonable opinion'" means an opinion formed in good faith which has regard to the need to preserve unborn human life and the life of the pregnant woman as far as practicable"

1.2 This proposed amendment would reflect the equal esteem for the lives of the unborn and of the pregnant woman expressed in Article 40.3.3 of the Constitution. As currently written the definition relates only to the need to preserve unborn life and while "as far as practicable" and the tenets of statutory interpretation might imply an equal concern with the pregnant woman's life it would be preferable for this to be expressly stated in the law.

Head 2

2.1 I propose renaming the Head 'Risk of loss of life' and applying the same test to suicide as to other risks to life. Consequently I propose the deletion of "other than by way of self-destruction" from proposed sub-head 1(b) of Head 2.

2.2 There is no legal reason for distinguishing between the two and, as noted by the Expert Group, a differentiated treatment does not appear to be required for medical or practical reasons. Moreover, differential treatment particularly of a kind that makes it more difficult to access abortion in one case of life threatening risk than another may place Ireland in violation of Articles 8 and 14 of the ECHR as it may constitute discrimination in exercising Article 8 rights. While differentiated treatments are permitted in many cases, these must be objectively justifiable. Given the fact that suicidal ideation is routinely diagnosed by medical practitioners, and that there appears to be a European consensus (as applied in the jurisprudence of the ECtHR) to treat risk to life from suicide and risk to life from other sources in the same way across the Council of Europe, differentiated treatment is unlikely to fall within Ireland's margin of appreciation.

2.3 I propose the amendment of proposed sub-head 1(b) of Head 2 to read "jointly certified in good faith that, as a matter of probability…" Such an amendment would reflect accurately the constitutional test laid down by Finlay CJ in *Attorney General v X* [1991] 1 IR 1, 53-54 where he held "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…" termination is possible under Article 40.3.3. As currently worded sub-head 1(b) of Head 2 appears to introduce a higher standard for termination that required under the terms of the Constitution. These standards ought to be reconciled in order to ensure that the Bill gives adequate effect to the constitutional right. Should a mismatch between the statutory and constitutional standards persist, the law would not give adequate effect to the constitutional right and may therefore fail to adequately implement the decision of the European Court of Human Rights in *A, B & C v Ireland* [2010] ECHR 2032 and, consequently, not resolve Ireland's violation of the ECHR.

2.4 In proposed sub-head 3 of Head 2 I propose insertion of a clause (c) requiring consultation with the woman in addition to consultation where possible with her GP and examination of the pregnant woman.
2.5 I propose insertion of a clear and reasonable time-limit within which decisions under this Head must be taken. Reasonableness in this context ought to be interpreted in line with the physical and mental strain on the pregnant woman of awaiting such a decision and I propose there ought to be a statutory requirement for the assessment to be completed within 7 days.

Head 3

3.1 I propose deletion of the words "other than by way of self-destruction" for the reasons outlined in para 2.2 above.

Head 4

4.1 I propose deletion of Head 4 for the reasons outlined in para 2.2 above.
4.2 In the event that Head 4 is retained, I propose amendment of proposed sub-head 1(b) of Head 4 to read "jointly certified in good faith that, as a matter of probability…" for the reasons outlined in para 2.3 above.
4.3 In the event that Head 4 is retained, I propose amendment of sub-head 1(b) to read "two medical practitioners, one of whom must be a psychiatrist" as the requirement of three medical practitioners' joint certification (implying that all three must agree) is a demonstrably higher standard for access to the constitutional right than is the case where the risk of life emanates from something other than the risk of suicide. The Supreme Court in *Attorney General v X* did not differentiate in the standard outlined for access to termination under Article 40.3.3 where suicide is at issue, and differentiation in this manner (i.e. in a way that makes it demonstrably more difficult to access abortion where one suffers a risk to life from suicide) does not seem justifiable under the Constitution or under the ECHR (see further para 2.2).
4.4 In the event that Head 4 is retained, I propose insertion of a clause (c) requiring consultation with the woman in addition to consultation where possible with her GP and examination of the pregnant woman in sub-head 2.
4.5 Throughout sub-head 4 I propose replacement of the term "self-destruction" with "suicide" for the purposes of linguistic clarity, coherence, and to reflect contemporary usage.
4.6 In the event that Head 4 is retained, I propose insertion of a clear and reasonable time-limit within which decisions under this Head must be taken. Reasonableness in this context ought to be interpreted in line with the physical and mental strain on the pregnant woman of awaiting such a decision and I propose there ought to be a statutory requirement for the assessment to be completed within 7 days.

Head 5

5.1 No amendments proposed.

Head 6

6.1 I propose amendment of proposed sub-head 1, sub-head 6 and sub-head 8 to reflect the adjusted tests ("as a matter of probability") proposed in paras 2.3 and 4.2 above in line with the Supreme Court decision in *Attorney General v X*.

6.2 I propose amendment of proposed sub-head 2 to include the words “within the time-limit laid down in Heads 2 and 4 respectively” to reflect the time-limitation proposed in paras 2.5 and 4.6 above.
6.2 I propose insertion of a clause specifying the composition of the committee convened under proposed sub-head 3. For the purposes of ensuring that the review will be timely and accessible I propose that the review committee ought to comprise three practitioners.
6.3 In the event that Head 4 is deleted as proposed above, all references to Head 4 ought to be removed.

Head 7

7.1 I propose the deletion of the words “not being a risk of self destruction” wherever they appear in the Head on the basis of my proposed deletion of Head 4 (above).
7.2 I propose the amendment of sub-head 1 and 3 to include the words “as a matter of probability” in line with para 2.3 above.
7.3 I propose express statutory confirmation of the right to appeal the decision to the High Court.

Head 8

8.1 I propose the deletion of Head 8 on the principle that Head 4 ought to be deleted for the reasons outlined in paras 4.1 and 2.2 above.
8.2 In the event that Heads 4 and 8 are retained, I propose amendment of sub-head 1 to read “two medical practitioners, one of whom must be a psychiatrist” for the reasons outlined in para 4.3 above.
8.3 In the event that heads 4 and 8 are retained, I propose express confirmation of the right to appeal the decision to the High Court.
8.4 I propose the amendment of sub-head 3 to include the words “as a matter of probability” in line with para 2.3 above.

Head 9

9.1 In order to ensure effective accessibility of the review process, I propose that consideration be given to providing for legal or other advocacy representation for pregnant women where they cannot afford same themselves.

Head 10

10.1 No amendments proposed.

Head 11

11.1 No amendments proposed.

Head 12

12.1 I propose insertion of a clause requiring practitioners invited to join the panel constituted under Head 6 to declare any conscientious objection to abortion. This will ensure the integrity of the review process and help to make the review process effective as members are less likely to have pre-determined positions on the general acceptability of termination. In my view, this would not infringe on practitioners’ freedom of religious belief under Article 9 as it would be a proportionate

interference when balanced against the Article 8 rights of prospective applicants, as well as their constitutional rights under Article 40.3.3.

12.2 The Oireachtas may wish to consider requiring that practitioners with conscientious objections are required to declare these as a general matter and not only at a time when a relevant case arises. This would also aid in ensuring that prospective applicants can effectively access their constitutional rights in line with the ECHR and, for the reasons outlined in para 12.1, would not unjustifiably interfere with practitioners' rights.

12.3 The Oireachtas might also consider a statutory requirement that every "appropriate location" would have an adequate number of medical professionals employed who do not have declared conscientious objections to administering abortion in the permitted circumstances, although the clear provision in sub-head 1 that conscientious objectors are required to provide procedures in emergency situations may be sufficient to ensure accessibility to women regardless of where they are receiving medical treatment.

Heads 13

13.1 No proposed changes.

Head 14

14.1 No amendments proposed.

Head 15

15.1 No amendments proposed.

Head 16

16.1 No amendments proposed.

Head 17

17.1 No amendments proposed.

Head 18

18.1 No amendments proposed.

Head 19

19.1 There does not appear to be any constitutional or ECHR impediment to the criminalisation of abortion outside of the exceptional circumstances of permitted abortion under Article 40.3.3.

19.2 It is submitted that sub-head 19(1) is extremely broad and has the potential to cover a wide range of activity, including and beyond that previously covered by s.s. 58 & 59 of the Offences Against the Person Act 1861. By means of example, serious violence intended to cause the death of a foetus but not involving the administration of drugs or use of instruments appears to be captured by this wording. The explanatory note does not suggest that this has been contemplated; rather it claims that "This section restates the general prohibition of abortion in the State in clear, modern terms". Members of the Oireachtas might want to consider whether they wish to include such activity within the offence.

19.3 The criminalisation of "any act *with the intent to* destroy human life" (emphasis added) is broad and does not require that human life is actually destroyed for an offence to be committed. It is not wholly clear—nor is it elaborated upon in the explanatory note—why acts done with intent to destroy are deemed an offence here. An alternative would be for the statutory provision to relate to

acts done *which destroy unborn human life* such that inchoate offences (such as attempt) might be employed (where appropriate) to deal with acts done with the intent of such destruction but where it does not actually occur. As a result of these significant concerns as to scope, I propose amendment to state more clearly, precisely and narrowly the activities subject to criminal prosecution under sub-head 1.

19.4 It seems clear that, as drafted, the offence outlined in sub-head 1 would criminalise the self-administration of abortifacients. While this is an infringement on a pregnant woman's autonomy and integrity it does not appear to be prohibited by the Constitution, is consistent with the general prohibition in Article 40.3.3 of abortion, and does not appear to be a violation of the ECHR. In spite of this, members of the Oireachtas might wish to consider the desirability of including self-administration of abortifacients within the offence. There are at least two possible reasons for excluding this: (i) the intellectual incoherence of asserting a pregnant woman's right to travel for the purposes of acquiring an abortion or taking abortifacients in another jurisdiction and the prohibition on such self-administration within the jurisdiction in this sub-head; (ii) the fact that the freedom to travel is in fact economically dependent such that poorer women are less likely to be able to travel to acquire an abortion lawfully outside of the jurisdiction and may be unduly burdened by this provision. That said, there may be good public health grounds for such criminalisation, especially if there are associated medical risks with self-administering abortifacients and this may be sufficient to justify including such women within the offence.

19.5 The appropriateness of the offence's inclusion of these circumstances is highly dependent on the requirement, in sub-head 4, for the DPP to consent to any prosecutions under Head 19. As a result I propose that this consent requirement be maintained and be made expressly non-delegable.

Head 20

20.1 No amendments proposed.

Biographical Note

Fiona de Londras is professor of law at Durham University where she is also co-director of Durham Human Rights Centre. In addition, she is a visiting professor at UCD School of Law and UNSW School of Law (Sydney). She is the founder of www.humanrights.ie and specialises in human rights law including Irish human rights law, the law of the ECHR and comparative constitutional law. She is a former director of the Dublin Well Woman and holds a publically-declared pro-choice position. This paper is submitted as an analysis of the heads of Bill's adequacy measured against the Constitution as it stands and the jurisprudence of the ECHR. Relevant publications include:

Fiona de Londras, (2013) "Suicide and Abortion: Analysing the Legislative Options in Ireland" Medico-Legal Journal of Ireland forthcoming

de Londras, Fiona & Graham, Laura (2013). Impossible Floodgates and Unworkable Analogies in the Irish Abortion Debate. Irish Journal of Legal Studies forthcoming

Fiona de Londras & Kanstantsin Dzehtsiarou, "Grand Chamber of the European Court of Human Rights, A, B and C v Ireland" (2013) 62(1) *International and Comparative Law Quarterly* 250

Fiona de Londras & Cliona Kelly (2010) *The European Convention on Human Rights Act: Operation, Impact and Analysis* Dublin: Round Hall/Thomson Reuters

Submission to the Department of Health and Children
Regarding
The Protection of Life During Pregnancy Bill 2013
From
Kevin Doran

This submission is made in a personal capacity by Fr. Kevin Doran, currently administrator of Donnybrook Parish. The author holds a PhD in philosophy, and is a specialist in the ethics of healthcare. He is a board member of the Mater Misericordiae University Hospital and has been active for over thirty years in the provision of voluntary services for women in crisis pregnancy.

Preliminary Comments

The *Protection of Life during Pregnancy Bill* traces its origins to the judgements of the Supreme Court in the so-called X case (1992) in the course of which the Supreme Court provided an interpretation of the Article 40.3.3 which I, in common with a great many citizens, believe to have been fundamentally flawed, because it provided for circumstances in which the life of the unborn could be directly ended by abortion, thereby implying that the right to life of the mother has priority over, rather than being equal to the right to life of the unborn child.

It has been argued by the Government that two opportunities were given to the people to reverse the effects of that judgement, by means of referenda. The truth is that both of those subsequent referenda gave the people a choice between a little abortion and a lot of abortion. No opportunity has been provided since 1992 to restore the constitutional position intended by the people in the eighth amendment to the constitution when article 40.3.3 was inserted in 1983.

My concerns with the present Bill relate primarily but not exclusively to Heads 2, 3 and 4.

Observations on Head 1:

To define a 'medical procedure' as including *the provision of any drug* is extremely loose. I note the appropriate definition of a psychiatrist as *a medical practitioner who is registered in the specialist division of the register* of medical practitioners. Regrettably, the Supreme Court in 1992 did not have recourse to a psychiatrist but rather to a clinical psychologist. Nor has the government, in preparing this bill, shown itself willing to hear the majority view of psychiatrists that abortion is never a treatment for suicidal ideation. The definition of the 'unborn' as *human life following implantation until such time as it has completely proceeded in a living state from the body of the woman* is controversial to say the least. There is no scientific basis to exclude the pre-implanted embryo which is a distinct living human being from the definition of the 'unborn'.

Observations on Head 2:

This section of the Bill provides for the medical care of women in pregnancy, taking into account the legal obligation on medical practitioners to preserve the life of the unborn as far as practicable.

a) It is perfectly consistent with respect for human life and with the ethos of healthcare that during pregnancy the mother should always be provided with any life-saving treatment which is necessitated by her medical condition, even if that treatment results in the unintended death of the foetus (or unborn). This is nothing new and it is the basic principle which has guided medical practitioners for generations.

b) The Bill refers to the carrying out of *a medical procedure, in accordance with this head, in the course of which or as a result of which unborn human life is ended,* but it also refers in the explanatory note to the termination of pregnancy as if it were itself a medical procedure. This is far too loose. There is a fundamental moral distinction between an unintended though foreseeable consequence and a directly intended action. This distinction is reflected in the terms of the 1861 *Offences Against the Person Act*,

which criminalises only an action which is intended to procure a miscarriage. The *Protection of Life During Pregnancy Bill* makes no distinction between the directly intended termination of pregnancy on the one hand and the unintended death of the unborn as a result of normal medical treatment on the other. When there is confusion between medical treatment and termination, it is inevitable that termination eventually ends up being considered as a medical treatment in its own right.

Observations on Head 3:

I agree with the stated principle that Doctors should not be prevented from saving a woman's life in a situation of acute emergency. I am concerned, however, that – as in the case of Head 2 – the distinction between a life saving intervention which results in the ending of the pregnancy on the one hand and termination of pregnancy as a direct act, is not at all clear.

Observations on Head 4:

As stated in my opening remarks, the judgement of the Supreme Court in the X Case seems not to have due regard to the equality of rights as between the unborn and the mother. Mr. Justice Finlay maintained that the threat to the life of the mother (which was a matter of speculation or at best probability), carried greater weight than the actual threat to the life of the unborn (which was certain). His judgement also failed to take account of the fact that, while the pregnancy was the circumstances in which the young woman in the X case found herself (through no fault of her own), whatever risk there might be to her life was not from the child in the womb but from herself. Finally, no psychiatric evidence was heard which would have suggested either that the woman in the X case could not be successfully treated, or that abortion would have resolved her problems.

The heart of the issue, however, is not whether the woman might actually have committed suicide OR whether good psychiatric care might have prevented this. The heart of the matter is that the *Protection of Life During Pregnancy Bill*, provides for the first time under Irish law for the deliberate destruction of innocent human life. I would submit that the very name of the Bill is deceptive in that the only "novelty" introduced by the Bill is the right to kill.

The right to life is a fundamental human right and the common good cannot be served while such a fundamental right is withdrawn by society for whatever reason. If it is acceptable to deliberately end the life of an unborn human being in the hope that her mother will not then commit suicide, how much more acceptable would it then appear be to accelerate the death of a critically ill adult in order to make space in the intensive care unit for someone else who is at risk. The acceptance of natural death is perfectly reasonable and the withdrawal of treatment which is no longer of any benefit is perfectly ethical, but the deliberate killing of the innocent, even if it appears that he or she may die anyway, is in a completely different category.

People sometimes talk of "opening the floodgates" to abortion on demand. In my view, the acceptance of the principle that innocent human life can ever be deliberately and directly terminated, extends far beyond abortion to undermine the very basis of our care for the sick and the dying.

Observations on Head 12:

I welcome the inclusion of a provision for conscientious objection on the part of medical practitioners and other healthcare personnel. I totally reject the manner in which the Bill specifically excludes the possibility that an institution might refuse on grounds of ethos

to implement elements of the Bill, when enacted, for example what is provided for under Head 4. This is totally unacceptable to me as a Director of a Catholic Voluntary Hospital

Observations on Head 19

In the context of Head 4, Head 19 is relatively meaningless, because the overall import of the Bill is to say that it is an offence for a person to do any act with the intent to destroy unborn human, except under those circumstances when it is not an offence.

For all of the above reasons, I do not find the *Protection of Life During Pregnancy Bill* to be acceptable and I would strongly request that the Oireachtas reject it.

Fr. Kevin Doran
1 Dunbur
Brookvale Road,
Dublin 4

Submission on the Protection of Life during Pregnancy Bill 2013

by Fr Richard O Connor, Cahereens, Castleisland, Co. Kerry at present professor of theology in the Angelicum University in Rome. Tel: 00353-87-2985903; email: roconnor@iol.ie. 8/5/13.

Head 1: Interpretation

My interpretation of this bill is simply that it is an attempt by the present Irish government to introduce wide scale abortion, undemocratically, on the Irish people. Labour, it is well known, are openly in favour of easily available abortion and Fine Gael are pandering to Labour on this. Both are using the excuse of having to comply with the ruling of the Strasbourg court in the ABC case in doing so. But this court is not compelling the Irish government to legalize abortion because it is not in their competence to do so. It asks for clarity, which can be given without legalizing abortion. Put briefly, the title of *Protection of life during Pregnancy Bill* is a misnomer. One life is to be protected at the expense of another which means certain death for the other,who happens to be the most helpless person in our society.

Head 2: Risk of loss of life from physical illness

It is noticeable that this heading does not specify which lives are concerned, even though there are two involved – child and mother. It seems to me to presume that only the mother's life is of interest.

The moral principles operating here are: a) that one may never do evil even to bring about good, b) that both lives are human, the lives of human persons; c) that the life of every human person has incalculable dignity and value as being made in the image and likeness of God; d) that each has his/her life and right to life from God, from the moment of conception to the moment of natural death, therefore not from any parliament whose duty it is instead to vindicate this right in the case of every person in its jurisdiction,(regardless of religious belief) but not one life at the expense of the other ; e) that therefore as human persons neither child or mother can be killed or used or ill treated for the sake of the other, f) that therefore, abortion - being the direct, intentional killing of the unborn child - may never be performed for any reason.

Neither, therefore likewise, may the mother be directly and intentionally killed to save the child.

When there is a risk of life from physical illness to the mother then normal medical treatment for the particular illness should be given, even if this results unintentionally and indirectly in the loss of the baby's life. But the direct, intentional abortion – i.e. the direct killing - of the child/ baby is not to be performed. However, it is permissible to terminate the pregnancy by removing the baby carefully from the womb and

placing him/her in an incubator to be cared for there, when there is a reasonable hope of survival. This is not direct abortion in the sense of direct intentional killing. If the baby has already died in the womb there is no moral problem in removing the lifeless body. If the baby is dying inevitably and incurably and posing a risk to the mother's life the baby still may not be directly killed ahead of natural death.

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

The same principle as above in head 2 applies here: the medics should do all in their power to save both lives but not by the direct intentional killing of either one. Because of the well developed state of gynaecology in Ireland we can be very hopeful that they will be successful in most cases. If they cannot save both lives then they must try to save one, but, again, not by directly killing the other. To comply with the Strasbourg court ruling in the A,B,C case clarity could be given by informing that court of the present good practices of our gynaecologists, which practices are founded on the moral principles outlined above and are of the highest standard because they result from years of experience of saving lives without resorting to direct abortion. Such practices can be regulated for.

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

This head arises from the judgement given in the infamous x-case, a judgement now widely considered to be flawed because it was given in the absence of proper medical evidence. Since then medical experts, especially psychiatrists, have stated repeatedly that abortion is not treatment for suicide, that it is more likely to lead to suicide later on. In any case it can be difficult to tell – even for experts – if a mother, claiming to be suicidal, will or won't act on that claim.

If, therefore, this bill goes forward to be legalized, founded on this flawed judgement, then, like a house built on a faulty foundation, it will inevitably yield bad results. It will lead to an opening of the floodgates on abortion itself and probably also to infanticide later, because if a mother can claim she is suicidal because of a baby that is unborn why not she claim the same on account of a born baby/child one year old and demand a right to put him/her to death ?

If despite this evidence the government still are making self-destruction a head it shows an utter disregard for these experts and a determination to legalize very wide ranging, easily available abortion, pandering to Labour and their socialist allies in the EU. It shows a disregard for the democratic system itself because I can say for certain that such an interpretation of the pro life amendment in our constitution was not envisaged by the people who voted for it in 1983 nor by those who are pro life today.

A solution would be to call on the judges of the x-case (those still living) to come forward and admit that their judgement was flawed and that they would then call on the present supreme court to over turn that judgement.

A genuine claim to be suicidal is a cry for help, which should be given, not by abortion which is morally wrong and more likely to make matters worse.

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

In light of the above I don't see the need to comment on this head or subsequent ones. If this bill goes through then not only will wide ranging abortion follow, and infanticide as explained above, but also the way will be opened for euthanasia, restricted at first, perhaps, but widening with time. It will also give encouragement to criminals committing murder – if the state can legalize murder, they will argue to themselves, for reasons important to them, why cant we commit murder for reasons important to us. Put briefly, we are then on the slippery slope to a regime in which might is right and law no longer has relation to morality. We are then into a new night of barbarism. It has happened before in Nazi Germany

and Stalinist Russia. It IS happening in Holland and Belgium and many other countries. Do we HAVE to follow suit in order to appear as “good Europeans” in front of our paymasters ? Now is the time to turn back, to good morals, good law and to God for His help.

Yours Truly
(Fr) Richard O Connor.

"Franciscan Friary" <friars.ennis@eircom.net>
08/05/2013 00:01 To
<healthandchildren@oireachtas.ie>
cc

bcc

Subject
FAO Paul Kelly

Dear Mr. Kelly,

The Franciscan Community of Ennis have the gravest concerns with respect to the Government's proposed legislation dealing with abortion. The protection of the unborn which was enshrined in our constitution and which represents a consistent value in this country for many years is now on the verge of being completely compromised. The grave concerns of eminent medical and mental health professionals underline the dangerous nature of the assumptions of this proposed legislation; that is, suggesting that abortion is in any way a proper treatment for pregnant women in danger of suicide. The evidence is to the contrary.

The two-patient model of health care, caring for mother and unborn child is the safest and most humane course, we abandon it at our peril. Legislation which targets an unborn human life is bad law. Protecting the right to life of the unborn is a Human Rights issue. Once the principle has been conceded and a unique, vulnerable human life is targeted and may be destroyed our society has crossed a moral line.

We submit to the members of the Oireachtas that the proposed legislation does not merit support, that it strikes against a core value of the Irish people and that it can only lead to harming women and unborn children and indeed the whole society, established as it is on principles of solidarity, care for the weakest and absolute respect for the gift of every human life.

Yours sincerely,

Franciscan Friars, Ennis, Co. Clare.

84 Manor Street
Dublin 7

Dear Mr Kelly

I am writing to you in connection with the proposed Protection of Life During Pregnancy Bill. Firstly let me give my reasons why I vehemently oppose the inclusion of suicide as grounds for abortion:

1 Legislating for abortion on the suicide ground is not required by the European Court judgment. We could provide the necessary clarity by introducing guidelines which would protect women in pregnancy by re-affirming that they receive all necessary life saving treatments in pregnancy and requiring that we also exercise a duty of care towards the unborn.

2 Legislation for abortion on the suicide ground is not required by the X-case. When he was Taoiseach, John Bruton said he would not introduce legislation in line with the X-case because that would have the effect of bringing abortion into Ireland. The Oireachtas has the prerogative of not legislating for a Supreme Court decision if it believes it would be harmful to do so.

3 The IMO recently voted against abortion on all grounds. They represent the people whom are expected to carry out these abortions.

4 This legislation will not be about 'life-saving' treatment but, in fact, the opposite. The Government has produced no evidence to show that abortion is ever beneficial in the treatment of the mental health of women. We know from the latest review of the evidence (Fergusson et al.) that abortion is not associated with any mental health benefit for women. In fact, it is associated with a low to moderate increased risk to women's mental health. And, of course, we know a child always dies. So it is dishonest to pretend that this proposal is about saving life.

5 In the Sunday Independent on 28/04/13, Labour's true agenda on abortion has been exposed. It is clear from both Anne Ferris and Aodhan O'Riordain that including a clause for suicide is just a stepping stone which they see as ultimately leading to abortion on demand in Ireland. I found their comments deeply worrying and distressing.

6 That is why over 100 psychiatrists last week signalled their opposition to being involved in certifying women as needing abortion because this is not evidence-based medicine. International experience shows that provision for abortion on the mental health ground will be abused. It is hard to see how things could be different in Ireland, given the nature of what is proposed today.

7 I have seen firsthand that abortion is not a treatment for suicide as someone very close to me went to the UK for an abortion and subsequently tried to take her own life. Not a day goes by that she doesn’t regret having had the abortion.

8 Precedence has clearly shown that legislating for abortion on the grounds of suicide will lead to abortion on demand. One needs to only look at the UK and Australia as prime examples.

9 Statistics show that Ireland is amongst the safest countries to have a child and we need to keep it that way.

10 As a taxpayer, I understand from my local Fine Gael TD, that my taxes will be used to pay for abortions in public hospitals. I believe this is contrary to my right to Religious Freedom. As I am a Catholic and

believe in the commandment, Thou Shall not Kill. I don't in any way want to be associated with the taking of innocent life.

11 Where will all this end I ask? President Obama, whom many saluted on his recent visit to Ireland, introduced in the State of Illinois what he calls comfort rooms. These are in effect rooms in hospitals where babies who survive abortions are left to die. They now have this prettily wallpapered room complete with a first photo machine, baptismal gowns, a foot printer and baby bracelets, so that they can offer keepsakes to parents of their aborted babies. There is even a nice wooden rocker in the room to rock live aborted babies to death. If a so called civilised country like the US can resort to these sickening measures, who is to say we won't end up following suit??

12 One of main reasons I have been so proud to call myself an Irish man is that we are one of the few remaining countries to stand firm against abortion. I'm sure you are aware that over 50 million babies lives are terminated in their mothers wombs every year. Future generations will look back on this in the same vain as the holocaust and slavery.

When drafting the final legislation I ask that you consider the points I have made above.

The poor unfortunate women who find themselves in a situation where they are suicidal over pregnancy need care, support and attention, not abortions. The legislation needs to address this and we must not introduce an unjust law which leads to the slaughter of innocent babies.

Yours sincerely,

Frank Burke

Submission from Frank Murphy

The Protection of life during Pregnancy Bill 2013.

The problem with the proposed Bill is that it will put into law a decision of the Supreme Court which was wrong. The decision, while binding, was wrong on three counts.

Firstly, it failed to distinguish between the *risk* to life, and the *right* to life which is what is guaranteed by the Constitution. The comment of Ronan Murphy S.C. in *Fleming v Ireland* is relevant. He said the right to life under the Constitution "belongs to the person living the life concerned". The key obligation of the State was to protect that life against interference by others, not against the interference by the person themselves (e.g. by suicide).

Secondly, the judgement was made without a *legitimus contradictor*, i.e. a valid contra argument. There is a legal view that suggests that without a *legitimus contradictor* the judgement is valid only for the case at hearing and does not have universal application. The Report of the Law Reform Committee (October 2011) recommended that the Courts should be empowered to appoint the Attorney General as a *legitimus contradictor* to argue in favour in support of a valid marriage where there was a constitutional imperative to protect the institution of marriage. The same principle should apply to the constitutional imperative to defend the life of the unborn.

Thirdly, the Court did not have psychiatric evidence to support the decision which it made.

To enact in law a wrong decision of the Court would compound the wrong.

The Twenty-first Amendment of the Constitution 2001, enacted in March2002, added to our Constitution Article 15.5.2. which states that "The Oireachtas shall not enact any law providing for imposition of the death penalty. Clearly the proposed Bill would have the effect of imposing a death penalty on unborn babies.

The Heads of the proposed bill at page 30 says "as far as we are aware there is no extant common law offence of abortion which required abolition". While it is not clear who the "we" are, it does not appear that the statement is correct. For example, when a person is charged with murder, it is "contrary to Common Law". The killing of an unborn baby is equally contrary to Common Law.

The draft denies hospitals the right to refuse to carry out abortions, despite the passing in 2000 of Resolution1736 of the Parliamentary Assembly of the Council of Europe (of which the ECHR is part) which 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 or the performance of a human miscarriage, or euthanasia, or any act which could cause the death of a human foetus or embryo for any reason".

There is no limit on the period of gestation within which an abortion would be permissible. The suggestion by supporters of the Bill that in the case of a viable foetus, it would be

delivered in the event of a threat of suicide by a mother makes no sense at all. Clearly if the mother is suicidal because she does not want a live baby, she will still be suicidal when she has been delivered of a live baby - that is if she was suicidal at all in the first place.

In setting out the regulations for those who would decide whether or not an abortion would be legally permissible, there is no suggestion that there should be anyone there on behalf of the baby. It should be remembered that the primary purpose of Article 40.3.3. was to protect the life of the unborn. It means, in effect, that every time the life of an unborn comes under threat, there is a constitutional imperative on the State to protect and vindicate that life. If it fails to do that, not only would it be failing in its constitutional duty but could be sued for its failure to so do.

It is claimed by the proposers of this Bill that it is very restricted in its application and that it will not lead to more widespread abortion. Once it is conceded that the life of an unborn baby may be terminated in any circumstances it is illogical to claim that it may not be terminated in others. All the evidence from other jurisdictions contradicts the claim that abortion would be restricted by this Bill. In fact, efforts to have a more liberal law has already begun, and it has been admitted by many abortion advocates and that it is their ultimate aim to have unrestricted abortion here. This is the official policy of the Labour Party, who appear to be calling the shots.

For the various reasons cited above the whole issue of the Bill needs to be revisited.

Frank Murphy,

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PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013 - REQUEST FOR SUBMISSIONS

Submission by the Working Group of the Standing Committee of the Church of Ireland

Introduction

The Church of Ireland welcomes the invitation to contribute to the *PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013.* As outlined in our submission to the Joint Committee on Health and Children on 10 January 2013 the Church of Ireland is a Synodical Church where the development of policy is guided by prayerful consideration and discussion of bishops, clergy and laity. The Standing Committee of the General Synod established a working group to make any submissions to the Government or an Oireachtas Committee should the need arise. This submission therefore is submitted in the names of the Working Group on behalf of the Church of Ireland.

The working group has considered the material in the *PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL* 2013 and makes the following submission to the Oireachtas Joint Committee on Health and Children for consideration.

Following the Executive Summary this submission will comment on a 'head by head basis' as requested. The introduction, Executive Summary, Comment on heads of Bill and the Addendum should be considered as one document.

The Church of Ireland as a province of the Anglican Communion of Churches affirms the report adopted at the Lambeth Conference, 1958 which states "In the strongest terms, Christians reject the practice of induced abortion … which involves the killing of a life already conceived.... save at the dictate of strict and undeniable medical necessity"

The position of the Church of Ireland on abortion is summarised in the addendum to this paper which includes excerpts from previous submissions to Oireachtas Committees. We recognise, however, that the decision in the AB & C v Ireland case and the decision of the Government to progress the matter through a combination of legislation and regulation had 'moved the issue on' somewhat and thus we will confine most of our submission to the Heads of Bill as requested.

It will suffice to say that the Church of Ireland opposes abortion in principle but recognises that there are exceptional cases of 'strict and undeniable medical necessity' where it is and should be an option. There would be a wide variety of sincerely held and conscientious views within the Church as to what constitute such 'exceptional cases' but there would be agreement that these include cases where the continuation of the pregnancy poses a risk to the life of the mother.

In all cases the Church of Ireland affirms the importance of sensitive pastoral care for mothers, their partners and their unborn baby. We recognise that, when faced with the possibility of terminating a pregnancy, parents and medical professionals are involved with emotive and complex issues and wrestle with ethical values and principles concerning human life. As a Church, our care is modelled on the compassion and unconditional love that God in Jesus Christ offers to all. This love supports our position that cherishes the lives of all yet recognises that at times the complexities of life present us with difficult choices and where such choices have to be made in cases of 'strict and undeniable medical necessity' that termination of pregnancy is sadly an option that must be considered. In addition to our care for parents and their unborn baby, our care also extends to all healthcare professionals who deserve support when faced with difficult decisions such as this.

Executive Summary

1. The Church of Ireland welcomes the invitation to contribute to the *PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013* and welcomes the decision of Government to proceed towards legislation and regulation in this area.
2. The Church of Ireland emphasises the right to life and this includes the right of the unborn.
3. The Church of Ireland opposes abortion in principle but acknowledges that there are exceptional cases of 'strict and undeniable medical necessity' where it is and should be an option.There is a variety of opinion within the Church of Ireland on what constitutes 'exceptional cases' but agreement that it includes circumstances where the continuation of the pregnancy poses a real

and substantial risk to the life of the mother.
4. In the context of the Church of Ireland's previous comments on abortion about the need for legal clarity, it is agreed that the position in the State at present is very unclear and unsatisfactory, and unfair to pregnant women and medical professionals who deserve to be able to make critical, clinical decisions in a secure and well regulated medical framework. Accordingly, the decision by the Government to seek to provide clarity on the issue is welcome.
5. It is agreed that where there is a strict and undeniable medical necessity requiring the ending of a pregnancy at a later stage, where possible, this should be done in a manner that preserves the life of the unborn, without compromising the life of the woman. This diagnosis should be made expeditiously and should be formally notified to the woman. This will require legislation as medical council guidelines on their own will not necessarily have this effect.
6. Special provision should be made for emergency situations where the continuation of the pregnancy occasions a risk to the mother's life that it real, substantial and imminent.
7. The Church has previously urged the Government to adopt a legislative and regulatory approach which will allow for easier alteration in the light of changes in medical science. Accordingly, the Government decision to do so is welcome.

HEADS OF BILL
PROTECTION OF LIFE DURING PREGNANCY BILL 2013
HEAD 1 – INTERPRETATION
We welcome:
-that where termination of pregnancy is required "in strict and undeniable medical necessity" that it will be only allowed in the 19 public obstetric facilities in the State, except in cases of emergency.
-that there will be adequate regulation, registration, quality control and audit of each facility carrying out termination of pregnancy.
-that the decision to carry out a termination of pregnancy will be taken at a senior clinical level and through reasonable opinion that has due regard for both the life of a pregnant woman and her unborn baby.

HEAD 2 – RISK OF LIFE FROM PHYSICAL ILLNESS, NOT BEING A RISK OF SELF DESTRUCTION
Subhead 1
We suggest:
-that greater clarity is given as to how certification may come about and that Clinical Practice Guideline(s) are drawn up as a matter of urgency in this area by the professional medical colleges.
We welcome:
-that greater clarity would be given to medical practitioners concerning the timing of intervention in line with the X Case "that the risk to the woman's life is inevitable or immediate".
-that two senior clinicians would be involved in the assessment and certification process.
We welcome the protection given to the autonomy of the woman to refuse a termination.
We would like consideration to be given to the place of birth in situations where a baby is close to or beyond viability and believe that, notwithstanding an emergency, such situations should be referred to an obstetric unit that has a neonatal intensive care facility and that the expertise of a Consultant Neonatologist should be sought.

HEAD 3 – RISK OF LOSS OF LIFE FROM PHYSICAL ILLNESS IN A MEDICAL EMERGENCY
In order to give clarity to emergency situations we recommend that there is a specific Clinical Practice Guideline drawn up for this situation. This would be particularly important should the emergency occur outside one of the dedicated 19 Obstetric Units so that the same levels of supportive care would be

provided for staff, a mother and her unborn baby.

HEAD 4 – RISK OF LOSS OF LIFE FROM SELF DESTRUCTION

In the X-case of 1992, the Supreme Court held that an abortion was constitutionally permissible under Article 40.3.3 in circumstances where the continuation of the pregnancy constituted a 'real and substantial risk' to the life (as distinct from health) of the mother and the risk can only be averted by the termination of a pregnancy. The circumstances of the case made clear that this included a credible risk of suicide.

While affirming the parity of both physical and mental health we acknowledge the complexity of trying to legislate for the area of suicidal ideation.

We welcome:

-the measures being suggested to make a clinical assessment in the situation of potential selfdestruction

- the process of review in a situation of appeal

We recommend that termination is only a matter of last resort to save the life of a pregnant woman and in situations of "strict and undeniable medical necessity".

We would like consideration to be given to the place of birth in situations where a baby is close to or beyond viability and believe that such situations should be referred to an obstetric unit that has a neonatal intensive care facility and that the expertise of a Consultant Neonatologist should be sought.

HEAD 5 – MEDICAL OPINION TO BE IN FORM AND MANNER PRESCRIBED BY THE MINISTER.

We welcome a clear and auditable certification process.

HEAD 6 - FORMAL MEDICAL REVIEW PROCEDURES

We welcome the review process suggested and in particular that a review mechanism 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

We suggest clarity is given to an appeal process in the cases where the pregnant woman is a minor and there is a conflict of opinion between the pregnant minor and their legal guardian and the review panel.

HEAD 7 – REVIEW WHERE RISK ARISES FROM PHYSICAL ILLNESS NOT BEING A RISK OF SELF DESTRUCTION

No further comment to make other than for Head 6.

HEAD 8 – REVIEW IN CASE OF RISK OF LOSS OF LIFE THROUGH SELF DESTRUCTION

No further comment to make other than for Head 6.

HEAD 9 GENERAL PROVISIONS FOR THE COMMITTEE

No further comment to make

HEAD 10 FORMAL MEDICAL REVIEW REPORTS TO MINISTER

We welcome this review process.

HEAD 11 – NOTIFICATIONS

We welcome this notification process as an integral part of ongoing audit and monitoring.

In addition:

-we recommend that an independent confidential audit be enjoined on all facilities to submit detailed data on terminations for clinical audit and research purposes. One example would be the approach of the National Perinatal Epidemiological Centre or the Maternal Death Enquiry process.

HEAD 12 – CONSCIENTIOUS OBJECTION

We welcome the inclusion of a conscientious objection on the part of certain health professionals. Where a decision has been made to carry out a termination of pregnancy in accordance with the Heads above this should be available in every public obstetric facility.

HEAD 13 – TRAVEL AND INFORMATION

No further comment to make.

HEAD 14 – REGULATIONS

No further comment to make.

HEAD 15 – REGULATIONS RESPECTING CERTICIFICATION OF OPINIONS REFERRED TO IN THIS ACT

No further comment to make.

HEAD 16 – REGULATIONS RESPECTING NOTIFICATIONS TO THE MINISTER

No further comment to make.

HEAD 17 LAYING OF REGULATIONS BEFORE THE OIREACHTAS

No further comment to make.

HEAD 18 REPEAL AND CONSEQUENTIAL AMENDMENTS

No further comment to make.

HEAD 19 OFFENCE

While we recognise the necessity for appropriate sanction, we express concern that sanctions should not deter people from seeking appropriate medical help. We welcome the repeal of Sections 58 and Section 59 of the 1861 Act .

HEAD 20 – COMMENCEMENT.

No further comment to make.

ADDENDUM

Submission by the Most Rev Dr Michael Jackson, Archbishop of Dublin and Mr Samuel Harper, Lay Honorary Secretary of the General Synod of the Church of Ireland to the Joint Oireachtas Committee on Health and Children in January 2013

Executive Summary

1. While welcoming the invitation to give evidence to the Committee, the Archbishop and Mr Harper express considerable disquiet at the timescale involved on a matter of such exceptional human complexity and sensitivity and the difficulty of involving the synodical structures of the Church. The Church of Ireland is a Synodical Church which develops policy guided by the prayerful consideration and discussion of bishops, clergy and laity. The time given to develop a written response to the Committee (de facto less than three working days) made this impossible. Accordingly, this document can only be considered a preliminary response.
2. The Church of Ireland emphasises the right to life and this includes the right of the unborn.
3. The Church of Ireland opposes abortion in principle but acknowledges that there are exceptional cases of ‘strict and undeniable medical necessity’ where it is and should be an option.There is a variety of opinion within the Church of Ireland on what constitutes ‘exceptional cases’ but agreement that it includes circumstances where the continuation of the pregnancy poses a real and substantial risk to the life of the mother.
4. In the context of the Church of Ireland’s previous comments on abortion about the need for legal clarity, it is agreed that the position in the State at present is very unclear and unsatisfactory, and unfair to pregnant women and medical professionals who deserve to be able to make critical, clinical decisions in a secure and well regulated medical framework. Accordingly, the decision by the Government to seek to provide clarity on the issue is welcome.
5. It is agreed that where there is a strict and undeniable medical necessity requiring the ending of a pregnancy at a later stage, where possible, this should be done in a manner that preserves the life

of the unborn, without compromising the life of the woman. This diagnosis should be made expeditiously and should be formally notified to the woman. This will require legislation as medical council guidelines on their own will not necessarily have this effect.
6. Special provision should be made for emergency situations where the continuation of the pregnancy occasions a risk to the mother's life that it real, substantial and imminent.
7. It is desirable that Review Panel group suggested by the Expert Group should include a lawyer.
8. The clauses of the 1861 Act should be amended or repealed.
9. The Church has previously urged the Government to adopt a legislative and regulatory approach which will allow for easier alteration in the light of changes in medical science. Accordingly, the Government decision to do so is welcome.

Submission by the Most Rev Dr Michael Jackson, Archbishop of Dublin and Mr Samuel Harper, Lay Honorary Secretary of the General Synod to the Joint Committee on Health and Children on the Implementation of the Government Decision following the publication of the Expert Group Report into matters relating to AB & C v Ireland.

Introduction

We are grateful for the invitation extended to make a submission to the Joint Committee on Health and Children on the issue of abortion and wish to express our gratitude to the Chairman and members for the opportunity afforded. However, we must express considerable disquiet at the timescale given for a response on a matter of this exceptional human complexity and sensitivity.

The Church of Ireland is a Synodical Church and has extensive structures and procedures to allow the policies of the Church to be guided by the prayerful consideration and discussion of bishops, clergy and laity. It was not remotely possible in the short timeframe allowed (de facto less than three working days) to undertake such a procedure and this is totally inappropriate in light of the complexity of the moral, ethical and legal issues involved. Accordingly this paper can only be considered a preliminary response. Some of what appears here expresses the personal opinions of the representatives of the Church (though guided by previous Church discussions) and where this is so, this has been highlighted. Obviously, we intend to convey the report and some of the issues raised to the appropriate bodies within the Church for their own consideration.

The position of the Church of Ireland on abortion is summarised on an addendum to this paper including excerpts from previous submissions to Oireachtas Committees. We recognise, however, that the decision in the AB & C v Ireland case and the decision of the Government to progress the matter through a combination of legislation and regulation had 'moved the issue on' somewhat and thus we will confine most of our submission to the issues raised by the Expert Group report. It will suffice to say that the Church of Ireland opposes abortion in principle but recognises that there are exceptional cases of 'strict and undeniable medical necessity' where it is and should be an option. There would be a wide variety of sincerely held and conscientious views within the Church as to what constitute such 'exceptional cases' but there would be agreement that these include cases where the continuation of the pregnancy poses a risk to the life of the mother.

The Current Legal Situation

In the X-case of 1992, the Supreme Court held that an abortion was constitutionally permissible under Article 40.3.3 in circumstances where the continuation of the pregnancy constituted a 'real and substantial risk' to the life (as distinct from health) of the mother and the risk can only be averted by the termination of a pregnancy. The circumstances of the case made clear that this included a credible risk of suicide.

The Church of Ireland welcomed the judgment at the time as the wording 'real and substantial risk to the life of the mother' was very similar to the 'strict and undeniable medical necessity' criterion which the Church has generally held to be appropriate. However, the legal situation has not been clarified and statutory provisions; particularly sections 58 and 59 of the Offences Against the Person Act 1861, remain in effect, and provide for severe criminal sanctions for both women and those who assist unlawful abortions.

In the context of the Church of Ireland's previous comments on the issue of abortion, we would agree

that the position at present is very unclear and that this is unsatisfactory and unfair to pregnant women and medical professionals who deserve to be able to make critical, clinical decisions in a secure and well regulated legal and medical framework. We therefore strongly welcome the decision by the Government to seek to provide clarity on this issue.

Expert Group Report & Implementation

Introducing the principles behind its paper, the expert group said that 'there is an existing constitutional right as identified and explained in the X case judgment of the Supreme Court. The State is entitled and, indeed, obliged to regulate and monitor the exercise of that right so as to ensure that the general constitutional prohibition on abortion is maintained. However, the measures that are introduced to give effect to this constitutional right should not act as obstacles to any woman who is legitimately entitled to seek a termination on lawful grounds.'

We would agree with this general approach.

The expert group went on to highlight the sensitive issue of what should happen in the event that a foetus is viable (or potentially viable) but the continuation of the pregnancy poses a 'real and substantial risk' to the life of the mother. We feel that this highlights the need for an effective decision making procedure. With regard to Chapter 6 of the Expert Group report, the report outlines the tests to be applied in the light of the Supreme Court decision in the X-case and that this should include the question of whether it is practicable to preserve the life of the unborn in the process of terminating the pregnancy without compromising the right to life of the woman. The Church of Ireland submission in 1998 to the Interdepartmental working group on abortion makes clear the Church's position on the right to life of the unborn. We would therefore, agree with the approach outlined and with the requirement that the diagnosis needs to be made expeditiously and should be formally notified to the woman. Such a device needs the protection of legislation as medical council guidelines on their own will not necessarily have this effect.

The Expert Group also raised the issue of whether there should be special provision for the rare occasions where the risk to a woman's life is real, substantial and imminent (IE Emergency provisions). Our view is that there should be special provision for such circumstances in the light of the provisions of the 1861 Act which makes the termination of pregnancy subject to severe criminal sanction. We do not feel that it is appropriate for a medical professional faced with an emergency situation where a woman's life is in danger to be constrained from giving necessary treatment in good faith by the risk of criminal conviction. We would emphasise, however, that the synodical bodies of the Church have not taken an official position on this issue.

As to the Review panel, we would agree with the general approach outlined by the Expert Group and of the two options given, we believe that Option 1 (including a lawyer on the panel) would be the preferred approach, although we would again add the caveat that there has not been an official decision on this within the Church of Ireland.

Turning to Chapter 7 and the options for implementation, as a group we welcome the Government's decision to seek to implement by means of Legislation and Regulations which is in keeping with the statement made by the Church in 1998. This approach allows for easier alteration as developments in medical science alter the context of decision making. Similarly we feel there is a strong argument for the abolition and replacement of the clauses of the 1861 Act with a more up to date legal framework but we cannot offer an official Church of Ireland position on this point.

Summary

Without entering into the issue of whether abortion should be available in circumstances beyond those outlined in the X-case (on which there are a variety of opinions within the Church of Ireland), we agree that legal clarity is required to enable women and medical professionals to make informed decisions where the continuation of a pregnancy poses a 'real and substantial risk to the life of the mother' and as such the Expert Group report and the Government's decision to provide a legislative and regulatory framework are overdue and welcome.

ADDENDUM

Church of Ireland's Position on Abortion

In 1958, the Lambeth Conference (a decennial conference of Anglican Bishops Worldwide) adopted a resolution stating:
'In the strongest terms, Christians reject the practice of induced abortion or infanticide, which involves the killing of a life already conceived (as well as a violation of the personality of the mother) save at the dictate of strict and undeniable medical necessity'.
While Lambeth Conference resolutions are only binding on individual Churches when formally incorporated into the internal legal systems of those Churches, the Church of Ireland has generally used this resolution as its starting point in previous submissions to Oireachtas Committees on the issue of abortion beginning in 1982. The phrase 'strict and undeniable medical necessity' clearly carries with it the implication that there are circumstances where abortion is a medical necessity.
In 1982, the Standing Committee of the General Synod sent an official comment on behalf of the Church of Ireland to the then Taoiseach, Mr Haughey which said that 'we cannot emphasise too strongly the right to life and this includes the right of the yet unborn.' After quoting the Lambeth Council resolution referred to above and highlighting the words 'strict and undeniable medical necessity' the statement went on to add, 'we greatly doubt the wisdom of using constitutional prohibitions as a means of dealing with complex moral and social problems.'
In 1998, the Church's Role of the Church Committee made a submission to the Interdepartmental working group on abortion which said inter alia:
'The deliberate termination of an intra Uterine life cannot be right but many in our church believe that exceptional cases may arise which mean that abortion ought to be an option and may even be a necessity in a few very rare cases. No abortion is ever desirable – at most it can only be described as the lesser of two evils, and always undertaken with a profound sense of sadness and regret. The legal framework should allow for such exceptional cases so that the tragedy is not compounded by public debate.'
It is fair to say that there are different opinions amongst Church of Ireland members at all levels, as to what constitute 'exceptional cases.' For example, in 2000, a Church of Ireland Medical Ethics Working Group proposed that these should include (amongst others) 'lethal or severe congenital abnormality in the foetus'. After some debate at the General Synod, this paper was withdrawn on a vote of 166 votes to 164.
The Church of Ireland's position can be summed up as recognising that there are (regrettably) exceptional circumstances of strict and undeniable medical necessity where an abortion should be an option (or more rarely a necessity) whilst also a concern to avoid a situation whereby legislating for such exceptions provides a 'back door' to widespread abortion, to which the Church is strongly opposed.

Submission to the Joint Oireachtas Committee on Health and Children

May 2013

From: Gearóid R ÓDubhthaigh; Caretaker's House, Waterworks, Lee Road, Cork.
email: cultureofpeace@gmail.com Tel.: (086) 129 33 84

Dear Chairman, Secretary, and Oireachtas members,

I wish to make three points concerning the Protection of Life During Pregnancy Bill 2013.

1. It has been said that nothing will change, however I believe everything will change.
   The 1992 Supreme Court *X* Case ruling which allowed for abortion was quickly followed by the Irish Medical Organisation, Ethics Committee Guidelines which made it clear that abortion was professional misconduct, and also that to deprive any mother of all necessary treatment on grounds that she was pregnant would also be professional misconduct. This has been the ethos which has prevailed within our hospitals, keeping them amongst the safest in the world. In effect there has been a stalemate, a standoff as it were between the Supreme Court decision and the medical professions unwillingness to consent to it. This is why, the Supreme Court decisions in the *X* and *C* cases could only be implemented over seas.

   In the Protection of Life During Pregnancy Bill 2013, the Government intends to break this stalemate by forcing health-care institutions to carry out abortions, or at least make provision to facilitate abortions. Hence forth Hospitals which would have regarded themselves as health-care centres of excellence will now have to include in their mission statement that they are also going to facilitate the killing of the unborn, something which is outside the scope of medical treatment, and was hitherto considered professional misconduct. This will make for a complete change in the ethos and culture of Hospitals and indeed the training given to all Medical professionals.

2. The Conscience clause extends only to doctors and nursing professionals, it does not apply to administrative staff or ordinary general Hospital staff for example trolley pushers, etc. Such staff must now to be available as enablers of abortion a non-medical, non-health-care intervention, discredited worldwide as a treatment and considered professional misconduct. Indeed the conscience clause available to the medical and nursing professionals is partial, it is akin to a pass-the-buck escape from the more gruesome aspects of what happens rather that an opt-out. It is difficult to determine if future generations of these professionals will have this extended to them as institutions will desire to employ only the most "ethically indifferent" staff.

3. Concerning the committees whose establishment is purposed under this bill, I wish to ask that no medical professional be required to sit on them, as to do so could only lead to the corruption of

these medical professionals and also give a false sense of acceptability, to what is in fact a horrendous undertaking without any medical justification whatsoever.

Geraldine Creaton <geraldinecreaton@gmail.com>
07/05/2013 23:41 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Forthcoming Protection of Life during pregnancy Bill

Dear Paul Kelly,
I wholly support the desire to ensure that women receive the life-saving treatment they need during pregnancy. However this bill is completely unnecessary. Appropriate guidelines and procedures giving heath professionals clear guidance is. I am very disappointed and indeed surprised at the Government's lack of interrogation of the medical evidence and best medical practice when preparing this legislation. Psychiatrists tell us that abortion is not a treatment for suicidal ideation, and that suicidal ideation may not have a singular cause. What a waste of an innocent life for something that is not best practice, that is giving the best outcome for the health of the mother, and that may do more harm than good, not least to the woman involved, whose very protection is being invoked in the title of this bill. It is furthermore all the more shocking that a baby in this case could be threatened with being aborted right up to full term.
Other countries that started with so-called 'restrictive' legislation have ended up with widespread abortion. In 2011, our nearest neighbours (England & Wales) quote mental health issues as the reason for abortion in 97% of their 200,000 abortions.
Legislation is not required. The proposals for Protection of Life during Pregnancy Bill 2013 make the direct and intentional killing of unborn children lawful in Ireland for the first time. The Bill represents a dramatic change in Irish law. The constitutional protection afforded to the unborn child must be respected, as well as that of the mother. Equally, the expressed opinion of overwhelming majority (77%) captured in the recent Milward Brown Poll in favour of constitutional protection for the unborn that prohibits abortion, as representative of the opinion of a very concerned public must be heard. Let's really take seriously the protection of the health of the mother during pregnancy, without unnecessarily taking another persons life. We really can do so much better than this for the sake of all.
Yours sincerely,
Geraldine Creaton
6 The Forts
Dooradoyle
Limerick

Cherie O'Sullivan <coscork@hotmail.com>
07/05/2013 09:05 To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
attn Paul Kelly: Legislation on Abortion

I am in agreement with a medical intervention to save the life of the mother in an emergency . but suicide as a solution is never the answer. I worked as a volunteer with the Samaritans for many years and many many women were suicidal as a result of an abortion . interestingly enough many men (the fathers) were also affected by their partners decision to abort their baby .
Enda Kenny stated that the constitution is the book of the people and we make the choice of what goes into the constitution. I say NO ABORTION ON THE GROUNDS OF SUICIDE. no restrictive abortion either, which has proved impossible to police in other countries. you are opening the floodgates here and this legislation is not for the COMMON GOOD. this is what legislators should do, legislate for the common good of all people.
It is a human right to be born and religion does not enter into it.
Murder is murder no matter what name it goes by, the DNA is present in the foetus, therefore let it live.
please do not legislate on the grounds of suicide or bring in abortion law in any restrictive form
thank you
Gerardine O Sullivan
Cork (S.C. Constitutiency)

"Gerardandbrid O'Brien" <gerardandbrid@gmail.com>
08/05/2013 16:59 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Proposed legislation on abortion

Members of the Oireachtas

We wish to express our objection to the proposed legislation on abortion. We under the need for clarity on this matter but legislation is not necessary for the Irish Government. We object strongly to the inclusion of the threat of suicide as a reason to terminate a pregnancy .There is no medical evidence to suggest that this will in any way help the mother.

Yours Sincerely

Gerard and Brid O Brien

13 Sandymount Dr
Wilton
Cork

gerrycello@eircom.net
08/05/2013 14:46 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Human Life in Pregnancy Bill

Mr. Paul Kelly,

Paul, as a person who voted for Fine Gael in last election, I wish to make know that any guidelines in relation to the health of women in pregnancy should only be drafted by qualified medical practitioners. This is a most complicated area of medicine and any guidelines should be equally designed to protect the life of the Mother and the Baby. Both are equal before the law, but they differ in capacity only.

I believe it is totally unfair to place a burden on Psychiatrists, by asking them give the go ahead for the termination of a pregnancy because someone says they are suicidal. I also think that if any person presents themselves before a panel of Psychiatrists as being suicidal that this fact should also be disclosed to future employers, especially if the person was to be employed as a nurse or a doctor later on in life as exposure to drugs should be considered a problem.

Psychiatrists, are there to help people with mental illnesses, and their job is to restore people to health. I do not believe that treating suicide by allowing a person to have an abortion is wise. It would be detrimental to the person.

More time is needed on this and I do not believe that Doctors in general have been properly canvassed on this all too important issue.

Under no circumstances should the Government go against the overwhelming evidence to the contrary given by Psychiatrists before the Committee.

I never gave my consent to my TD to do such a thing as is being presently proposed.

Gerard Quinn,
Headley,
Sandyford Road,
Dundrum,
Dublin 16. 0878172728 012982794 gerrycello@eircom.net

"Ger & Mary Cott" <gmcott@eircom.net>
08/05/2013 14:53 To
<healthandchildren@oireachtas.ie>
cc

bcc

Subject
human life in pregnancy bill

To Paul Kelly
I do not support abortion as a treatment for suicide. We do not want to introduce a culture of death into our country. Every child has a right to life. Please acknowledge this email.
Regards
Gerard Mary Deirdre jonathan Cott
Cill rua hse,
Garrienderk,
Kilmallock
Co.Limerick

Gobnait Mc Sweeney <gobnait77@gmail.com>
08/05/2013 15:17 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
RE: Submissions on the Maternity Bill

Dear Mr Kelly,

I'm contacting you in relation to the upcoming Maternity Bill.

I understand you are the contact for submissions from the public on this Bill.

I wish to register my families views on the proposed change in the constitution regarding abortion. I am a mother of a young family. While I am a practising catholic, I am writing this email not just as a catholic (this is not a CHURCH versus STATE or RELIGION versus non-religion issue) but I'm writing this as a young person, mother, daughter, sister, sister-in-law, aunty, niece etc.
The media have turned this into an ANTI-CHURCH Bill. Whether or not you believe in God or a higher being or not, this Bill has the potential to introduce abortion, which is quite simply the taking of another human life.

We are a Pro-Life family - we wish that the lives of both the mother and her unborn child be given EQUAL status and rights. BOTH lives are of equal value and importance.

I can understand the need to CLARIFY the law in Ireland as it stands currently but I DON'T believe there is a need to CHANG it. Presently in this country, if a woman's life is at risk during her pregnancy (due to illness or complications in pregnancy, and not due to a risk of suicide) medical terminations ARE carried out.

It would appear from the recent case of the late Savita, that there is a lack of certainty in the medical profession as to how gravely ill the pregnant woman must be to carry out a medical termination but from reading the report, there were many other issues at play....her vitals were not monitored closely enough....and tests not followed up on quickly enough.....it is unjust to try to hijack this case of medical negligence to call on the Government to change the constitution and seek abortion in this country.
As for allowing abortion when there is a threat of suicide, we are completely opposed to this. We, as a nation have voted against allowing abortion in this country. Why should threat of suicide be allowed as grounds for abortion. I don't see a threat of suicide being used to allow

any other illegal practise in this country, why should abortion be any different. The unborn child has the same right to live and any other human being. Providing free medical care,counselling and on-going support would be much better for a woman who is suicidal that simply taking the life of another. This makes no sense.

While it must be deeply upsetting for a woman to find herself pregnant after the trauma of a rape or to have an unplanned, unwanted pregnancy, terminating the life of the unborn child is certainly NOT the answer. It does not help them or heal them or deal in any way with the trauma they have endured. It would be much more beneficial in these circumstances to provide free / heavily subsidised medical care, counselling and any other assistance.

I implore those of you in government who have the power in your hands, please don't allow abortion into this country and don't be fooled into thinking that you can allow it in just limited cases. This is how it has been introduced in many countries, who now have abortion on demand. The media would like us to believe that the public in general would be in favour of abortion in certain cases (such as for threat of suicide or in case of a rape) but I know that this is simply not the case.

Thank you for taking the time to read this email.

Kind Regards

Gobnait Mc Sweeney
--
Gobnait

Gretta Flynn <gretta.flynn@gmail.com>
08/05/2013 16:57 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Submission re: Protection of life pregnancy Bill 2013

Dear Paul

I do not know what St Paul would say to our Oireachtas if he were around to-day. I feel he would be at least as horrified as I am when I consider this bill. Some of our legislators have made it clear that they have difficulty with this bill. It is deceiving the people of Ireland that you care for Mothers and the Unborn.
As you all are aware abortion is an act which is directly aimed at ending the life of the unborn child. The Oireachtas is overturning in law the fundamental principle of the inviolability of innocent life. Ireland ranks among the safest countries in the world for women in pregnancy. Abortion is never the solution to problems in pregnancy.
Irish psychiatrists have told us that abortion is not a medical treatment for suicidal thoughts and feelings in a pregnant woman.
This bill will create a new and dangerous environment for a woman, her future and the life of her family and all of us. Research over the last two decades has consistently found that women can be/have been seriously wounded by their abortion experience.
Professor David Ferguson, an avowed atheist and pro choice found that the results of the study undertaken in New Zealand were not what he had hoped for or expected. He was disturbed at the results which showed psychological damage to some women. Women who abort have a higher risk of mental health problems - depression, anxiety, substance abuse etc. Study done by Professor Priscilla Coleman (2011 and published in the British Journal of Psychiatry) also confirms the damage which abortion does to women. Research done in China has reported a sharp increase in breast cancer following abortions (44%). Studies have also shown that males have all been severely affected by their post abortion distress. This distress touches others in their life and also reaches out to the community in general.
For women who have had abortions their crisis has passed but the memory of taking their own child's life comes back to continually haunt them.

I ask through the powerful intercession of St Paul and Blessed Teresa of Calcutta that the Oireachtas will not pass this bill which does nothing to protect the life of mothers and their unborn child.

Gretta Flynn
Concerned Irish citizen

PRO-LIFE Vigil 4th December 2012


NDA, KEEP YOUR
RO-LIFE PROMIS
LOVE THEM BOTH
Fine Gael:
Keep Your
Pro-Life
Promise
N 11

We'd rather give up medicine than perform an abortion

Gemma O'Doherty

Maria Coleman had just started medicine at the Royal College of Surgeons when she became pregnant through difficult circumstances. Canadian by birth, she grew up in a culture where abortion is available on demand up to full term.

The 24-year-old went to her GP and was told that abortion was the best route to take; that having a baby would mess up her career. Maria was surprised. It was the sort of reaction she expected from a Canadian doctor, not an Irish one.

By that point she had made her mind up anyway. That happened the moment she did a pregnancy test.

"From the second it showed positive, I knew there was another life growing inside me," she recalls.

"There was no denying that. As easy as it might have seemed to get rid of the 'problem', I knew I had no right to end another human life."

Almost three years on, Maria has a beautiful two-year-old boy who is the light of her life. Now in her third year of medicine, she's also a first-class honours student.

Her personal experience has deeply informed her professional ethic as a young medic planning to specialise in obstetrics. She has observed the recent abortion controversy here with deep concern, fearing that if Ireland legislates for abortion, it will end up going down the road of her own country, where up to 100,000 terminations take place every year.

"We all know there is no difference between a baby five minutes before it's born and five minutes afterwards, but in Canada, they don't consider it a human being until it has arrived in the delivery ward," she says.

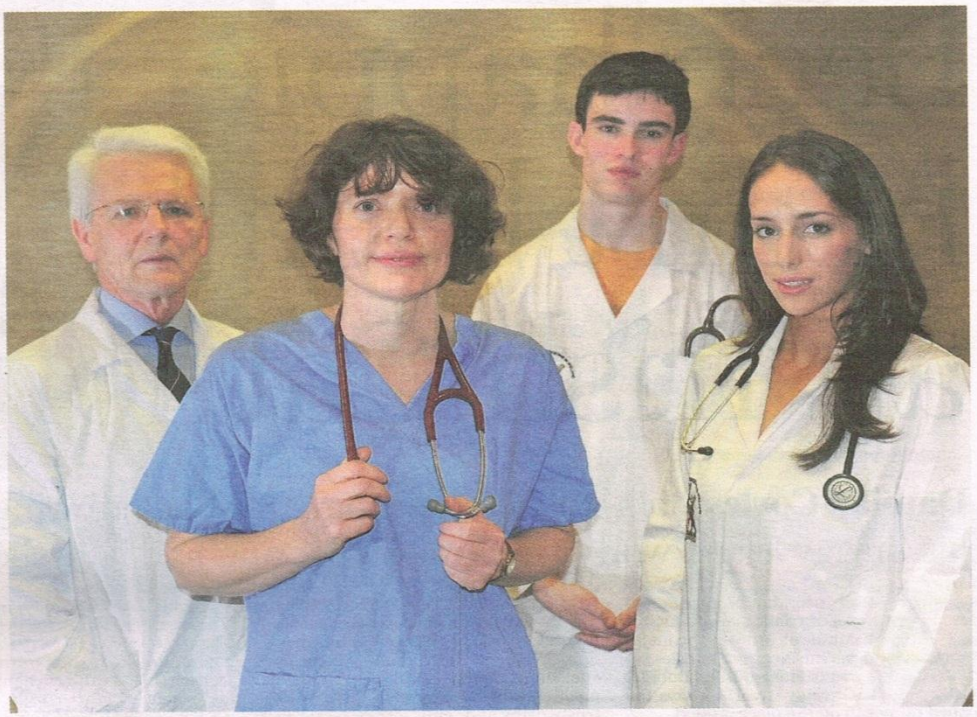
"Until the baby has fully exited the birth canal, anything can be done. In a 10-year period, about 490 babies have been born alive in Canada after failed abortions. They are left to die on a cold table.

"For me, as a trainee doctor, that is nothing less than criminal. Every day in college, we are reminded of our Hippocratic oath which we take on graduation — 'above all, do no harm'.

Maria has decided to continue her medical career in Ireland but may change her mind if abortion is legalised.

"I would give up medicine before doing that sort of work. I just have to look at my son to realise that. He's the best thing that ever happened to me."

Dr John Monaghan has been an obstetrician for more than 30 years. Based at Portiuncula Hospital in Ballinasloe, Co Galway, he is one of a significant number of Irish doctors who are opposed to abortion legislation and believe the guidelines of their regulatory body, the Medical Council, make it 'crystal clear' that they can and must end a pregnancy when a woman's life is in clear danger.



Do no harm: Pictured (from left) are doctors John Monaghan and Eileen Reilly, and medical students Cormac Duff and Maria Coleman. DAVE MEEHAN

"I have never encountered a clinical situation where I needed a legislator to tell me what to do," he says.

"We are the experts and many of us see absolutely no grey areas. In my opinion, most of us believe the guidelines are perfectly adequate. They cover every clinical situation I have ever been involved in.

"If a woman's life is in immediate danger, you have to end the pregnancy. A properly trained obstetrician is well able to make that decision on their own or in consultation with their colleagues. We don't need lawyers telling us what to do."

Dr Monaghan has grave reservations about the abortion regime which would be introduced here if the "X case" judgment is legislated for. The 1992 Supreme Court ruling does not mention time limits and could allow abortion on the grounds of a threat of suicide.

"In my entire career, I have never seen any evidence that abortion can cure somebody of suicidal feelings," says Dr Monaghan.

"Yet you only have to look at Britain where a woman just has to say she is feeling suicidal and she gets an abortion. Today, more than 90pc of abortions there are done on mental health grounds."

"We must give a woman every help we can during a difficult pregnancy, but if we consider ourselves civilised we must also defend the rights of the life that has no voice"

Dr Monaghan also believes there is growing concern within the world of Irish obstetrics that doctors may be compelled by the HSE to perform terminations under their terms of employment.

"My understanding of the expert group report on abortion is that conscientious objection may not be allowed for, and that your employer may be able to force you to carry out terminations.

"As a professional, I am not prepared to accept that I would be directed to perform abortions by my employer or the State. If I receive a direction to do one, I will not do it and will face the consequences. I think the bulk of Ireland's obstetricians would feel the same way.

"I will not practise obstetrics if I am compelled to kill babies."

Another obstetrician who fears the arrival of abortion to Ireland is Dr Eileen Reilly, who came from Scotland to work in Galway. Some of her concerns are based on her experience of Britain, where more than 200,000 abortions are performed each year.

"On my first day in the job in the UK, I was asked if I was 'a terminator'," she says.

"It was just shocking. I went into gynaecology to bring life into the world, not to destroy it.

"It's the most privileged speciality of them all. Doctors do not have the right to play God nor should they have to.

"In my job, I have two patients to look after: one who can talk and one who can't. We must give a woman every help we can during a difficult pregnancy, but if we consider ourselves a civilised society, we also have to defend the rights of the other life who has no voice."

Dublin medical student Cormac Duff would also refuse to perform abortions when he qualifies as a doctor.

"When abortion was introduced in Britain, it was supposed to be very limited. Now babies with Down's Syndrome can be aborted up to 36 weeks.

"Ireland very proudly hosted the Special Olympics in 2003. We have a great tradition of recognising that not everyone is equally able but they can still contribute a lot to society. We don't believe children with special needs should be obliterated, just because they might not go to college. It is morally reprehensible to say that because someone is not genetically as good as the average person that we can take their life away.

"As a doctor, my job will be to preserve life, not to take it. And I know very few people in my class who would have the stomach to carry out abortions."

Don’t throw the baby out with the bath water!

"...the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life; the sick, the needy and the handicapped.” ~ Last Speech of Hubert H. Humphrey 1977

“The thing that will destroy us is politics without principles” Mahatma Gandhi

"A NATION'S GREATNESS IS MEASURED BY HOW IT TREATS ITS WEAKEST MEMBERS." ~ MAHATMA GHANDI

-- the last, the least, the littlest."
Added to Gandhi’s quote by ~Cardinal Roger Mahony, in a 1998 letter, **Creating a Culture of Life**

‘‘ An event is happening about which it is difficult to speak but which it is difficult to remain silent.’

’’ For evil to triumph, it only needs for good men to do nothing!’ Edmund Burke

“Abortion corrupts medical practice” – the late Brendan Shorthall

The information in these spread sheets speaks for themselves as outlined below.

Country	Rank by Maternal/Birth Rate	Rank by Quality of Care relative to income	Savina's
Ireland	1	1	1
Denmark	8	9	3
Spain	13	19	3
Norway	18	8	3
Netherlands	28	21	4
UK	33	29	5
USA	58	36	9
Slovenia	65	44	11
India	141	138	59

The factor that is different in Ireland compared to these countries is that we do not have legalised abortion! This proves Brendan Shorthall’s dictum! As sure as night follows day, if we were insane enough to bring it in, our maternal care would inevitably decline. Women will die that would have lived – that is beyond doubt from these figures! The situation is stark, dark and we are on the edge of the abyss. This truth has to be told frankly: any TD or Senator who votes for abortion legislation will be signing the death warrants of the women they were elected to represent and protect. It would be a shameful dereliction of duty.

Is anyone there? Does anyone see what I see? Does anyone care?

Is there any other measurable endeavour in which Ireland comes No 1 in the World? If we won the World Cup in Soccer or Rugby would we sack the manager? If we came 1st in the Olympic

table for medals would we dissolve the Olympic Council? For External Debt we are 158 of 169 on the Table – down in the equivalent of the Vauxhall Conference in English soccer as we are at the very top of the Premiership League of maternal care! But say we were at NO 1 like Brunei with no Debt whatsoever? (Think of the Budget we would have had now compared to the one we have just had?). What would we think of a Minister of Finance, who would come into the Dail, and propose he would introduce legislation that would be similar to countries down at no 123 like India? For male suicide we are No 82 of 99. Again, say we were at No 1 would the Minister for Health came into the Dail to bring in legislation similar to a country at No 82? What would be the reaction?

In fact if the proverbial Man from Mars were to visit the Dail recently, and saw the antics of some Deputies clamouring for policies, that would be, literally, deadly for mothers and their unborn children, he would come to the conclusion that the lunatics has taken over the asylum! Have they lost all sense of reality, logic or reason?

Of course the people pushing for abortion are in reality hell bent on changing the culture of care, compassion and love that is part and parcel of the people who work in our hospitals to one of a Darwinian utilitarian survival of the fittest mentality leading us down a Nietzschian black hole.

The cause of the unborn is truly the cause of their mothers!

First they came for the Communists, and I did not speak out--

Because I was not a Communist.

Then they came for the Social Democrats, and I did not speak out--

Because I was not a Social Democrat

Then they came for the Trade Unionists, and I did not speak out--

Because I was not a Trade Unionist.

Then they came for the Jews, and I did not speak out--

Because I was not a Jew.

Then they came for the Catholics, and I did not speak out,

Because I was a Protestant

Then they came for me--and there was no one left to speak for me.

Pastor Martin Neimoller

Turning and turning in the widening gyre
The falcon cannot hear the falconer;
Things fall apart; the centre cannot hold;
Mere anarchy is loosed upon the world,
The blood-dimmed tide is loosed, and everywhere
The ceremony of innocence is drowned;
The best lack all conviction, while the worst
Are full of passionate intensity.

The darkness drops again but now I know
That twenty centuries of stony sleep
Were vexed to nightmare by a rocking cradle,
And what rough beast, its hour come round at last,
Slouches towards Bethlehem to be born? **The Second Coming** William Butler Yeats

Notes:

1 185 Countries are listed though there are 182 involved as the U.K is listed on its own as well as its principalities, kingdoms and devolved administrations of England & Wales, Scotland and Northern Ireland. As well as the UK, I have highlighted the countries that have criticised at The European Court us for not providing abortion when their own maternal mortality deaths are significantly higher than ours.

2. On the Excel Spread sheet one need only to click on each country and the details of that country are highlighted on the Internet (a copy will be sent to you by email if I have your email).

3. I have used the statistics from 2008 as that year has the maximum information over all. Also, the figures for Ireland for 2010 are no longer as reliable as previously as there is not universal agreement on their validity. There has been a slight slippage from previous years which may have been the result of severe health cuts. However, despite that, we are still joint third with Iceland at 0.38, behind Israel at 0.37 and Greece at 0.31. In any event, these difference are very marginal compared to the difference with our nearest neighbours culturally, the UK and the USA. (And the former geographically of course).These two countries lead the World technologically and yet they are far behind Ireland. (See above)

Sources: Mainly CIA Fact book & Wikipedia (There were many other sources too numerous to mention)

Left or right, we need to allow Savita's doctors a fair hearing

By Billy Keane

Monday November 26 2012

I have no agenda and I'm one of the few. In Irish public life, it seems to me that if you are left then you comment from a leftist perspective and if you're right you take the conservative view. You are branded as left or right wing and the name sticks for life. Most take the side they have become aligned to over the years, on every single issue.

Take gay marriage as an example. Most Irish people are in favour. I am too.

Does that make us left wing? I have a gay pal who wants to bring back the death penalty. Does he kick with the left or the right? I'd love to nationalise the banks. Am I a commie?

All for divorce? So I am, and contraception. Ciotogish left.

Like most of you I am not in favour of abortion on demand. Some might even say that's a chauvinist view. I do agree with the saving of the mother if her life is in danger while she is in labour. So does that opinion make me right wing?

Most of my female colleagues have called on men to do their bit in sticking up for Savita.

Men it seems are a different and autonomous species. That for me is the definition of feminism, an outdated and jaded concept in an Irish context. There should be no such thing as women's rights or men's rights. We are one and the same. It's about people's rights.

Thousands marched for Savita.

Were they marching for justice for a dead woman and her little baby? Was it for abortion on demand? Was it for better guidelines? Was the march a gesture of sympathy with a lady and her baby who died so tragically?

There is a 'we want something done movement'. But what is there to do? How do you legislate for making a man into a God? Who can define in exact terms what is to be done in cases where the mother's life is in danger and the child's life is in danger? Is it always possible for a doctor to diagnose the exact moment when the mother's life will expire if the child's life isn't terminated?

It's not like a bookie's board at the races where the prices are put in front of the public who bet on the outcome.

The only politician who emerged with any credit from all this is the Taoiseach. He stood back from the fray and asked that we wait for the result of an all-party review. He cares and he takes care.

Whatever decision is taken must provide a framework for the balancing of the right to life of mother and child.

Your heart would have to go out to any woman who has to make such a choice. It doesn't bear thinking about. This is a terrible situation none of us would ever wish on our loved ones. And what of the mental condition of the mother after the death of her baby on her say so? Who would be a woman?

We grieve for Savita's husband Praveen. He has called for a fully sworn inquiry. That will take months and cost millions, if previous experience is anything to go by. Women and their babies may die in the meantime and in the end the judges will tell us what we know already.

The doctors do have a guideline. It is a simple one. The doctors can only terminate a pregnancy if there is a clear and substantial risk to the life of the mother.

This is very vague but it does encapsulate the core principle most of us agree with in this country as laid down by the Supreme Court. Men and women.

I'm afraid this is about as much as we can do. It's not like an instruction manual for a flat pack kitchen where every piece fits exactly in its place. Birth and death at maternity time offer no such certainties.

There is a basic principle of justice and that is no man should be a judge in his own case. I worry about the Health Minister James Reilly. He doesn't seem to understand a problem until it becomes a controversy.

We will have a properly and fairly constituted clinical enquiry. What happens after that is anyone's guess.

None of the thousands who marched were present at the deaths of the mother and child. Those who were must provide answers. But they are entitled to a fair hearing.

No man or woman should make a decision until the results of the inquiry are made public. Yet many commentators have already made up their minds because they are left or right even though they are not aware of the actual facts of the diagnosis and the rationale between the subsequent decision-making process.

It was more than 80 years ago and the mother was gone full term. She had three kids under five. Back then the infant mortality rate was very high. Her husband was a good man and he tried his mightiest to get her the best of medical attention.

The good mother died from septicaemia but her baby was saved. He is a wonderful person and did his mother proud by helping so many people.

That mother who died was my grandmother and I don't know if she was left or if she was right.

- Billy Keane

9 November 2012 Last updated at 21:02 GMT

Sarah Dunlop died after Northampton hospital failures

Northampton General Hospital NHS Trust said procedures had been tightened since Sarah Dunlop's death

A mother died shortly after giving birth to twins following a series of failures by hospital staff, an inquest heard.

Sarah Dunlop, 35, of Northampton, suffered a cardiac arrest after undergoing a caesarean section at Northampton General Hospital last year.

A drug was wrongly administered and test results were incorrectly analysed.

The hospital has apologised for its errors and said improvements to its procedures had been put in place. “We offer our deepest sympathies”

Mrs Dunlop was showing signs of pre-eclampsia before her caesarean section, but staff at the hospital did not spot them, the inquest at Northampton's County Hall heard.

"I knew the anaesthetist would look at them. I didn't look at them myself.”End Quote Susan **Lloyd Consultant obstetrician**

Her twin boys were delivered at 12:40 BST on 11 July, and she was then moved to the observation area of the labour ward.

Her kidneys failed and she started haemorrhaging. She went into cardiac arrest, and despite efforts to resuscitate her, died just after 22:30 BST.

The two-day hearing was told she was given a pain relief drug that should not be given to women with pre-eclampsia.

After being transferred to the observation area she was not closely monitored, her urine was not tested and her blood tests were not analysed properly.

'Should have looked'

Susan Lloyd, the consultant obstetrician who carried out Mrs Dunlop's caesarean, admitted she did not go through blood test results before the operation.

She said: "I knew the anaesthetist would look at them. I didn't look at them myself.

"I should have looked at them myself."

Dr Mohammed Khakil, a registrar, examined one set of results but failed to notice anything unusual.

Clearly the severity of Mrs Dunlop's illness was not recognised.”

End Quote Owen Cooper Consultant

An ECG test, used to measure heart activity, was not carried quickly enough.

When it was conducted it showed irregularities, but doctors began to question the equipment rather than accept and address the results.

Coroner Thomas Osborne said a senior midwife failed to convince the doctors that something was wrong.

'Let her down'

Owen Cooper, the consultant who led an initial investigation into Mrs Dunlop's death, said: "There were failings.

"I'm not going to defend it. We let this woman down.

"Clearly the severity of Mrs Dunlop's illness was not recognised."

The coroner said had Mrs Dunlop's symptoms been identified, she would have probably survived.

Recording a narrative verdict, he said staff failed to recognise the serious nature of her condition, resulting in failure to treat it.

But he said he was satisfied that the trust had investigated thoroughly.

Dr Sonia Swart, medical director at Northampton General Hospital NHS Trust, said in a statement: "We offer our deepest sympathies to Sarah's family and we are very sorry for the failings in the care that were identified by our own investigation and have been confirmed by the inquest.

"The trust fully accepts the coroner's verdict."

She said the circumstances leading to Mrs Dunlop's death had been very rare and the trust was confident its maternity service was "fit for purpose".

Dr Swart said procedures had been changed and the Royal College of Obstetricians and Gynaecologists had been asked to review the maternity unit and its processes.

Summary of Failures

1. High levels of potassium in her blood staff failed to act upon – they had risen throughout her pregnancy but doctors misread the results
2. Heart Tests: Two scanners failed and another had a flat battery
3. Staff missed symptoms of **pre-eclampsia** even though she suffered from the condition previously
4. She was given a dangerous combination of pain-killers that should never have been given to a pregnant woman
5. Her urine was not tested
6. Because the Labour ward was “extremely busy” that day, it meant there was a delay in ordering and electrocardiogram (ECG) heart scan. When a scan was finally completed the

printout results – which could have saved Mrs Dunlop's life – could not be read and it had to be repeated.

Mother of twins neglected by private hospital

Daily Mail Sunday, Nov 18 2012

Laura Touche

The family of a woman who died after giving birth in a private hospital tonight attacked Britain's private health care system.

Laura Touche, 31, died nine days after giving birth by Caesarean section to twin boys at the Portland Hospital in London, which has treated celebrity mothers such as Victoria Beckham and Patsy Kensit.

She was not given basic medical checks for two and a half hours after surgery, including blood pressure monitoring, and suffered a brain haemorrhage and brain damage.

The Harvard Law School graduate, who is a direct descendant of former US President Thomas Jefferson, died from natural causes "contributed to by neglect", an inquest jury found today.

Her husband Peter, 33, said the couple had chosen to go private for the birth of their first children because they had believed it would ensure the highest possible standards of medical care.

But he said a "catalogue of errors" surrounding his wife's death had revealed problems in the private sector, just as the Government was beginning to contract out NHS operations to private hospitals.

Mr Touche, whose great grandfather founded the accountancy firm which became Deloitte & Touche, said he now believed his wife's death was "completely avoidable".

"The picture is far bleaker than I had imagined and the catalogue of errors is just unbelievable," he said.

He said there was a lack of proper record keeping or basic medical attention and a delay in administering drugs, and accused the hospital of trying to mount a cover-up about the death.

His family has since settled out of court with the hospital, which admitted breaching its duty of care, he said. The settlement was understood to involve a six-figure sum.

Mr Touche said: "This all took place in a private hospital at the end of the 20th century. "I understand that the government is now contracting out NHS operations to the private sector. Finally the NHS is opening up and publishing statistics. So should the private sector.

"The irony is that often, as in Laura's case, a patient is transferred from a private hospital to an NHS bed and so the death is registered at the NHS hospital.

"Furthermore, these private blunders cost the NHS money as they have to pick up the pieces. The cost of Laura's final days in an NHS intensive care unit will have cost considerably more than the Caesarean operation."

He said he had instructed his solicitor to write to the UK Central Council for Nursing and Midwifery to ask that a midwife criticised by the coroner should be struck off.

Mrs Touche should have been checked every 15 minutes after the surgery, according to the hospital's own protocol.

Her blood pressure was normal before the operation but was not checked again for two and a half hours. When she complained of an agonising headache her blood pressure was found to be abnormally high.

The former lawyer was given drugs and transferred to a specialist NHS hospital the day after the Caesarean but died nine days after she had given birth to twin boys Alexander and Charles.

St Pancras Coroner Dr Susan Hungerford said she accepted that the Portland had investigated the tragedy and changed some of its procedures, but said she would still refer the case to the relevant authorities.

She said midwife Grace Bartholomew should have checked Mrs Touche's blood pressure and said the woman might have been treated earlier if her high blood pressure was spotted sooner.

Dr Hungerford said: "The principal and most catastrophic, and at present inexplicable error, was the failure by Mrs Grace Bartholomew to carry out routine but vital post operative monitoring."

A spokesman for Portland Hospital said Mrs Bartholomew was an agency bank nurse and had not worked at the hospital since the tragedy, adding: "She won't work there again."

Mr Touche said today's unanimous verdict by the seven-man two-woman jury was the end of a three-year battle to get information about his wife's death.

Inner London Coroner Dr Stephen Chan originally ruled that Mrs Touche, from Chelsea, south west London, had died from natural causes and ruled no inquest was necessary.

That decision was overturned by the high court following a legal challenge by Mr Touche, a 33-year-old film executive.

Inquest told midwife who 'brainwashed' woman into having home birth made a series of errors that led to mother's death

*www.dailymail.*5 Sep 2012

A mother died within hours of giving birth at home after a private midwife committed a horrifying catalogue of errors, an inquest heard.

Claire Teague, 29, was left bleeding in bed after Rosie Kacary allegedly pulled out her placenta following the delivery.

The midwife is also accused of failing to realise a large section of the placenta had not come out and not stitching a tear.

Simon Teague (left) leaves Windsor Guildhall on the first day of the inquest into the death of his wife, Claire Teague. Rosie Kacary (right) allegedly pulled out her placenta following the delivery

Mrs Teague complained to her husband, Simon, about feeling weak and in pain after the birth but Kacary left and only returned after 'repeated contact'.

When she came back to the couple's home in Woodley, near Reading, Berkshire, she discovered Mrs Teague had stopped breathing.

Instead of performing CPR on a firm area such as the floor, Kacary is said to have done it on the bed, where it was less effective.

Mrs Teague, who suffered haemorrhaging and three cardiac arrests, was taken to hospital by ambulance but died later that day.

Giving evidence in Windsor yesterday, Mr Teague said he and his wife lost a twin following an emergency caesarean at the Royal Berkshire Hospital in Reading in 2009. A girl, now three, survived.

Following the trauma, when Mrs Teague conceived again she wanted to give birth at North Hampshire Hospital in Basingstoke.

Claire Teague was rushed to the Royal Berkshire Hospital in Reading (pictured) after she stopped breathing at home following the birth of her child

But he said his wife was 'brainwashed' into having a home birth by the midwife, who insisted it was safe. Mrs Teague gave birth to their son, Harrison, at home at around 6am on August 1, 2010.

Her husband told the hearing he became 'anxious' as Kacary 'pulled on the cord six or seven times in an aggressive manner'. He added: 'Eventually the placenta came out with a lot of force and tugging.'

The midwife, he said, examined the placenta by torchlight in the dark bedroom and told the couple that parts remained in the uterus but would come out naturally.

Dr Helen Allott (pictured) said in good light it would have been apparent part of Mrs Teague's placenta was missing

Mr Teague also said Kacary insisted a tear his wife suffered during the delivery was not serious enough to need a suture.

The midwife left at 10am. Mr Teague claimed that when she eventually returned and attempted to resuscitate his wife, she 'didn't seem to know what she was doing'.

The inquest heard from a paramedic who described the ambulance that took Mrs Teague to the Royal Berkshire Hospital as 'swimming in blood'.

Doctors established around a third of the placenta – measuring 8in by 3in – had not been delivered. Dr Helen Allott, a consultant gynaecologist, told the hearing haemorrhaging could be caused by a section of placenta remaining in the mother as it would prevent the uterus from contracting.

She also said the placenta should never be 'tugged' and the decision to have a home birth after previous complications was 'high risk'.

Another doctor, Suad Hirsi-Farah, who treated Mrs Teague, said she had suffered a tear which would normally be stitched immediately in hospital under anaesthetic.

Mr Teague claimed Kacary expressed doubts about her own conduct. 'She came up to me and said “I should have stayed longer, shouldn't I?”' he said. But Kacary, 50, told the inquest she tried to pull out the placenta only three or four times. She said she believed it had emerged complete and would have recommended hospital treatment if she thought otherwise.

She denied claims she examined Mrs Teague in a dark room and said she attended refresher emergency medicine courses each year and had never been told to move someone on to a floor to perform CPR.

'My whole practice has always been extremely kind and gentle and thoughtful and caring,' she added. 'I did the best I could under the circumstances.'

The midwife, who qualified in 1998 and has practised privately since 2003, has overseen 96 home births.

A post mortem examination found Mrs Teague died from lack of oxygen caused by severe haemorrhaging due to a retained placenta.

The inquest continues.

Maternal Mortality Statistics

from the UK 2006-2008 report and MDE Ireland report 2009-2011

Comparing maternal mortality figures in different countries:

When comparing the maternal mortality figures from one country with that of another, it is very important to confirm that the **maternal mortality figures attributed to the countries being compared**, have been derived using the same **method** of calculating maternal mortality.

What methods are used to calculate maternal mortality?

*The **two** main methods used are:*

1. '*Maternal Mortality Ratio (MMR)*
2. 'Maternal Mortality Rate (MMRate)'

1. Maternal Mortality Ratio (MMR):

The international definition of the ***Maternal Mortality Ratio (MMR)*** is the number of *Direct* and *Indirect* deaths per 100,000 live births.[4,5]

NOTE: These figures are calculated only from those *Direct* and *Indirect* maternal deaths notified on death certificates, the method used by all countries other than the UK.[6]

The '*Maternal Mortality Ratio (MMR)* is used by the WHO. The *Maternal Mortality Estimation Inter-Agency Group (MMEIG)* which comprises the World Health Organisation (WHO) among others,[1] work together to generate internationally comparable *Maternal Mortality Ratio (MMR)* estimates in 181 countries.[1,2]

2. **Maternal Mortality Rate (MMRate)**

The ***'Maternal Mortality Rate (MMRate)*** is defined as the number of *Direct* and *Indirect* deaths per 100,000 maternities.[9] *(**'Maternities'** are defined as "the number of pregnancies that result in a live birth at any gestation or stillbirths occurring at or after 24 completed weeks of gestation and are required to be notified by law."* [9]*)*

The UK *'Maternal Mortality Rate (MMRate)'* is calculated through official death certification by the central statistics office (CSO), **and in addition** through deaths known to their Enquiry.[10] This yields an increase of up to 41% in the number of maternal deaths especially those classified as *Indirect* deaths.[27] (see Table 1). According to Prof G Lewis, this method of documenting maternal deaths increases the UK maternal mortality rate when compared with other countries.[10]

The ***(MMRate)*** 'was used only in the UK up to 2008,[7] but since 2009 it is now also used in Ireland as well as in the UK. [8]

What is the definition of a **Maternal Death?**

The international definition of a maternal death is taken from the 10th revision of the International Classification of Diseases (ICD-10) and is defined as follows:

> *"the death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes"* [11,12,13]

Maternal Deaths are further subdivided into ***Direct*** and ***Indirect*** maternal deaths which are defined as follows:

- **Direct maternal death:**
  "Deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium*), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above."[12,13]
  (*puerperium is the period following childbirth, lasting approximately 6 weeks.)

- **Indirect maternal death:**
  "Death resulting from previous existing disease, or disease that developed during pregnancy and which was not the result of direct obstetric causes, but which was aggravated by the physiological effects of pregnancy."[12,13]

Deaths which have a temporal or other relationship to pregnancy are classified as **'Coincidental deaths'** or ***Late* maternal deaths** and are not included in the international definition of maternal mortality.

- **Coincidental deaths:**
  "Deaths from unrelated causes which happen to occur in pregnancy or the puerperium." [12,13]
  NOTE: 'Coincidental deaths' are not included in the definition of either the *Maternal Mortality Ratio (MMR)* or in the *Maternal Mortality Rate (MMRate)*.

- ***Late* maternal deaths**:
  "Deaths occurring between 42 days and 1 year after abortion, miscarriage or delivery that are the result of *Direct* or *Indirect* maternal causes." [12,13]
  NOTE: *Late* maternal deaths are not included in the international definition of maternal mortality.

Ireland's maternal mortality figures compared to other countries

using the *Maternal Mortality Ratio (MMR)* method for assessment from WHO

The World Health Organisation (WHO) has published the internationally comparable *Estimates of the Maternal Mortality Ratio (MMR)* for the year 2010 from 181 countries.[2] (*Maternal Mortality Ratio (MMR)* is the ratio of the number of *Direct* and *Indirect* maternal deaths per 100.000 live births.)

For the year 2010, according to the WHO figures, Ireland has an MMR of 6 per 100,000 live births. MMR figures from other countries for comparison are shown on Table 1 and it should be noted that Ireland without abortion has a lower maternal mortality ratio (MMR) than the other countries on this list, all of whom have legalised abortion.

Table 1: Estimates of the *MMR* for Ireland in **2010** in comparison with other countries

TABLE 1: Estimates of Maternal Mortality Ratio (MMR)* for 2010
compiled by the World Health Organisation (WHO)
taken from *'Trends in Maternal Mortality: 1990 to 2010'*; WHO[2]

Country	MMR	Number of Maternal deaths	Live Births Thousands
Ireland	**6**	**4**	**71**
Australia	7	19	265
India	**200**	**56,000**	**27,146**
United Kingdom**	12	92	745
USA	21	880	4,265

* *Maternal Mortality Ratio (MMR)* is the ratio of the number of *Direct* and *Indirect* maternal deaths per 100.000 live births.

**The UK uses the *Maternal Mortality Rate (MMRate)* to calculate its data, and its proactive searching for maternal deaths other than those documented as such on the death certificate accounts for 41% of the total of maternal deaths mainly due to *Indirect* causes, (e.g. from cardiac disease).[27] This of course increases the UK maternal mortality figures when compared with other countries.[10] (see page 1)

Prof G Lewis states,[6] that for **international comparison** the UK *Maternal Mortality Ratio (MMR)* to be used for **2006-2008,** is **6.69 per 100,000 live births**, i.e. the number of *Direct* and *Indirect* maternal deaths divided by the number of live births (ICD-10). This is calculated only from those

Direct and *Indirect* maternal deaths notified on death certificates, the method used by all other countries.[6]

Ireland's maternal mortality figures compared to the UK

using the *Maternal Mortality Rate (MMRate)* method for assessment

The **CMACE report** of the number of maternal deaths in the UK for the 3-year period **2006-2008** was published in 2011.[4] According to the CMACE report in the UK, there were 107 *Direct* and 154 *Indirect* maternal deaths in the 3-year period 2009 -2011,[18] (Table 2). The causes of these deaths are outlined in Table 5.

The maternal mortality figures for the UK for 2006-2008, using the MMRate calculation[18, 27] are on Table 2

TABLE 2: *Direct* and *Indirect* deaths and mortality rates per 100,000 maternities
Data from Table 1.3, CMACE, UK, 2006-08: Page 34

3-year period	Total UK Maternities	*Direct* deaths number	*Direct* Rate per 100.000 maternities	*Indirect* deaths number	*Indirect* Rate per 100,000 maternities	TOTAL *Dir+Indir* Number	TOTAL Rate per 100,000 maternities
2006-08	2,291,493	107	4.67	154	6.72	**261**	**11.39**

Medical Death Enquiry Ireland (MDE Ireland)

In 2009,MDE Ireland was set up to carry out confidential enquiries into maternal deaths occurring within Ireland using the UK model.[8] As Ireland began to use the *MMRate* method of calculation only in 2009, there are no comparable figures for Ireland for 2006-2008 using the *MMRate* method of calculation to compare with the UK figures.

MDE Ireland, in their **Confidential Report for the Triennium 2009-2011,** (Aug 2012), [5] have documented 6 *Direct* and 13 *Indirect* maternal deaths in Ireland in the 3-year period 2009-2011, (Table 4).[25] The causes of these deaths are listed below and in Table 6.
These figures are based on the *Maternal Mortality Rate (MMRate)* method of calculation and cannot be compared to the WHO figures which are derived using a different method.

Causes of the 6 *Direct* maternal deaths were:

- Pulmonary embolism (3),
- Amniotic fluid embolism (1),
- uterine rupture with no known uterine scar (1),
- multi-organ failure secondary to HELLP *(1)

(*HELLP Syndrome = haemolysis, elevated liver enzymes, and low platelet count)

Causes of the 13 *Indirect* maternal deaths were:

- Cardiovascular disease (5)
- Suicide (2)

- HINI Influenza (2)
- Epilepsy (2)
- Chronic obstructive pulmonary disease (1)
- Bleeding oesophageal varices (1)

Ireland's maternal mortality figures compared to the UK (continued)

using the *Maternal Mortality Rate (MMRate)* method for assessment

How many maternities* in Ireland for the years 2009-2011?

(*Maternities = "the number of pregnancies that result in a live birth at any gestation or stillbirths occurring at or after 24 completed weeks of gestation and are required to be notified by law.") [9]

In **2011** the data for the number of maternities is **not available** in Ireland at the time of writing.[25]
For **2009** and **2010**, there were a total **149,128 maternities** in Ireland.[25] There were 12 maternal deaths, (includes *Direct* and *Indirect* causes but not 'coincidental' causes).[25] This gives a maternal death rate of 8.0 per 100,000 maternities for the combined years 2009 and 2010,[25] using the *MMRate* calculation method but **UK figures are not available for 2009-2011**.

The maternal mortality figures for Ireland for the 2-year period, 2009-2010, using the *MMRate* method of calculation,[25] are on Table 3

TABLE 3: *Direct* and *Indirect* deaths and mortality rates per 100,000 maternities
Data from MDE Ireland, 2009-11: Page 5 ; ***(maternities =. live babies + stillbirths at or after 24 weeks)***

2-year period.	Total maternities in Ireland available for 2009 and 2010 only. **(number of maternities for 2011not available).**[25]	*Direct* deaths number	*Direct* Rate per 100.000 maternities	*Indirect* deaths number	*Indirect* Rate per 100,000 maternities	TOTAL *Dir+Indir* Number	TOTAL Rate per 100,000 maternities
2009-10	**149,128**	**?**	**-**	**?**	**-**	**12**	**8***

NOTE:** As the figure of 8.0 per 100,000 is based on the ***MMRate method of calculation used only in the UK and Ireland, this figure for Ireland can be used to compare with the UK figures alone, and it cannot be used for comparison with the WHO international figures, as the **WHO uses a different method** to calculate the maternal mortality, namely the ***MMR*** method.

The maternal mortality figures for Ireland for the 3-year period 2009-2011using the *MMRate* method of calculation,[25] are on Table 4

TABLE 4: *Direct* and *Indirect* deaths and mortality rates per 100,000 maternities
Data from MDE Ireland, 2009-11: Page 5 ; ***(maternities =. live babies + stillbirths at or after 24 weeks)***

3- year period.	Total maternities in Ireland available for 2009 and 2010 only. **(number of maternities for 2011not available).**[25]	*Direct* deaths number	*Direct* Rate per 100.000 maternities	*Indirect* deaths number	*Indirect* Rate per 100,000 maternities	TOTAL *Dir+Indir* Number	TOTAL Rate per 100,000 maternities

2009-11	**?**	**6**	**-**	**13**	**-**	**19**	**?**

The six deaths classified in Ireland as ***'Coincidental'*** [26], *RTA (1), Cancer (2), Lymphoma (1), Substance abuse (2),* cannot be listed as maternal deaths, as a **'Coincidental' death** is not included in the international definition of a maternal death. Only *Direct* and *Indirect* causes of maternal death are included in the definition of a maternal death.

Leading causes of maternal death in the UK 2006-2008

Maternal deaths are extremely rare in the UK.[32,6] In the UK, the leading cause of *Direct* deaths for 2006-2008 was genital tract infection, described as 'sepsis', and the leading cause of *Indirect* death was cardiac disease, (Table 5).[28]

TABLE 5: Leading causes of maternal deaths; UK 2006-2008;[19] numbers and rates per 100,000 maternities
Data from Table 1.4, CMACE, UK, 2006-08; (page 36)[19]

Number of maternities *in the 3-year period*, **2006-2008** = **2,291,493**

Direct deaths			*Indirect* deaths		
Cause of death	Number	Rate/100,000 maternities	**Cause of death**	Number	Rate/100,000 maternities
Sepsis	26	1.13	Cardiac Disease	53	2.31
Pre-eclampsia and eclampsia	19	0.83	neurological conditions	36	1.57
Thrombosis and thromboembolism	18	0.79	Psychiatric causes	13	0.57
Amniotic fluid embolism	13	0.57	malignancies	3	0.13
Haemorrhage	9	0.39	Other *Indirect* causes	49	2.14
Anaesthesia	7	0.31			

Leading causes of maternal death in Ireland 2009-2011

The number of maternal deaths in Ireland is small. There were six *Direct* and thirteen *Indirect* maternal deaths in Ireland for the 3-years 2009-2011.25 The causes of these deaths are listed on Table 6.[26]

TABLE 6: Causes of maternal deaths; Ireland 2009-2011; numbers and rates per 100,000 maternities; Data from 'Confidential Maternal Death Enquiry in Ireland, August 2012; page 5

Number of maternities in Ireland in the ***2-year*** *period*, 2009-2010 = 149,128;
the number of maternities for the year 2011 not available at the time of printing

Direct deaths			*Indirect* deaths		
Cause of death	Number	Rate/100,000 maternities	**Cause of death**	Number	Rate/100,000 maternities
Sepsis	0	0	Cardiac Disease	5	?
Pre-eclampsia and eclampsia	0	0	neurological conditions	2	?
Thrombosis and thromboembolism	3	?	Psychiatric causes	2	?
Amniotic fluid embolism	1	?	malignancies	0	0

Haemorrhage	0	0		H1N1Iinfluenza	2	?
Anaesthesia	0	0		chronic obstru-ctive pulm dis.	1	?
Uterine rupture,no known scar	1	?		Bleeding oes. varices	1	?
HELLP multiorgan failure: HELLP Syndrome = haemolysis, elevated liver enzymes, and low platelet count	1					

Sepsis in Pregnancy

Dr Ann Harper,[29] Consultant Obstetrician, Belfast, author of Chapter 7 on 'Sepsis' in the CMACE, UK report 2006-08, states the following:

- "Sepsis should never be underestimated. Its course is often insidious and staff need to be aware that women with serious illness, especially sepsis, may appear deceptively well before collapsing, often with little or no warning." [29]
- "Once established, sepsis may be fulminating and irreversible with rapid deterioration into septic shock, disseminated intravascular coagulation and multi-organ failure." [29]
- "The clinical course is often so short, especially in Group A streptococcal infection, that by the time the women present to hospital, it is too late to save them."[29]
- "Sepsis is complex, incompletely understood, often difficult to recognise and manage, and presents a continuing challenge."[29]

In the UK in the 3-year period 2006-2008, there has been a rise in the number of deaths from infections of the genital tract (sepsis). These infections are largely caused by community-acquired ***β***-haemolytic streptococcus Lancefield Group A (streptococcus pyogenes).[6, 29]

In 2006-2008 in the UK there were 26 *Direct* deaths from genital tract infection which gives a rate of 1.13 deaths per 100,000 maternities (see Table 5). There were also 3 *Late Direct* deaths occurring more than 6 weeks after delivery outside the international classification for maternal deaths.[29] The most common pathogens are listed in Table 7.[33]

TABLE 7: UK 2006-2008: most common pathogens identified among the women who died.[33]

Causative organism	number of deaths
β-haemolytic streptococcus	13
Escherichia coli (E coli)	5
Staphlococcus aureas	3

Deaths in the UK due to sepsis occurring in early pregnancy before 24 completed weeks of gestation[30]

Eight women, including one *Late* death, died from complications of infections arising before 24 completed weeks of gestation. Two women died from septic miscarriage and **two died after a termination of pregnancy**.[30]

Deaths in the UK due to sepsis occurring before delivery after 24 completed weeks of gestation[30]

Nine women including one *Late* death developed sepsis before delivery after 24 weeks gestation.[30]

> "Severe maternal infection also affects the fetus – five babies died in utero ... Severe infection is often a cause of atonic uterine haemorrhage, which may be further exacerbated by disseminated intravascular coagulation. For example one woman had uncontrollable bleeding after vaginal delivery and suffered a cardiac arrest <10 hours after admission; another woman who had an emergency caesarean section under general anaesthesia because of abnormal fetal cardiotocograph had a major intrapartum haemorrhage and cardiac arrest post-operatively." [30]

> "Of note, the membranes were intact in eight of the nine women who developed sepsis before delivery."[30]

Deaths in the UK due to sepsis occurring after vaginal delivery[31]

Seven women died from sepsis after vaginal delivery. Sepsis is often insidious in onset and may not reveal itself for several days postpartum, when most women will be at home.[31]

Suicide in Pregnancy

sources of data:

- **UK Report:** CMACE: Centre for Maternity and Child Enquiries; 'Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer; 2006-2008'; March 2011
- **MDE Ireland Report:** 'Confidential Maternal Death Enquiry in Ireland; Report for Triennium, 2009-2011, August 2012

Childbearing protective against suicide:

The rates of suicide in most countries are higher in males than in females and in recent years there is an overall increase in male suicide rates and a decrease in female suicide rates.[34] Qin et al identified the protective role in females of having a young child. [34, 35] Having a child less than 2 years old significantly reduced the risk of suicide for women.[35] This confirms previous research findings regarding childbearing, which indicate that pregnancy is also a time of reduced risk.(Appleby, 1996).[34]

Dr Margaret Oates, (Consultant Psychiatrist, Nottingham), author of Chapter 11, "Deaths from Psychiatric Causes" in the 2006-2008 *UK* Report on *Maternal Mortality* states the following:[15]

- "Suicide during pregnancy remains relatively uncommon, and the **majority** of **suicides** associated with pregnancy **occur following childbirth**."[16]
- "The majority of women who develop mental health problems during pregnancy or following delivery suffer from mild depressive illness, often with accompanying anxiety. Such conditions are probably no more common than at other times.[15]
- "In contrast, the **risk** of **developing** a **serious mental illness** (bipolar disorder, other affective psychoses and severe depressive illness) is **reduced during pregnancy** but markedly **elevated following childbirth**, particularly during the first 3 months."[15]
- "The prevalence of all psychiatric disorders, including substance misuse, schizophrenia and obsessive compulsive disorder, is the same at conception as in the nonpregnant female population." [15]
- "Pregnancy is not protective against relapses of pre-existing serious mental illness, particularly if the woman has stopped her usual medication at the beginning of pregnancy."[16]

Is a history of psychiatric illness associated with suicide in pregnancy?

Dr Oates, in her analysis states that:

- "The majority of women who suffer maternal deaths from suicide have a past history of serious affective disorder."[23]

- "Women with previous bipolar disorder, other affective psychoses and severe depressive illness face a substantial risk of recurrence following delivery even if they have been well during the pregnancy."[23]

Dr Oates recommends that:

- "previous psychiatric history must be identified in early pregnancy."[23]

- "Psychiatrists should proactively manage this risk and, at the very least, frequently monitor and support these women in the early weeks following delivery." [23]

How is a maternal death due to suicide classified?

According to international classification, deaths from suicide due to psychiatric illness are classified as *Indirect* maternal deaths only if those women committed suicide during pregnancy or within 42 days (6 weeks) of the end of their pregnancy.[16]

The UK Enquiry classifies most deaths from suicide as *Indirect* maternal deaths because they were usually the result of **puerperal mental illness**, although this is not recognised in the International Classification of Diseases (ICD) coding of such deaths.[24]

What is puerperal psychosis?

The term 'puerperal psychosis' usually refers to a severe mental illness with a dramatic onset shortly after childbirth – the majority in the first few postpartum days.[17]

The term 'puerperal psychosis' is usually reserved for the acute onset shortly after childbirth, within weeks rather than months, of an episode of severe affective psychosis, including manic, depressive and schizoaffective forms in a woman who has previously been well, even though she may have a previous history.[17]

Incidence

The incidence of 'puerperal psychosis' is about 1 in 1000 deliveries.[17] Women with bipolar illness are at particularly high risk during the puerperium.* [17]

(*puerperium is the period following childbirth, lasting approximately 6 weeks.)

Prognosis and what should women be told

The prognosis of recovery from the initial episode is excellent but women remain at risk for subsequent puerperal or non-puerperal episodes.[17] Drs Ian Jones and Sue Smith in their article "*Puerperal Psychosis: identifying and caring for women at risk"*[17] state, "Despite the high risk of recurrence following further deliveries, many women make the decision to become pregnant again and it is our strongly held view that women with **puerperal psychosis**, or indeed bipolar disorder more generally, should not be told that they should not have children. Sadly, it is our experience that many women are still given this advice by healthcare professionals."[17]

How many maternal deaths from suicide in the UK Report 2006-2008?

There were 13 maternal deaths due to suicide in the UK in the triennium 2006-2008,[16] out of a total of 2,291,493 maternities in the UK in those three years.[18] (See Table 8

TABLE 8: Number of suicides during pregnancy in UK 2006-2008
ref from CMACE: Centre for Maternity and Child Enquiries; 'Saving Mothers' Lives, Reviewing maternal deaths to make motherhood safer: 2006-2008; page 134; Table 11.2

Years 3-year period	Total number of maternities* [18]	Total number of suicides during pregnancy and up to 6 weeks after delivery[16]	rate per 100,000 maternities [20]
2006-2008	**2,291,493**	**13**	**0.57**

*maternities = the number of pregnancies that result in a live birth at any gestation or stillbirths occurring at or after 24 completed weeks of gestation and are required to be notified by law.[19]

When in relation to pregnancy did the deaths from suicide occur?

- The majority of suicides occur after the baby is born.
- Of the thirteen maternal deaths due to suicide in the UK in the 3-year period 2006-2008,[16] four occurred during pregnancy, and nine occurred after the baby was born, (Table 9).
- Three women who were drug-dependent committed suicide during pregnancy and two other women who were drug-dependent committed suicide after delivery within 42 days.[21]
- Some suicides in drug-dependent women occurred after a decision to remove the child into care.[21]
- Three women who died in pregnancy were not booked so there was no opportunity to identify the risk.[22]

How many maternal deaths from suicide in the report for 2009-2011?

TABLE 9: Timing of maternal deaths due to suicide (UK 2006-2008)[20]
ref from CMACE: Centre for Maternity and Child Enquiries; 'Saving Mothers' Lives, Reviewing maternal deaths to make motherhood safer:2006-2008';page 134; Table 11.2 2006-2008 UK

Timing of Death*	Number	Rate per 100,000 maternities
*In Pregnancy** Before 28 weeks	2	0.09
*In Pregnancy** 29-41 weeks undelivered	2	0.09
Postnatal *Indirect*	9	0.39

*three women who were drug-dependent committed suicide during pregnancy and two other women who were drug-dependent committed suicide after delivery within 42 days.[21] Some suicides in drug-dependent women occurred after a decision to remove the child into care.[21] Three women who died in pregnancy were not booked so there was no opportunity to identify the risk.[22]

The MDE Ireland state that there were six *Direct* maternal deaths and thirteen *Indirect* maternal deaths in Ireland for the triennium 2009-2011.[25] There were two cases of suicide listed as an *Indirect* cause of maternal death,[26] but relevant clinical details details for example, the **timing** of the maternal death *(whether during pregnancy or after childbirth)*, or any previous history of psychiatric illness are not given in the report.

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5. In the 1997-1999 Report of the Confidential Enquiries into Maternal Deaths (CEMD, 2001), in the UK, the suicide rate is 2 per 100,000 maternities which contrasts with the rate among all women of 3.4 per 100,000, (Schapira et al, 2001).[14]

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USA urged to confront shocking maternal mortality rate

12 March 2010

USA urged to confront shocking maternal mortality rate

Enlarge

Amnesty International has called on US President Barack Obama to tackle soaring rates of maternal mortality and pregnancy-related complications that particularly affect minorities and those living in poverty.

Amnesty International's report *Deadly Delivery: The Maternal Health Care Crisis in the USA*, urges action to tackle a crisis that sees **between two and three women die every day during pregnancy and childbirth in the USA.**

A total of 1.7 million women a year, one-third of all pregnant women in the country, suffer from pregnancy-related complications.

The report also revealed that severe pregnancy-related complications that nearly cause death -- known as "near misses" -- are rising at an alarming rate, increasing by 25 percent since 1998.

Minorities, those living in poverty, Native American and immigrant women and those who speak little or no English are particularly affected.

"This country's extraordinary record of medical advancement makes its haphazard approach to maternal care all the more scandalous and disgraceful," said Larry Cox, executive director of Amnesty International USA.

"Good maternal care should not be considered a luxury available only to those who can access the best hospitals and the best doctors. Women should not die in the richest country on earth from preventable complications and emergencies," said Larry Cox.

With **a lifetime risk of maternal deaths that is greater than in 40 other countries**, including virtually all industrialized nations, the USA has failed to reverse the two-decade upward trend in preventable maternal deaths, despite pledges to do so.

"Mothers die not because the United States can't provide good care, but because it lacks the political will to make sure good care is available to all women," said Larry Cox.

Amnesty International's analysis also shows a health care reform proposal before the US Congress does not address the crisis of maternal health care.

"Reform is primarily focused on health care coverage and reducing health care costs, and even optimistic estimates predict that any proposal on the table will still leave millions without access to affordable care," said Rachel Ward, one of the authors of the Deadly Delivery report.

"Furthermore, it does not address discrimination, systemic failures and the lack of government accountability documented in Amnesty International's report."

Rapid and comprehensive federal leadership is required, as the report found numerous systemic failures, including the following:

• Obstacles to care are widespread, even though the US A spends more on health care than any other country and more on pregnancy and childbirth-related hospital costs, $86 billion, than any other type of hospital care.
• Nearly 13 million women of reproductive age (15 to 44), or one in five, have no health insurance. Minorities account for just under one-third of all women in the US A (32 percent) but over half (51 percent) of uninsured women.
• One in four women do not receive adequate prenatal care, starting in the first trimester. The number rises to about one in three for African American and Native American women.
• Burdensome bureaucratic procedures in Medicaid enrollment substantially delay access to vital prenatal care for pregnant women seeking government-funded care.

• A shortage of health care professionals is a serious obstacle to timely and adequate care, especially in rural areas and inner cities. In 2008, 64 million people were living in "shortage areas" for primary care (which includes maternal care).

• Many women are not given a say in decisions about their care and the risks of interventions such as inducing labor or cesarean sections. Cesarean sections make up nearly one-third of all deliveries in the US A – twice as high as recommended by the World Health Organization.

• The number of maternal deaths is significantly understated because of a lack of effective data collection in the US A

Amnesty International also called on the US authorities for vigorous enforcement of federal non-discrimination laws and an increase in support for Federally Qualified Health Centers by 2011 to expand the number of women who can access affordable maternal health care.

This work is part of Amnesty International's Demand Dignity campaign which aims to end the human rights violations that drive and deepen global poverty. The campaign will mobilise people all over the world to demand that governments, corporations and others who have power listen to the voices of those living in poverty and recognise and protect their rights

Marla Cardamone, Abortion Death

Drugs meant to kill fetus also killed mother

Suit by survivors of Marla Anne Cardamone, age 18, mother of 1, alleged that Marla became pregnant while on Tegretol and Elavil for depression.

Marla's mother, Deborah Cardamone, commented:

> *Originally, she had planned to put her baby up for adoption, since she already had a toddler to take care of, but a medical-social worker at the hospital strongly urged Marla to have a safe and legal abortion.*
>
> *The social worker argued that Marla had damaged her baby because of medication she had taken. Statistics gave a 92% chance that the baby was fine, but Marla had a sonogram to be sure. After the sonogram, that social worker kept pressuring Marla to have an abortion. Finally, Marla gave in.*

Marla was admitted to Magee Women's Hospital for the abortion August 15, 1989.

Although the urea induction technique was contraindicated due to Marla's medical history, Michael W. Weinberger injected urea into MarlaÂ"s uterus.

Either an error during this injection or some other mishap caused generalized necrosis of MarlaÂ"s uterine wall. The laminaria were also inserted by Weinberger in a manner resulting in septicemia, and massive cortical necrosis of the kidneys.

Marla became ill during the night, with nausea, vomiting, urinary incontinence, and dried blood on her teeth. Her pulse and temperature were severely elevated.

At 6:30 AM the charge nurse contacted a the first of several doctors to treat Marla, but no were cultures taken.

By 7 AM Marla was "increasingly disoriented and speaking inappropriately."

By 7:15, her blood pressure had fallen to 80/40, her pulse had shot up to 144, and she was "unresponsive, grunting loudly, and having seizures."

At 10 AM, intravenous antibiotics were administered. Marla was dead from septicemia at 12:15 PM.

The suit filed by Marla's family noted failure to notify them of her deteriorating condition. Marla's mother and quadriplegic father, who Marla had helped to care for, adopted Marla's child.

The suit faulted the doctor and hospital with performance of a psychiatrically contraindicated abortion, failure to evacuate the dead fetus, administering an overdose of Pitocin, and failure to consult qualified doctors.

Marla's mother adds bitterly:

I had to file a lawsuit to get any answers. Marla had died of --a massive infection from the abortion. I also learned that the social worker had never seen MarlaÂ"s sonogram or discussed the results with her. Marla never saw the words on the sonogram report that would have changed everything: No abnormalities detected. My daughter was pressured to have an abortion, and there had been no reason for it, no reason at all.

I've often wondered why pro-choice women's groups have never expressed any sympathy or concern over Marla's death. Why aren't they demanding justice? Why aren't they concerned that Marla was lied to about the condition of her baby and wasnÂ"t shown the sonogram results? Why aren't they concerned that proper treatment was delayed because Marla was misdiagnosed by a resident who was only two months out of medical school? Why are they so quiet?

I believe it's because pro-choice groups don't want women to read or hear about abortion injuries and deaths. Bad publicity hurts their cause. That's why they prefer that Marla and her baby remain hidden statistics.

Helen Dore
Brooklands
Nenagh
Co. Tipperary

May 7th 2013

Dear Committee Members

Like many mothers in the Ireland, I am deeply concerned about the incorrect legislation that the government is bringing in regarding abortion. While a certain element of clarity is expected, how can the X case be legislated for, when it was based of incorrect information (absence of any psychiatrist). Aren't governments and the judicial system supposed to correct bad decisions?

I would also like you to clarify the following points.

1) How will doctors who carry out abortions be monitored and will this be available to the public? There are grave concerns that pro-choice doctors will get around the rules and abortions due to suicide will jump?
2) What does the Health Committee expect the number of abortions due to suicides to be? We are been told that this should be very rare (2-4 abortions, which is obviously 2-4 too many)? If the numbers are higher than this, what corrective measures will be taken? Will these pro-choice doctors be removed from panels? There should be severe penalties for quotas been surpassed?
3) What reassurances from the Pro Choice politicians will the public be given that they won't immediately look for another referendum once they railroad this legislation through?
4) What mechanism will there be to repeal the legislation, once as many suspect this opens the floodgates to more liberal abortion? I propose that within 12 months that the legislation falls away if certain quotas are breached?
5) Hospitals should be allowed to use the conscientious objection as there are many like myself who will not go to a hospital that carry out abortions. Therefore we will be forced to travel to hospitals abroad that respect life and don't carry out abortions.

Yours Sincerely,

Helen Dore

Helen Doyle

43 Waltham Terrace

Blackrock

Co. Dublin

May 8th, 2013

Members of the Health Committee on Abortion

The Heads of Terms of the so called Protection of Life Bill are completely flawed. Furthermore as the floodgates open due to the inclusion of suicide, will expectant mother like me be subject to abortions being carried out a few doors down from where many of us are giving birth.

You are legislating without a shred of evidence and regardless of what safeguards you put in place, the system will be abused on the suicide grounds.

Thanks,

Helen Doyle

Helena Casey <caseyh15@yahoo.com>
08/05/2013 02.01 p.m.
Please respond to
Helena Casey <caseyh15@yahoo.com> To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Objection to Proposed Maternal Health Bill

Mr Paul Kelly,
I wish to communicate my complete dissatisfaction with the proposed maternal health bill for the following reasons:
The bill proposes to abolish sections 58 & 59 of the Offences Against The Person Act 1861, under which abortion in general remains a criminal offence. That provision is retained even in Britain.
Regarding abortion for suicidal mothers, the bill goes beyond both the mental health grounds of Britain's 1967 Abortion Act and of British case-law. The bill makes suicide an explicit, statute-level ground for abortion.
Proposed changes to the definition of 'unborn' explicitly removes protection for unborn children before implantation in the womb, thus ensuring that they can be aborted legally by drugs and devices such as the morning-after pill.
Legislating for abortion on the suicide ground is not required by the European Court judgment. We could provide the necessary clarity by introducing guidelines which would protect women in pregnancy by re-affirming that they receive all necessary life saving treatments in pregnancy and requiring that we also exercise a duty of care towards the unborn.
Legislation for abortion on the suicide ground is not required by the X-case. When he was Taoiseach, John Bruton said he would not introduce legislation in line with the X-case because that would have the effect of bringing abortion into Ireland. The Oireachtas has the prerogative of not legislating for a Supreme Court decision if it believes it would be harmful to do so.
This legislation will not be about 'life-saving' treatment but, in fact, the opposite. The Government has produced no evidence to show that abortion is ever beneficial in the treatment of the mental health of women. We know from the latest review of the evidence (Fergusson et al.) that abortion is not associated with any mental health benefit for women. In fact, it is associated with a low to moderate increased risk to women's mental health. And, of course, we know a child always dies. So it is dishonest to pretend that this proposal is about saving life.

That is why over 100 psychiatrists last week signaled their opposition to being involved in certifying women as needing abortion because this is not evidence-based medicine. International experience shows that provision for abortion on the mental health ground will be abused. It is hard to see how

things could be different in Ireland, given the nature of what is proposed today. It is ridiculous to assert that Irish women or doctors are more honest than our British or American counterparts. This legislation will be wxploited and abused to the detriment of women and babies.

Obvious bad features of this legislation:
- Abortion on the suicide ground
- No apparent time limits
- No appeal process on behalf of unborn child
- Limited conscientious objection rights for doctors and none for healthcare institutions with a pro life ethos.

Even the name of the bill "Protection of Life during Pregnancy Bill 2013" is misleading and hypocritical, as it does not protect unborn life in a wide variety of circumstances and is contrary to the equal protection for mothers and their unborn children under the Irish Constitution.
Please consider these points. I am very disturbed by any intention to alter the Constitution in such a damaging and anti-life way.
Thank you,
Helena Casey

Submission

1. My experience is that I have worked in the Irish health service as a midwife. I also worked in a voluntary capacity with a crisis pregnancy counselling agency.
2. Legislating for abortion on the suicide ground is not required by the European Court judgement. We could provide the necessary clarity by introducing guidelines which would protect women in pregnancy by re-affirming that they receive all necessary life saving treatments in pregnancy and requiring that we exercise a duty of care towards the unborn.
3. Legislation for abortion on the suicide is not required by the X-case. The Oireachtas has the prerogative of not legislating for a Supreme Court decision if it believes it would be harmful to do so.
4. This legislation will not be about saving lives but the very opposite. The Government has produced no evidence to show that abortion is ever beneficial in the treatment of the mental health of women.
5. What is very bad about this legislation is:
    - Abortion on the suicide ground
    - No apparent time limits
    - No appeal process on behalf of the unborn child
    - Limited conscientious objection rights for doctors and none for healthcare institutions with a prolife ethos

Helen Williams

Submission to the

Joint Committee on Health and Children

On

Protection of Life During Pregnancy (Heads of Bill) 2013

About the ICCL

The Irish Council for Civil Liberties (ICCL) is Ireland's independent human rights watchdog which monitors, educates and campaigns for the respect and protection of human rights in Ireland. Founded in 1976 by Mary Robinson and others the ICCL has campaigned on a number of human rights issues including, but not limited to, the decriminalization of homosexuality, the introduction of divorce, the establishment of an independent Garda Ombudsman Commission, marriage for same-sex couples, the rights of victims and reproductive rights including the implementation of the ECHR judgment in the case of A, B and C and for the introduction of legislation to provide legal certainty following the 1992 judgment of the Supreme Court in the case of *Attorney General v X*.

In January 2013, the ICCL made submission to the Joint Committee on Health and, by invitation, appeared before the Committee in its capacity as an expert in national and international human rights law 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 v. Ireland*, at the express invitation of the Committee.

Following the judgment of the European Court of Human Rights (ECtHR) in the case of *A, B and C v Ireland* in 2010, and the subsequent commitment by successive Governments to implement the decision including the establishment of the Expert Group to report on the options and requirements for implementation of the judgment the ICCL has had occasion to write periodically to the Committee of Ministers of the Council of Europe regarding the tardy implementation of the judgment. The ICCL submissions under Rule 9.2 of the Rules of Procedure of the Committee of Ministers may be found on the website of the Council of Europe.

The ICCL has also coordinated the compilation, recommendations and submission of a number of shadow reports under the United Nations international treaty monitoring system including in relation to Ireland's third periodic examination under the International Covenant on Civil and Political Rights (ICCPR) in 2008 and under the Universal Periodic Review (UPR) process in 2011. Both reports recommended that the State provide legal clarity in relation to reproductive rights and were endorsed by the ICCL. In particular, the reports recommended that the State enact legislation to provide for safe and legal abortions in Ireland (Shadow Report-ICCPR), the repeal of sections 58 and 59 of the Offences Against the Person (1861) Act, clarification on when an abortion may be legal in Ireland as recommended by the Constitution Review Group 1996 and the ECtHR 2010 (Civil Society Stakeholder Report - UPR).

We welcome the opportunity to provide further legal expert testimony to the Joint Committee on Health and Children.

Signed on Behalf of the ICCL

Mark Kelly, Director (8 May 2013)

Executive Summary

This submission reviews the Protection of Life During Pregnancy (Heads of Bill) 2013 on the basis of the judgment of Irish Supreme Court in the *X* case[19] and that of the European Court of Human Rights in *A, B and C v Ireland*.[20] The ICCL considers that the Bill largely addresses the recommendations of the *Report of the Expert Group on the Judgment in A, B and C v. Ireland*; although, some critical matters require further consideration in order to ensure full compliance with the settled constitutional position and Ireland's obligation to implement in full the judgment in *A, B and C v Ireland*. In particular, the General Scheme of the Bill does not yet guarantee an effective and accessible process in cases involving suicidal intent.

It is arranged according to the following sections:

The ICCL makes fourteen amendments for the Committee's consideration.

[19] *Attorney General v. X* [1992] 1 IR 1.
[20] Application No.25579/05, Judgment of 16 December 2010 (2011) 53 EHRR 13. Hereinafter referred to as the *A, B and C* case.

Recommendations

1. Amend Head 2 to provide that two doctors can certify as the necessity of an abortion, with the requirement that one be an obstetrician/gynaecologist. In Head 2(2) the words "and one shall be a medical practitioner who is registered on the Specialist Division of the register of medical practitioners established under section 42(2)(b) of the Medical Practitioners Act 2007 under a relevant speciality" should be deleted.

2. Amend Head 2 to include an express statement that this definition applies to the provisions of the current Bill only.

3. Head 3 should remain unchanged.

4. Amend Head 4 (1) (b) to provide for psychiatric examination by one psychiatrist who is employed at a centre which is registered by the Mental Health Commission and is attached to a centre where the procedure is carried out.

5. Amend Head 6 to include a specific reference to the open and transparent appointment of the HSE Review Panel.

6. Head 7 should remain unchanged**.**

7. Amend Head 8 to require a review process which is comparable to that where the risk posed is physical in nature i.e. the Review should be conducted by one obstetrician and one psychiatrist. Head 8 should be further amended to allow *attachment* of the relevant psychiatrist to the obstetric unit rather than requiring *employment* at the unit.

8. Head 3 of the Bill governing cases of medical emergency should also apply in situation where the risk to life results from suicidal intent.

9. Amend Head 12 to include a clause setting out the procedures involved in documenting a conscientious objection and information referral to the HSE.

10. Amend Head 12 to impose a duty of care, under law, on a doctor or other health professional to ensure the care of the woman is transferred expeditiously to another doctor/health professional.

11. Amend Head 12 to include a clause providing that once a medical practitioner has made the objection, they will be excluded from sitting on a review panel under head 7 or 8.

12. Amend Head 19 to include specific reference to the exclusion of the pregnant woman in the applicability of any offence set out in the Bill.

13. The Bill should not be amended to include a sunset clause.

14. To ensure that Irish law is in complete compliance with the European Convention on Human Rights, the Committee should consider the inclusion of a clause in the Bill to allow for the lawful termination of pregnancy where a fatal foetal abnormality has been diagnosed.

XIV. Introduction

1. The ICCL welcomes the publication of the Protection of Life During Pregnancy (Heads of Bill) 2013[21] following the consideration of the Joint Committee on Health and Children on the *Implementation of the Government Decision following the publication of the Expert Group Report into matters relating to A, B and C v Ireland*. The Expert Group considered that the State must do the following in order to meet its obligations under the European Convention on Human Rights (ECHR):[22]

a. Provide effective and accessible procedures to establish a woman's right to an abortion as well as access to such treatment.

   This is partially covered by the Bill; although real and meaningful access could be in doubt. See sections IV, VI and IX.

b. Establish criteria or procedures in legislation or otherwise for measuring or determining the risk.

   This matter has been addressed by setting out procedures, including the number of medical opinions necessitated, in reaching a medical decision that a termination of pregnancy is required. The test for determining risk to the life of the woman has already been set out by the Supreme Court in the X case. See section IV.

c. Provide precision as to the criteria by which a doctor is to assess that risk.

   The Bill is largely silent on this matter and it is likely that this matter is will be addressed by Regulation and/or Medical Council Guidelines which is a more appropriate avenue.

d. Set up an efficient independent review system where a patient disputes her doctor's refusal to certify that she is entitled to a lawful abortion or where there is a disagreement between doctors as to whether this treatment is necessary.

   The review system proposed follows that set out in the Mental Health Act 2001. However, the review process for women whose risk relates to suicidal ideation, taken together with the requirements with respect to the initial decision, place unjustifiable barriers which could prevent access to a termination. See section IX.

e. Address sections 58 and 59 of the Offences Against the Person Act, 1861.

   This has been addressed by Head 18 although pregnant women will remain open to prosecution under Head 19. See section XI.

2. The ICCL considers that the Bill largely addresses these recommendations; although, some critical matters require further consideration and these will be addressed in turn below.

[21] Hereinafter referred to as the "Bill".

[22] *Report of the Expert Group on the Judgment in A, B and C v. Ireland* (hereinafter referred to as the "*Report of the Expert Group*"), November 2012, p 26.

3. This analysis is founded on the judgment of the *X* case[23] (and subsequent cases where the principles have been followed) and that of the European Court of Human Rights in *A, B and C v Ireland*.[24] With regards to the latter, the Court stated the necessity for Irish law to provide a "transparent decision-making mechanism with clear lines of responsibility for circumstances where a woman needs an abortion in Ireland because of a risk to her health". The requirements of the *A, B and C case* are that access to a termination of pregnancy should be **timely**, **accessible** and **effective**.

[23] *Attorney General v. X* [1992] 1 IR 1.

[24] Application No.25579/05, Judgment of 16 December 2010 (2011) 53 EHRR 13. Hereinafter referred to as the *A, B and C* case.

XV. Head 1 (Interpretation)

Good faith

4. Head 1 defines the "reasonable opinion" of medical practitioners as that "formed in good faith which has regard to the need to preserve human life as far as practicable". The ICCL welcomes the inclusion of a 'good faith' requirement in the Bill with respect to the need to preserve human life. It is essential that medical practitioners feel supported in making their own clinical judgments in order to facilitate the termination of a pregnancy. This "good faith" foundation operates in relation to a 'real and substantial' risk to the life of the mother; however, as per the *X* case, risk does not need to be immediate or inevitable.[25]

Unborn

5. The definition of the "unborn" in the Bill is that which relates to "human life following implantation until such time as it has completely proceeded in a living state from the body of a woman". As set out in the Explanatory Notes, this definition has been inserted to protect the life of a baby who is in the process of being delivered. As was identified by the Expert Group, a baby who is being delivered is not clearly protected either under the offence of murder or the offence of abortion.

6. While applicable within the narrowly defined parameters of the Bill, if applied in a broader sense, this definition amends the position of the Irish government adopted in the *D v. Ireland*[26] case before the European Court of Human Rights where it was argued that (to demonstrate that a remedy was available to D in the Irish Courts), "[i]f therefore it had been established that there was no realistic prospect of the foetus being born alive, then there was "at least a tenable" argument which would be seriously considered by the domestic courts to the effect that the foetus 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".[27]

7. In this case, the Court found that "a legal constitutional remedy was in principle available"[28] to the applicant on this very point stating:

> [I]t is precisely the interplay between the equal right to life of the mother and the "unborn", so central to Article 40.3.3, that renders it arguable that the *X* case does not exclude a further exception to the prohibition of abortion in Ireland. 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.[29]

[25] *Attorney General v. X, op cit*, p. 3.
[26] Application No.26499/02, Judgment of 28 June 2006.
[27] *Ibid*, para 69.
[28] *Ibid*, para 92.
[29] *Ibid*, para 90.

8. The ICCL further points to the case of *Roche v. Roche* (on which it is stated this definition is based), where Mrs Justice Denham gave insights into the definition of the "unborn" in Article 40.3.3:

> The concept of unborn envisages a state of being born, the potential to be born, the capacity to be born, which occurs only after the embryo has been implanted in the uterus of a mother.[30]

5. The Irish Courts can be expected to draw on Supreme Court jurisprudence in *Roche* in any future determination of the definition of the "unborn". The interpretation section in Head 1 does state that the definitions contained in Head one apply 'in this Act' It may be of value to further clarify this limitation. There may be circumstances in which a case falling outside the scope of this Bill requires further interpretation of the meaning of unborn. For example, the *dictum* of Denham J in the *Roche* case would suggest that a non-viable fetus, being incapable of birth, does not come within the constitutional concept of 'unborn'. The ICCL suggests that it would be unwise to seek to apply the definition in this Bill to such a case as to do so may not be in keeping with the constitutional interpretation that the *Roche* case suggests.

Recommendation:

Amend Head 1 to include an express statement that this definition applies to the provisions of the current Bill only.

[30] *Roche v Roche & ors* [2009] IESC 82 (15 December 2009), para 61.

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

9. Under Head 2 of the Bill, two doctors must certify as to the necessity of termination of pregnancy due to a real and substantial risk to the life of the woman and they must be (a) an obsetrician/gynaecologist and (b) a doctor registered on the Specialist Register of the Medical Council.[31]

Measuring the risk to the life of the woman

10. One of the requirements of the *A, B and C* judgment is to establish criteria or procedures for measuring or determining the risk to the life of a woman, and to provide precision as to the criteria by which a doctor is to assess that risk.[32] As the Expert Group rightly noted, the current test under Irish law as it stands was set out by the Supreme Court in the *X* case:

    The termination of pregnancy is 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.

    In this regard, according to the Court, it is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate.[33]

11. The ICCL agrees with the opinion of the Expert Group that:

    > 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.[34]

    However, the issue of probability is not included explicitly in Head 2 or Head 4. Although the legislation would be read in light of the *X* case and the standard of proof is clear at the constitutional level, the ICCL considers that a definition in the Bill would lend itself towards greater certainty and clarity.[35] Probability is mentioned in the explanatory notes of Head 3 and Head 4, but not in the text itself.

Access to treatment

12. Under Head 2 of the Bill, one of the decision-making medical practitioners must be on the Specialist Register of the Medical Council. However, as the Expert Group pointed out, situations may arise where the "clinicians with in-depth information regarding the case under review are not entered on the Specialist Division of the Register, and this requirement would preclude them from being decision-makers. Such a scenario could

[31] So, for example be of 'consultant' grade.
[32] *A, B and C case, op cit*, para 253.
[33] *Attorney General v. X, op cit*, p. 3.
[34] *Report of the Expert Group, op cit*, p 30.
[35] Note the issue of probability is referenced in the Explanatory Notes to the Bill but not in the Heads of the Bill.

lead to delays in reaching a diagnosis and limit access to treatment.[36]Access to the process could also be curtailed by the uneven availability of experts in particular specialties across the country; for example, in smaller hospital settings it is possible that logistical difficulties could potentially impede expeditious decision-making.[37]

13. Legislation to facilitate a woman's access to abortion when her life is at risk must be meaningful. Accessibility is a key issue in this regard. Creating barriers to abortion where it is technically legal will not be sufficient to meet our obligations under the ECHR.

Recommendation:

Amend Head 2 to provide that two doctors can certify as the necessity of an abortion, with the requirement that one be an obstetrician/gynaecologist. In Head 2(2) the words "and one shall be a medical practitioner who is registered on the Specialist Division of the register of medical practitioners established under section 42(2)(b) of the Medical Practitioners Act 2007 under a relevant speciality" should be deleted.

[36] *Report of the Expert Group, op cit*, para 6.3, p 32.
[37] *Report of the Expert Group, op cit*, p 34.

XVII. Head 3 (Risk of loss of life from physical illness in a medical emergency)

14. The ICCL welcomes this provision which limits any practical delays which might arise in a medical emergency. To this end, the necessity for one medical opinion only, in addition to the removal of the requirements found in Heads 2 and 4 that a doctor must be on the specialist register and that the termination of pregnancy must take place in an obstetric unit will provide clarity to doctors and enable them to save the life of a pregnant woman when a medical emergency arises.[38]

15. Despite the repeal of sections 58 and 59 of the Offences Against the Person Act 1861 and consequent removal of the "chilling effect" identified by the European Court of Human Rights in the *A, B and C* case,[39] Head 3 remains necessary and relevant to enable doctors act within the realm of their professional clinical judgment without fear of prosecution under the proposed Head 19 of the Bill.

Recommendation:

Head 3 should remain unchanged.

[38] Head 1(1).
[39] *A, B and C case*, *op cit*, para 254.

XVIII. Head 4 (Risk of loss of life from self-destruction)

16. Head 4 sets out a different procedural framework for pregnant women whose lives at are risk due to mental health difficulties as opposed to physical ill health (under Head 2). While recognising the differences in treating medical conditions, the ICCL considers that the significantly restricted procedures in place under Head 4 (and Head 8: Review in case of risk of loss of life through self-destruction, see below), are not mandated by the judgment in the *X* case; nor supported by current medical practice.

Potential discrimination

17. People experiencing mental health difficulties should not be discriminated against in accessing life-saving medical treatment. The Expert Group was also clear in finding that, "termination of pregnancy should be considered a medical treatment regardless of whether the risk to the life of the woman arises on physical or mental health grounds".[40]

Head 4 is an essential component of the Bill

18. To omit Head 4 of the Bill would almost certainly render the proposed legislation unconstitutional. As we know, *X* affirmed that where the right to life of the mother is threatened by the continuation of the pregnancy, the woman has the right of access to a termination of pregnancy. This includes a risk of suicide and to legislate without its inclusion would produce a legal anomaly whereby the Oireachtas intentionally passes legislation which is inconsistent with the settled constitutional position.

19. The ICCL considers that it is not acceptable to selectively transpose a constitutional position as the Supreme Court was quite clear regarding the inclusion of the threat of suicide. As a result, this matter is not open for legislative debate: it is a settled constitutional principle that can only be changed by a Supreme Court decision overturning the *X* case ruling or a referendum. However, *X* is a judgment which has been followed and applied by the Irish Courts in the 21 years since it was handed down and constitutional change on the specific issue of abortion in cases of risk to suicide has been rejected twice by the Irish people.[41] The legal position post-*X* is a matter of settled law.

20. To exclude the risk of suicide would be a counter-productive and retrograde step which would leave Ireland in continuing breach of its international law obligations and would call the constitutionality of the legislation itself into question. In the event that termination in cases of a risk of suicide was not included in the legislation, the constitutional right to have a termination in such a case would still exist. However, a woman seeking a termination on grounds of a risk of suicide would continue to lack an effective mechanism to access that right. Ireland would therefore remain in violation of Article 8 in light of the *A, B and C* case. Furthermore, the legislation may well be unconstitutional if the risk of suicide is excluded. Head 19 contains a criminal prohibition on abortion outside the scheme of the Bill. If the risk of suicide were excluded, then such a case would be subject to criminal sanction. It is strongly arguable that a criminal

[40] *Report of the Expert Group, op cit*, p 28.
[41] Twelfth Amendment to the Constitution (1992) and Twenty-Fifth Amendment to the Constitution (2002).

prohibition on the exercise of a constitutional right will be struck down by the courts as unconstitutional.[42]

Requirement of three doctors

21. In considering the option as has been adopted in the Bill, - that is, a requirement of two psychiatrists plus an obstetrician – the Expert Group listed four significant *disadvantages* in choosing this route compared to a single *advantage* (that the woman and her doctor may be more secure in their diagnosis). The Expert Group opined that the proposal for two psychiatrists plus an obstetrician would:

    - put an extra burden on a patient and her treating doctors (s);
    - risk curtailed access to a necessary medical treatment due to geographical and service delivery issues;
    - risk stigmatising mental health conditions and making them a "separate case;

    In addition, the diagnosis of expressed suicide intent is a routine process for psychiatrists and a second psychiatrist is not required when a pregnancy is not involved.[43]

22. As referenced in paragraph 18 above, access to abortion must be real and meaningful. This includes the availability of suitable and sufficient medical personnel. Under Head 4 (1) (b), the two psychiatrists must be employed in a centre registered by the Mental Health Commission (that is *"a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder"*). In addition, one of the two psychiatrists must be attached to the "institution where such a procedure is carried out".[44] The ICCL is concerned that the requirement of two psychiatrists in these circumstances will, in practice, render ineffective the availability of abortion where there is a risk to the life of the woman due to suicidal intent. Such a practical application of the Bill would leave the State open to challenge for failing to vindicate the constitutional rights of the woman. Overly-stringent requirements for multiple psychiatric examinations will fail to protect women in need of medical treatment. In this regard, please see sections VI - VIII below, which deal with the formal review process.

23. With respect to a psychiatric diagnosis of suicidal intent, as mentioned above, the Expert Group stated that the "diagnosis of expressed suicide intent is a routine process for psychiatrists and it would therefore be hard to justify formally requiring a second psychiatrist when this does not occur when a pregnancy is not involved".[45] In this regard, the Committee should note the opinion of the European Court of Human Rights in *R.R v Poland* that a [State Party] must not structure its legal framework in a way which would limit real possibilities to obtain it [abortion].[46]

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[42] See for example: *Dillon v Director of Public Prosecutions* [2008] 1 IR 383, in which the High Court struck down sections of the Vagrancy (Ireland) Act 1847 on the grounds *inter alia* that the criminalization of begging interfered with the constitutional right to freedom of expression.
[43] *Expert Group Report, op cit*, p. 35.
[44] Head 4(1) (b).
[45] *Expert Group Report, op cit*, p. 35.
[46] *R.R v Poland*, Application No. 27617/04, Judgment of 26 May 2011, para 200.

Recommendation:

Amend Head 4 (1) (b) to provide for psychiatric examination by one psychiatrist who is employed at a centre which is registered by the Mental Health Commission and is attached to a centre where the procedure is carried out.

XIX. Head 6 (Formal Medical Review Procedures) and Head 9 (General Provisions for the Committee)

24. The establishment of a formal framework whereby "any difference of opinion between the woman and her doctors or between different doctors consulted" could be examined and resolved is one of the requirements under the *A, B and C* case.[47] In the case of *Tysiac v Poland*, the European Court of Human Rights set down the necessary attributes of such a review as required under the ECHR.

25. As the Committee will be aware from previous hearings on this matter, "medical diagnosis is not always such a simple or clear cut process as to exclude differences of opinion".[48] However, as the Expert Group pointed out 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*".[49]

26. As is set out in Irish law, the jurisprudence of the European Court of Human Rights[50] and the findings of the Expert Group: any review mechanism must, at a minimum:
    - be independent;
    - be competent to review the reasons for the decision and the relevant evidence;
    - have procedures in place to allow the woman to be heard;
    - provide written reasons for the decision, and;
    - carry out the review in a timely manner.[51]

Establishment of the Review Panel

27. The Review Panel must be populated by experts subscribing to the core Nolan Principles[52] of integrity, objectivity, accountability, openness and honesty. It is imperative that their appointment by the Health Service Executive (HSE) is open and transparent. The Bill draws on the medical model of the Mental Health Act 2001 with oversight by a HSE-appointed official. Given the considerable implications attached to decisions of a Review Committee, it is imperative that the convener of the Committee (i.e. HSE-appointed official) is qualified to ensure the efficient operations of committees and the application of fair procedures.

[47] *A, B and C* case, *op cit*, para 254.
[48] *Expert Group Report, op cit*, para 5.2, p 27.
[49] *Expert Group Report, op cit*, para 6.7, p 37.
[50] *Tysiac v Poland*, Application No 5410/03, 20 March 2007.
[51] *Expert Group Report, op cit*, para 6.7.3. See also *Tysiac v Poland, ibid.*
[52] The Nolan Principles emanate from the Committee on Standards in Public Life in the United Kingdom. Further information is available at http://www.public-standards.gov.uk/.

Protection of maternal life

28. The ICCL notes the following statement in the explanatory notes under Head 6: "[c]onferring these 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".[53]

29. Under Irish legal and administrative procedures, it is correct that a cause of action around the procedural component of a decision-making process should be open to the Irish High Court under judicial review procedures. Theoretically, this action may be taken by:

    a. The woman;
    b. The father of the child, not married to the mother;
    c. The father of the child, married to the mother;
    d. A third party.

30. Should the woman have a cause of action in administrative law relating the conduct of the review, then she will, as a matter of current constitutional and administrative law, be entitled to seek judicial review.

31. A cause of action by any of these parties raises separate and particular constitutional and administrative issues. However, regardless of the party to a potential cause of action, the Committee should be aware that the European Court of Human Rights has clearly stated that the disclosure of private medical data with respect to pregnancy and abortion services (without legitimate justification) could amount to a breach of Article (right to private and family life).[54] In the event that a third party was given unauthorized access to a pregnant woman's medical information, there is a strong argument that this would constitute a breach of Article 8.

32. This Bill purports to establish a legal framework which will protect the life of the woman in circumstances where there is a risk of death. As such, in circumstances where time will be of the essence, it is essential that a pregnant woman whose life is in danger has access to timely, effective and definitive decision-making. Moreover, a legal framework which enables infringement on that right due to unreasonable delay in accessing a final decision will not be compliant with the *A, B and C* decision.[55]

Recommendation:

Amend Head 6 to include a specific reference to the open and transparent appointment of the HSE Review Panel.

[53] *Explanatory Notes to the Protection of Life During Pregnancy Bill 2013*, p 16.
[54] *P and S v. Poland*, Application No 57375/08, Judgment of 30 October 2012.
[55] See also *Tysiac v. Poland*, *op cit*.

XX. Head 7 (Review where the risk arises from physical illness, not being a risk of self destruction)

33. Under Head 7, a pregnant woman may seek a review a decision not to terminate a pregnancy on grounds of ill health giving rise to a threat to life. This review will be conducted by an obstetrician and doctor on the Specialist register, and may take up to 14 days to complete. The ICCL welcomes the inclusion of Sub-Head (6) which provides for the application of emergency decision-making under Head 3 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 suicide).

Recommendation:

Head 7 should remain unchanged**.**

XXI. Head 8 (Review in case of risk of loss of life through self-destruction)

34. In contrast to Head 7 where the opinion of two doctors is deemed sufficient, for pregnant women facing a real and substantial risk of suicide, three doctors are required to perform the assessment review: one obstetrician and two psychiatrists. Again this follows Head 4 of the Bill by imposing more stringent conditions on women experiencing mental health difficulties rather than physical ill-health.

Number of doctors to review is prohibitive

35. If a woman who is suicidal (or her advocate or GP) considers that termination of the pregnancy is necessary to safeguard her own life and she follows the procedures set out in the proposed legislation to their conclusion, she must be examined by (in addition to her GP who must be consulted where practicable):

    a. Obstetrician/gynaecologist (1) working in an obstetric unit (initial decision);
    b. Psychiatrist (1) working in a psychiatric centre registered with the Mental Health Commission (initial decision);
    c. Psychiatrist (2) working in a psychiatric centre registered with the Mental Health Commission who is also attached to the obstetric unit as set out in a. (initial decision);
    d. Obstetrician/gynaecologist (2) who is a member of the Review Panel (review);
    e. Psychiatrist (3) working in a psychiatric centre registered with the Mental Health Commission;
    f. Psychiatrist (4) working in a centre which is registered with the Mental Health Commission and who is also employed by an obstetric unit.

    For the sake of clarity, it is important to note that psychiatrist (4) must be, under the current provisions in the Bill, both employed by a centre registered with the Mental Health Commission *and* in the case of psychiatrist (4) employed by an obstetric unit and in the case of psychiatrist (2) 'attached to' an obstetric unit. This would suggest that in most instances both psychiatrist (2) and psychiatrist (4) will need to be peri-natal psychiatrists. The Committee should examine this with care to ensure that the proposed scheme will provide timely, accessible and effective access to decision making as is required under the *A, B and C* case. For example, his could have particular implications for women who attempt to access abortion services outside of the large obstetric units.

36. The ICCL points to the judgment of the European Court of Human Rights in *R.R v Poland* where the Court stated that:

> Whilst Article 8 contains no explicit procedural requirements, it is important for the effective enjoyment of the rights guaranteed by this provision that the relevant decision-making process is fair and such as to afford due respect for the interests safeguarded by it.[56]

[56] *R.R v Poland, op cit,* para 191.

Timely access to medical information

37. The Court further found that the "right of access to such information falling within the ambit of the notion of private life can be said to comprise, in the Court's view, on the one hand, a right to obtain available information on one's condition".[57] Although there are defined time limits for the determination of a review (14 days in total), Head 4 of the Bill is silent on the timeframe to be applied in reaching the initial decision. To this end, there is the potential for a delay to the woman in accessing a final decision on her mental health. In this respect, the European Court of Human Rights has stated that, "in the context of pregnancy, the effective access to relevant information on the mother's and foetus' health, where legislation allows for abortion in certain situations, is directly relevant for the exercise of personal autonomy".[58]

Lack of provision for medical emergencies

38. In contrast to Head 7(6), Head 8 does not contain an express provision applying the emergency procedures in Head 3 should the need arise. However, it could take up to 14 days for a medical review to be completed, in cases where there is a risk of suicide for the woman. [59] This is the same timescale as that applicable where the risk is of a physical nature. It appears to place physical ill-health on an elevated position on the hierarchy of ill-health (by providing for emergency situations) and fails to adequately address the differences in monitoring the physical or mental health difficulties of a woman. For example, such an extended timescale gives rise to questions as to the care given to a woman who claims suicidal ideation? Will doctors be forced to involuntary detain pregnant women under the Mental Health Act 2001[60] during the timescale allowed for the review process? If a pregnant woman were detained while waiting a review decision, such a deprivation of liberty carries with it certain procedural requirements under the Constitution and the European Convention on Human Rights, including a review of that detention under the
Mental Health Act 2001.[61]

Recommendations:

- Amend Head 8 to require a review process which is comparable to that where the risk posed is physical in nature i.e. the Review should be conducted by one obstetrician and one psychiatrist. Head 8 should be further amended to allow *attachment* of the relevant psychiatrist to the obstetric unit rather than requiring *employment* at the unit.
- Head 3 of the Bill governing cases of medical emergency should also apply in situation where the risk to life results from suicidal intent.

[57] Para 197. Timely access to a medical diagnostic service – insert references *to P and S v. Poland.*
[58] *R.R v Poland*, *op cit*, para 197.
[59] See Heads 8(2) and (3).
[60] Mental Health Act 2001, section 3.
[61] Mental Health Act 2001, Part 3.

XXII. Head 12 (Conscientious Objection)

39. The ICCL considers that the issue of conscientious objection in relation to medical ethics is one primarily one for the governing medical body in each profession. The Convention provides for the right of conscientious object subject to limitations. The ICCL is of the view that service providers in receipt of public monies should provide legally available public services to service users, including where a medical patient has a right to access an abortion.

40. The Irish Constitution contains explicit provisions protecting freedom of religion. Article 44.2.1 of the Constitution affords citizens the right to freely express their conscience as well as the profession and practice of their religion subject to public order and morality. Any restriction on this right must be proportionate under the Constitution: that is, the restriction must be rational, intrude as little as possible and be proportionate to the aim that it seeks to achieve.[62] Article 44.2.3 also provides that the State cannot discriminate against any person on the grounds of religious beliefs.[63] However, this does not mean that any "distinction necessary to achieve this overriding objective will be valid".[64] The free practice of religion is subject to public order and morality[65] and restrictions must be proportionate bearing in mind constitutional rights and the common good.

41. The right to freedom of thought, conscience and religion is protected under Article 9 of the ECHR. This is an absolute right and cannot be curtailed by any State or individual action. Again, however, the freedom to manifest one's religion or belief under Article 9(2) is qualified and therefore, may be justifiably limited. Any restriction must be set down in law and necessary in a democratic society in pursuit of one or more of the following legitimate aims: the interests of public safety, protection of public order, health or morals or the protection of the rights and freedoms of others.

42. On the face of it, Head 12 provides a route through which doctors and other health professionals may refuse to carry out an abortion on the grounds of freedom of conscience and religion, in manner compatible with the Constitution and the ECHR. Head 12 (4) provides that the conscientious objector "will have a duty to ensure that another colleague takes over the care of the patient as per current medical ethics". While noting the imposition of this duty of care under medical ethics, given the gravity of the circumstances, the ICCL considers a duty of care on doctors and other health professionals to ensure that the care of the woman is transferred expeditiously to another practitioner should be set down in law. In fact in this respect, a time limit may be required in the legislation to prevent Head 12 from falling foul of the jurisprudence of the European Court of Human Rights which has categorically stated that:

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[62] *Heaney v. Ireland* [1994] 3 IR 531.
[63] *Quinn's Supermarket Ltd. v. Attorney General* [1972] IR 1. *Re Article 26 and the Employment Equality Bill 1996* [1997] 2 IR 321 at p. 358.
[64] Casey (2000) *Constitutional Law in Ireland*, Thomson & Maxwell, 3rd Ed, at p. 698.
[65] *The People (DPP) v. Draper* (1988) Irish Times, 24 March and *Murphy v. Independent Radio and Television Commission* [1999] 1 IR 12.

> States are obliged to organise their health service system in such a way as to ensure that the effective exercise of freedom of conscience by health professionals in a professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation.[66]

43. Under the ECHR, Ireland must ensure that doctors and other health professionals are not obliged to carry out services to which they object and put in place a "mechanism by which such refusal can be expressed". However, this mechanism must include,

> "[E]lements allowing the right to conscientious objection to be reconciled with the patient's interests, by making it mandatory for such refusals to be made in writing and included in the patient's medical record and, above all, by imposing on the doctor an obligation to refer the patient to another physician competent to carry out the same service".[67]

44. Furthermore, the ICCL is concerned that Head 12 is silent on the position of a conscientious objector with respect to future decision-making on a woman's need to access an abortion. If a conscientious objection has been noted, there should be a requirement that this be forwarded to the HSE official overseeing the Review Panel.[68] If a conscientious objector were involved in a review process, it is likely that a challenge would be open to their objectivity. The principles of natural and constitutional justice require public decision-makers to be free from any apprehension of bias.[69] In order to bring the requisite clarity and speed to the review process, there should be an express exclusion for medical practitioners who have previously made a conscientious objection. It is highly likely that such a person would be excluded in any event, but express exclusion in the legislation will prevent the need for recourse to the courts to confirm this.

Recommendations:

- Amend Head 12 to include a clause setting out the procedures involved in documenting a conscientious objection and information referral to the HSE.
- Amend Head 12 to impose a duty of care, under law, on a doctor or other health professional to ensure the care of the woman is transferred expeditiously to another doctor/health professional.
- Amend Head 12 to include a clause providing that once a medical practitioner has made the objection, they will be excluded from sitting on a review panel under head 7 or 8.

[66] *R.R. v. Poland*, no. 27617/04, para 206; P and S v. Poland, para 106.
[67] P and S v. Poland, para 107.
[68] Head 6(4).
[69] See the test for apprehended bias set out in *Dublin Well Woman Centre Ltd v Ireland* [1995] 1 ILRM 408, at p.420 *per* Denham J..

XXIII. Head 18 (Repeal and Consequential Amendments) and Head 19 (Offence)

45. The ICCL welcomes the repeal of sections 58 and 59 of the Offences against the Person Act 1864. However, Head 19 provides for the continued criminalisation of a pregnant woman, with potential imprisonment up to 14 years. The Explanatory Notes to the Bill state that this provision is necessary to reflect the State's constitutional obligation arising from Article 40.3.3.

46. Under Article 12 of its General Recommendation 24, the Committee for the Elimination of All Discrimination against Women provides that punitive provisions imposed on women who undergo abortions should be removed.[70] Its rationale centres on the argument that abortion is a medical procedure that only women need and States have an obligation not to put barriers in place that prevent women's access to appropriate health care. The Committee has explicitly cited laws that criminalise medical procedures only needed by women and that punish women who undergo these procedures.[71] The potential application of a criminal penalty of this magnitude to a pregnant woman is grossly disproportionate to the legitimate aim of seeking to prohibit unlawful termination of pregnancy.

47. Furthermore, in 2011, the UN Committee against Torture has indicated that Ireland may be in breach of the Convention should the risk of criminal prosecution and imprisonment continue to face women and their physicians with respect to accessing abortion.[72]

Recommendation:

Amend Head 19 to include specific reference to the exclusion of the pregnant woman in the applicability of any offence set out in the Bill.

[70] 31(c)
[71] For example under general recommendation 24, see http://www2.ohchr.org/english/bodies/cedaw/index.htm.
[72] Committee against Torture, Forty-sixth Session, 9 May - 3 June 2011, UN Doc CAT/C/IRL/CO/1, para 26.

XXIV. Proposed Application of a Sunset Clause

48. Sunset clauses are used throughout common and civil law jurisdictions. However, it is worth considering the type of legislation to which they are applied. Typically, as is also the case within this jurisdiction, sunset clauses are applied to legislation containing measures which run to the edge of constitutional and human rights protection and with specific security or corporate implications for the State. They are commonly conceived to be a "safeguard against panicked and ill-conceived legislation". Having waited 21 years since the *X* case, there is no doubt that the introduction of this Bill is neither panicked nor ill-conceived. In Ireland, sunset clauses have been applied to the Offences against the State Acts 1939 and 1988 and the Criminal Law (Amendment) Act 2007.

49. The provisions of the Bill do not project the startling potential of misuse or infringement of constitutional rights. Rather the Bill sets out, rather faithfully, a legislative statement of the current constitutional position regarding access to termination of pregnancy in the State.

50. Moreover, to suggest to the Committee of Ministers of the Council of Europe, that Ireland is seeking to comply with the European Convention on Human Rights (ECHR) for a certain limited period of time will not satisfy the principle of subsidiarity nor our obligations under the ECHR.

Recommendation:

The Bill should not be amended to include a sunset clause.

XXV. Access to Terminations for Medical Reasons

51. As set out in our evidence to the Committee on 9 January 2012, the ICCL feels obliged to point out that the State's obligations in relation to abortion under the Convention run deeper than merely implementing the judgment in *A, B and C*.

52. The most recent case law from the European Court of Human Rights on the issue of reproductive rights, as set out, *inter alia*, in the cases of *RR v Poland*[73]and *P and S v Poland*[74] indicates that Council of Europe states are obliged to ensure that the women seeking lawful terminations are not exposed to inhuman and degrading treatment contrary to Article 3 of the Convention. Applying this principle in an Irish context, it seems clear to the ICCL that the current treatment of women with pregnancies involving a defined set of fatal foetal abnormalities (i.e. where it is clear that carrying a foetus to term will not result in a viable life) potentially falls foul of Article 3 of the Convention.

53. The ICCL considers that it is constitutionally permissible under Irish law to provide for the termination of such pregnancies (i.e. without a violation Article 40.3.3). In the case of *D v Ireland*[75] the Irish Government argued before the European Court of Human Rights that it was possible to interpret Article 40.3.3 as permitting termination of pregnancy in cases of fatal foetal abnormality. The European Court of Human Rights agreed that such an interpretation by the Irish Courts was possible.

54. The ICCL also notes that the Expert Group Report lists a number of other scenarios in which lawful terminations are available in most other European states, including in cases of rape, incest and threats to the health of the woman not amounting to a threat to her life. The ICCL accepts that the current constitutional framework prevents the development of Irish law to include such situations. The ICCL hopes to see, in the future, a referendum to change this constitutional position sufficiently to enable the introduction of a progressive and human rights based approach to protecting the lives and health of pregnant women in Ireland.

Recommendation:

To ensure that Irish law is in complete compliance with the European Convention on Human Rights, the Committee should consider the inclusion of a clause in the Bill to allow for the lawful termination of pregnancy where a fatal foetal abnormality has been diagnosed.

[73] Application No.27617/04, Judgment of 26 May 2011; (2011) 53 EHRR 31.
[74] Application No. 57375/08, Judgment of 30 October 2012.
[75] Application No. 26499/02, Decision on admissibility of 27 June 2006; (2006) 43 EHRR SE 16.

XXVI. International Human Rights Standards

55. The provision of legal and regulatory systems which establish the circumstances in which abortion can be carried out is in line with – and indeed required by - international human rights standards. This is evidenced by the judgment set down by the legally binding judgement of the European Court of Human Rights in the *A, B and C* case. Here the Court found that the 'lack of effective and accessible procedures to establish a right to an abortion' under Article 40.3.3, 'has resulted in a striking discordance between the theoretical right to a lawful abortion in Ireland on grounds of relevant risk to a woman's life and the reality of its practical implementation'[76].

56. Under Article 46 of the European Convention on Human Rights (ECHR), Ireland is legally obliged to implement the judgment of the European Court of Human Rights in the *A, B and C* case. As the Committee will be aware, the Irish government is required to report its progress on implementation to the Committee of Ministers of the Council of Europe.

57. Although only of persuasive effect in the Irish Courts, the Committee may wish to note that Ireland's record on access to abortion has also been examined within the UN human rights framework (these standards are often used to inform the deliberations of the European Court of Human Rights).

58. In 2011, the UN Committee against Torture (CAT) made the following recommendation to Ireland:

> The Committee urges the State party to clarify the scope of legal abortion through statutory law and provide for adequate procedures to challenge differing medical opinions as well as adequate services for carrying out abortions in the State party, so that its law and practice is in conformity with the Convention.[77]

59. Specifically highlighting potential violations of Articles 6 and 26[78] of the Convention, it is important to note that this Committee examines the most serious of alleged violations – that of torture as well as inhuman and degrading treatment or punishment. As such, the threshold of applicability of rights under the Torture Convention is one of the highest. The Committee has voiced particular concerns around the criminalisation of women and doctors, and this is discussed further herein (section XI).

60. Similarly, the UN Human Rights Committee also has urged Ireland towards legislative reform in this area in order to "bring its abortion laws into line with the Covenant". This includes the protection of the right to privacy (Article 17), the prohibition on cruel, inhuman or degrading treatment or punishment (Article 7), right to a remedy and non-discrimination (Article 2).[79] In 2000, the Committee expressed its concern that "the circumstances in which women may lawfully obtain an abortion are restricted to when the life of the mother is in danger and do not include, for example, situations where the pregnancy is the result of rape".

61. 2005 and 1999 saw additional recommendations by the UN Committee on the Elimination of Discrimination against Women (CEDAW). In 2005, the Committee urged Ireland:

[76] *A, B and C, op cit*, para 264.
[77] *Committee against Torture, op cit*, para 26.
[78] These provisions relate to the procedural rights to make a complaint.
[79] Under General Comment No. 28, the Committee seeks information on whether the "State party gives access to safe abortion to women who have become pregnant as a result of rape (paragraph 11).

> [T]o continue to facilitate a national dialogue on women's right to reproductive health, including on the very restrictive abortion laws. It also urges the State party to further strengthen family planning services, ensuring their availability to all women and men, young adults and teenagers.[80]

62. Should legislation not be forthcoming or legislative measures fall short of the *X* parameters, Ireland will continue to fall foul of international human rights standards.

[80] Committee on the Elimination of Discrimination against Women, Thirty-third session , 5-22 July 2005, para 39.

Recommendations by the Irish Family Planning Association to the Oireachtas Health Committee in relation to the General Scheme of the Protection of Life During Pregnancy Bill 2013

(Heads of Bill)

RECOMMENDATION 1

Head 1 - Interpretation

The Heads of Bill unduly limit the scope of the Oireachtas to address the needs of women who have received a diagnosis of foetal abnormality incompatible with life outside the womb.

Recommendation

The Oireachtas Health Committee must revisit the definition of "unborn" and ensure that no definition in the legislation when enacted has the consequence of limiting the scope of the Oireachtas to introduce therapeutic abortion in cases of fatal foetal abnormality.

RECOMMENDATION 2

The Heads of Bill do not place sufficient emphasis on duty of care to ensure access to a lawful treatment and thereby fail to ensure legal certainty and the guarantee of practical and effective exercise of a constitutional right.

Recommendation

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

Head 2 should be amended to place a duty of care on the Health Services Executive to facilitate speedy access to appropriate services when a risk to life first presents and should include specific reference to minors, migrant women and women living in poverty. Consistently with Heads 15 and 16, which apply to the making of regulations of certification of opinion and notifications to the Minister respectively, a new head, "Regulations respecting the establishment of referral pathways" should be inserted. This Head should state that the Minister shall make regulations regarding timely and appropriate referral pathways from primary to tertiary care, including self-referral.

RECOMMENDATION 3

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

The Heads of Bill do not include sufficient safeguards to ensure that a woman will not experience undue delays in referral for examination by a medical practitioner at an appropriate location.

Recommendation

Head 2 should specify that referral to a medical practitioner at an appropriate location should be made within 2 days. The certifying consultants must examine the woman within 5 working days of such referral; the termination should be carried out within 5 days of a decision that as a matter of probability there is a real and substantial risk to life.

RECOMMENDATION4

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

The language used in the Heads of Bill should reflect the aim of ensuring access to the right to a lawful medical treatment.

Recommendation

Where the phrase "it is not an offence" is used in Head 2, subhead (1) (and also in Head 3, subhead (1 and Head 4, subhead (1)), it should be deleted and replaced with "it shall be lawful".

RECOMMENDATION 5

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

In order to give sufficient clarity to women and their doctors: Head 2 must not only refer to "real and substantial risk to life", but also include the full X case criteria.

Recommendation

All references to "real and substantial risk" should be qualified by the phrase "as a matter of probability". Head 2 should be renamed: Risk of Loss of Life from Physical Illness, Not Being Immediate or Imminent, Not Being a Risk of Self Destruction.

RECOMMENDATION 6

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction (and Head 4)

The Heads of Bill create an unnecessary additional obstacle to access to appropriate care and could render the legislation impractical and ineffective. The legislation must give the woman a more active role in the decision making process.

Recommendation

Head 2, subhead 3 (a) and Head 4, subhead 2 (a) which require mandatory consultation with a woman's general practitioner must be deleted and replaced with a provision that a qualified doctor of the pregnant woman's choosing may, with the pregnant woman's consent, consult with the doctors who are empowered to certify that a risk to life exists.

RECOMMENDATION 7

Head 4 - Risk of Loss of Life from Self Destruction

The provisions of Head 4 place unjustifiable obstacles in the path of a woman in a situation where risk to life arises because of threat of suicide.

Recommendation

Head 4 should be amended so that the number of doctors required to certify a risk to life should be the same as in Head 2. Recommendation 5 in relation to the requirement to consult a general practitioner also applies to Head 4.

RECOMMENDATION 8

Head 6 - Formal Medical Review Procedures

The timeframe specified in Head 6 in relation to formal medical review procedures is too lengthy and could unduly delay a woman's access to a lawful termination.

Recommendation

The legislation should provide that once an application for an appeal is made, a decision should be given within no more than 3 days. The review committee must be required to notify to the woman not only the outcome of the review, but also the reasons for the decision.

RECOMMENDATION 9

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

The review process where risk to life arises because of threat of suicide is more onerous than in the case of physical threat to life.

Recommendation

The number of doctors required to review a refusal to certify a risk to life should be the same whether the risk arises from mental or physical health. The legislation should provide that once an application for an appeal is made, a decision should be given within no more than 3 days. The review committee must be required to notify to the woman not only the outcome of the review, but also the reasons for the decision.

RECOMMENDATION 10

Head 9 - General Provisions for Committee

The general provisions are insufficiently clear and do not include sufficient safeguards for a woman who makes an application for a review of a decision under Head 2 or Head 4.

Recommendation

The legislation must require that a woman who makes an application for a review of a decision under Head 2 or Head 4 is furnished with copies of any direction under this head and guaranteed access to any "document or thing" sought by the review committee by way of direction.

RECOMMENDATION 11

Head 12 - Conscientious Objection

Conscientious objection has been used in many countries to frustrate, delay or refuse access to lawful abortion; in the case of life-saving treatment it is especially important that women are not refused care because of the exercise of conscientious objection.

Recommendation

Head 12 must be amended to ensure that doctors who have an objection to abortion must be under a duty of care to ensure that the woman is referred to another doctor who does not have such an objection.

RECOMMENDATION 12

Head 19 - Offence

The IFPA is of the view that the retention of severe criminal penalties for both women and their doctors is ineffective, disproportionate and inconsistent with the State's obligations under the European Convention on Human Rights, and international human rights law generally. The inclusion of the very heavy maximum penalty of fourteen years will not only maintain, but substantially reinforce, the chilling effect.

Recommendation

The Oireachtas Health Committee must take into consideration the impact and appropriateness of criminal sanctions in relation to women and revisit the inclusion of pregnant women among those to whom criminal liability may apply.

RECOMMENDATION 13

Head 19 Offence

The IFPA is of the view that the phrase "destroying unborn human life" is open to interpretations which could have implications beyond the aim of the Heads of Bill.

Recommendation

The word "destroying" should be deleted and replaced with the word "ending".

Submission by the Irish Family Planning Association to the Oireachtas Health Committee in relation to the General Scheme of the Protection of Life During Pregnancy Bill 2013 (Heads of Bill)

Executive Summary

The Irish Family Planning Association (IFPA) is Ireland's leading sexual health charity. The organisation promotes the right of all people to sexual and reproductive health information and to dedicated, confidential and affordable healthcare services. The IFPA makes this submission based on its experience in providing information, counselling and medical health care to women and girls living in Ireland who are forced to travel abroad to access safe abortion services.

The IFPA has a particular standing in relation to the A, B and C v Ireland case at the European Court of Human Rights. The IFPA provided professional, specialist counselling and emotional support to the three applicants. The IFPA was not a formal applicant in A, B and C v Ireland, but assisted the applicants' legal team with respect to administration and coordination of the case.

The IFPA makes this submission based on this experience as a medical and counselling services provider to assist the Oireachtas Health Committee in its discussion of the proposals contained in the General Scheme of the Protection of Life During Pregnancy Bill 2013 (Heads of Bill).

The IFPA submission makes 13 recommendations (listed separately) for amendments to the Heads of Bill. These recommendations are intended to support the Committee process of amending the legislation so that it will provide sufficient legal certainty and safeguards to satisfy the Council of Europe which monitors the implementation of the judgment under its enhanced supervision procedure.

The IFPA's recommendations fall under the following areas of concern

1. Definitions/interpretation

It is the view of the IFPA that The definition of "unborn" in Head 1 limits the scope of the government to introduce measures to allow terminations in cases of foetal abnormality incompatible with life. (Recommendation 1)

It is of great concern that the Supreme Court judgment in the X case is only partially reflected in the Heads of Bill, which refers to "real and substantial risk", but omits, except in the explanatory notes, to specify that it is not necessary that medical practitioners are of the opinion that the risk is immediate or inevitable. (Recommendation 5)

2. Referral pathways

As a primary medical services provider, the IFPA's particular concern is that women who fall within the criteria of the X case are assured of access to appropriate services. To ensure compliance with international human rights law and ensure that all women can exercise their right under the Constitution, the legislation must guarantee clear referral pathways for terminations that take place under Head 2. (Recommendation 2)

3. Timely access to a life-saving procedure

Delayed access to services and lack of public awareness are strongly associated with subsequent adverse health outcomes. Delays in decision-making could make the difference between a minor procedure and a more invasive procedure that would involve more risk for a woman whose health is already compromised.

The Heads of Bill must also specify clear timeframes for access to the examination by two consultants which is required for certification that risk to a pregnant woman's life exists. The Heads of Bill must also be amended to reduce the maximum time allowed for a review and decision by an appeal committee in cases where there is a difference of opinion between doctors or between a woman and her doctors. (Recommendation 3, 8 and 9)

4. Chilling effect

The IFPA is of the view that the language used in the Heads of Bill is not consistent with a guarantee of access to the exercise of a right. The term "lawful", is more appropriate language to give legal certainty to doctors and to reassure pregnant women that they are both protected by the law and guaranteed access to services. (Recommendation 4)

The IFPA is of the view that the retention of severe criminal penalties for both women and their doctors is ineffective, disproportionate and inconsistent with the State's obligations under the European Convention on Human Rights, and international human rights law generally. The inclusion of the very heavy maximum penalty of fourteen years, which could apply to pregnant women and to doctors will not only maintain, but substantially reinforce, the chilling effect. (Recommendation 12 and 13)

5. Women's wishes central to decision-making

The pregnant woman's wishes and views must be central to any decision-making about a pregnancy that involves risk to her life. The IFPA is concerned that some provisions in the Heads of Bill appear to override a woman's consent. For example, Head 2 requires that a woman's general practitioner be

consulted, but does not specify that such consultation can only be with the woman's consent. Rather than impose a mandatory additional layer of consultation, the legislation must give the woman a more active role in the decision making process and allow her, if she so wishes, to nominate a qualified doctor to be consulted by the medical practitioners who are empowered to certify that a risk to a her life exists. (Recommendation 6 and 10)

6. Provisions relating to risk to life because of threat of suicide

The Heads of Bill require that while two doctors can certify that a real and substantial risk exists in the case of physical threat to a pregnant woman's life, in the case of mental health grounds, three doctors must make the decision. The IFPA believes that the higher number of doctors and the requirement of unanimity place unwarranted obstacles in the path of a woman seeking life-saving medical care. The diagnosis of expressed suicide intent is a routine process for psychiatrists and the requirement of a second psychiatrist when this does not occur when a pregnancy is not involved has no justification. Imposing a different standard of decision-making in cases where the risk arises from threat of suicide risks stigmatising mental health conditions. (Recommendation 7)

7. Conscientious Objection

Conscientious objection has been used in many countries to frustrate, delay or refuse access to lawful abortion. The Heads of Bill place some necessary limits on its exercise. But they do not place sufficient duty on a doctor who refuses to perform a lawful termination to save a woman's life to ensure that the procedure is carried out by another doctor. The IFPA is concerned that the provisions in this head do not provide adequate safeguards against refusal of care and do not sufficiently ensure women's access to life-saving treatment. Subhead 4 does not place sufficient duty on a doctor who exercises conscientious objection to ensure timely referral so that a termination can take place. The IFPA is concerned at the change in language in subhead 4—the duty is to "ensure that another colleague takes over the care", rather than ensuring that the procedure is carried out. (Recommendation 11)

Irish Family Planning Association Submission to the Oireachtas Health Committee May 2013

Submission by the Irish Family Planning Association to the Oireachtas Health Committee in relation to the General Scheme of the Protection of Life During Pregnancy Bill 2013 (Heads of Bill)

The Irish Family Planning Association (IFPA) is Ireland's leading sexual health charity. The organisation promotes the right of all people to sexual and reproductive health information and to dedicated, confidential and affordable healthcare services. The IFPA makes this submission based on its experience in providing information, counselling and medical health care to women and girls living in Ireland who are forced to travel abroad to access safe abortion services.

In 2012, IFPA medical clinics provided sexual and reproductive health services to over 19,000 clients, and provided information and support to almost 5,000 women and girls experiencing pregnancies that were unplanned, unwanted or that had developed into a crisis because of changed circumstances.

The Heads of Bill aim to implement the 2010 ruling of the European Court of Human Rights in A, B and C v Ireland that the failure to give effect to the limited constitutional right to terminate a pregnancy lawfully within the State where there is risk to a woman's life which was outlined by the Supreme Court in the X case in 1992 is a violation of the European Convention on Human Rights.

The IFPA has a particular standing in relation to the A, B and C v Ireland case at the European Court of Human Rights. The IFPA provided professional, specialist counselling and emotional support to the three applicants. The IFPA was not a formal applicant in A, B and C v Ireland, but assisted the applicants' legal team with respect to administration and coordination of the case.

The IFPA welcomes the Government's decision to implement the A, B and C judgment by way of legislation. To fulfil Ireland's obligations under the Convention, the legislation must give absolute clarity that abortion to save a woman's life is lawful. It should guarantee the right to appropriate services within the State as guaranteed by the Constitution. It should place a duty of care on the Health Service Executive in this regard.

The IFPA makes this submission based on this experience as a medical and counselling services provider to assist the Oireachtas Health Committee in its discussion of the proposals contained in the General Scheme of the Protection of Life During Pregnancy Bill 2013 (Heads of Bill).

This submission makes 12 recommendations for amendments to the Heads of Bill. These recommendations are intended to support the Committee process of amending the legislation so that it will provide sufficient legal certainty and safeguards to satisfy the Council of Europe which monitors the implementation of the judgment under its enhanced supervision procedure.

The submission is in the format of a head-by-head analysis of the Heads of Bill.

RECOMMENDATION 1

Head 1: Interpretation.

The Heads of Bill unduly limit the scope of the Oireachtas to address the needs of women who have received a diagnosis of foetal abnormality incompatible with life outside the womb.

Recommendation

The Oireachtas Health Committee must **revisit the definition of "unborn"** and ensure that no definition in the legislation when enacted has the consequence of limiting the scope of the Oireachtas to introduce therapeutic abortion in cases of fatal foetal abnormality.

Supporting evidence

The IFPA is of the view that the definition of "unborn" as "human life means following implantation until such time as it has completely proceeded in a living state from the body of the woman" is unduly restrictive and has the effect of affording equal protection to a non-viable foetus as to a woman.

The explanatory note states that the definition is based on the Supreme Court judgment in Roche v Roche & Others, which "deemed that embryos acquire legal protection under Article 40.3.3 of the Constitution only from the moment of implantation". In Roche v Roche the protection to the unborn provided under the Constitution was deemed by the Supreme Court not to include an embryo that has not implanted in the womb. The IFPA is of the view that the restrictive definition in Head 1 is not in fact required by case law or necessary to vindicate the rights of the unborn under Article 40.3.3.

The Irish state has in fact argued to the contrary before the European Court of Human Rights in 2006 in D v Ireland. In that case, a woman who was pregnant with twins, one of which died within the womb and one was diagnosed with Edwards Syndrome, argued that Ireland's ban on abortion in the case of fatal foetal abnormalities violated the European Convention on Human Rights.

The State argued that there was "at least a tenable' argument" that the that right to life is not actually engaged in the case of a foetus that has no prospect of life outside the womb and that such a foetus may not be considered 'unborn' for the purposes of Article 40.3.3.

The European Court of Human Rights accepted that there was a possibility that the Irish Supreme Court could rule that termination of pregnancy could take place lawfully in the State in these circumstances. The definition proposed in Head 1 would appear to close off this possibility.
Such an outcome of the legislation would be devastating to the clients of the IFPA and other women who have received a diagnosis of severe foetal abnormality. Many women in these circumstances see no alternative but to avail of costly private treatment in the UK, and they express anger at the lack of appropriate, compassionate services within the State and what they experience as abandonment by the health service in Ireland.
The case law of the UN Human Rights Committee indicates that failure to provide for terminations of pregnancy in the case of severe foetal abnormality inconsistent with life outside the womb may give rise to liability under international human rights law. In the 2005 K.L. v Peru case, K.L. a 17-year-old, was pregnant with an anencephalic foetus and was denied an abortion. Although Peruvian abortion law permits abortion when the life or health of the mother is in danger, K.L. was denied an abortion and had to deliver the baby and breastfeed her for the four days she survived. K.L.'s pregnancy severely compromised her life by endangering her physical and psychological health during the second half of her pregnancy (when she desired but was denied an abortion). The United Nations Human Rights Committee found that this constituted cruel, inhuman and degrading treatment by state officials and was a clear violation of international standards prohibiting violence against women and was a violation of the International Covenant on Civil and Political Rights.

The UN Special Rapporteur on Torture and Cruel, Inhuman and Degrading Treatment in his April 2013 report highlighted that denial of abortion in certain circumstances may cross the threshold into cruel, inhuman and degrading treatment.
Further cases relating to the denial of abortion in cases of foetal abnormality may well come before the Irish courts and the international human rights monitoring committees.

RECOMMENDATION 2

The Heads of Bill do not place sufficient emphasis on duty of care to ensure access to a lawful treatment and thereby fail to ensure legal certainty and the guarantee of practical and effective exercise of a constitutional right.

Recommendation 2

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

Head 2 should be amended to place a duty of care on the Health Services Executive to facilitate speedy access to appropriate services when a risk to a pregnant woman's life first presents and should include specific reference to minors, migrant women and women living in poverty.
Consistently with Heads 15 and 16, which apply to the making of regulations of certification of opinion and notifications to the Minister respectively, a new head, "Regulations respecting the establishment of referral pathways" should be inserted. This Head should state that the Minister **shall** make regulations regarding timely and appropriate referral pathways from primary to tertiary care, including self-referral.

Supporting evidence

The IFPA knows from our services that women who are concerned about a possible risk to their life tend to present at a primary care setting before the risk becomes imminent. As a medical services provider, the IFPA's particular concern is that women who fall within the criteria of the X case have timely access to appropriate services.
The legislation must ensure that women in the situation of Applicant C in A, B and C v Ireland never again experience the violation of their rights that occurred in her case.
Applicant C was in remission from cancer when she became pregnant. Unaware that she was pregnant she underwent a series of check-ups contraindicated during pregnancy. Upon learning she was pregnant, she was unable to find a doctor willing to make a determination as to whether her life would be at risk if she continued with the pregnancy.
It is critical that women in the situation of Applicant C are guaranteed a referral pathway under the legislation.
The IFPA is also aware that most of the cases that have come before the courts in Ireland have involved minors in the care of the State (e.g. the X case (1992), the C case (1997) and the Miss D case (2007)). While the Heads of Bill define "woman" as a female person of any age, the IFPA is of the view that without specific reference to a duty of care to ensure that young women and girls, particularly those in the care of the State, are facilitated to access speedy care pathways, the legislation will fail to give sufficient legal clarity in regard to such cases and that further cases will come before the courts.

The United Nations Committee on Torture in 2011 expressed its concern that "despite the already existing case law allowing for abortion, no legislation is in place and that this leads to serious consequences in individual cases, especially affecting minors, migrant women, and women living in

poverty (arts. 2 and 16)."
The UN Special Rapporteur on Health, in his 2011 interim report, has criticised the criminalisation of reproductive health services as unduly shifting the burden of exercising the right to health from the state onto the woman—in this case a seriously ill / extremely distressed woman or girl.
Women faced with a possible risk to their life in pregnancy need information on their options and on relevant service provision. Information must include what services local health providers, including general practitioners, must offer and should be in a range of formats and provided in a range of settings.
To ensure compliance with international human rights law and ensure that all women can exercise their right under the Constitution, the legislation must guarantee clear referral pathways and timeframes for terminations that take place under Head 2.

RECOMMENDATION 3

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

The Heads of Bill do not include sufficient safeguards to ensure that a woman will not experience undue delays in referral for examination by a medical practitioner at an appropriate location.

Recommendation 3

Head 2 should specify that referral to a *medical practitioner at an appropriate location* should be made within 2 days. The certifying consultants must examine the woman within 5 working days of such referral; the termination should be carried out within 5 days of a decision that as a matter of probability there is a real and substantial risk to the pregnant woman's life.

Supporting evidence

Delayed access to services and lack of public awareness are strongly associated with subsequent adverse health outcomes. Delays in decision-making could make the difference between a minor procedure that does not require a general anaesthetic and a more invasive procedure. This would involve more risk and more distress for a woman whose health is already compromised and who fears for her life.
However, the Heads of Bill do not stipulate a time-frame within which a termination must take place once a risk to a pregnant woman's life is certified under Head 2.
A woman who is concerned that pregnancy involves a risk to her life must not be subjected to additional stress or risk to her health or life because of delays while waiting for appointments with the two consultants who must certify that a real and substantial risk to her life exists.

RECOMMENDATION 4

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

The language used in the Heads of Bill should reflect the aim of ensuring access to the right to a lawful medical treatment.

Recommendation 4

Where the phrase "it is not an offence" is used in Head 2, subhead (1) (and also in Head 3, subhead (1 and Head 4, subhead (1)), it should be deleted and replaced with "it shall be lawful".

Supporting evidence

The ECtHR in A, B and C v Ireland considered it evident that the serious criminal penalties for having or assisting in an unlawful abortion would constitute a significant "chilling factor" for both women and their doctors, regardless of whether or not prosecutions have been pursued under that Act. The chilling effect has been described by the World Health Organisation as "suppression of actions because of fear of reprisals or penalties".
We return to a consideration of the proposed new penalties in our analysis of Head 19.
In relation to Head 2, the IFPA is of the view that the language used in this head—"It is not an offence"—is not consistent with a guarantee of access to the exercise of a right. The term "lawful", is more appropriate language to give legal certainty to doctors and to reassure pregnant women that they are both protected by the law and guaranteed access to services.

RECOMMENDATION 5

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

In order to give sufficient clarity to women and their doctors: Head 2 must not only refer to "real and substantial risk to life", but also include the full X case criteria.

Recommendation 5

All references to "real and substantial risk" should be qualified by the phrase "as a matter of probability". Head 2 should be renamed: Risk of Loss of Life from Physical Illness, Not Being Immediate or Imminent, Not Being a Risk of Self Destruction

Supporting evidence

Very few of the women who avail of our services do so because of risk to their lives but some women do. The women who come to the IFPA in life threatening circumstances tend to present at an early stage of pregnancy before the risk is imminent. They tend to be women who have had serious

complications during previous pregnancies, or have underlying health conditions and have been advised not to become pregnant. These women have taken a decision to terminate the pregnancy rather than incur the risks their lives. They are not prepared to wait until the risk to their health deteriorates to an immediate risk to their life.

In this context, it is of great concern that the Supreme Court judgment in the X case is only partially reflected in the Heads of Bill, which refers to "real and substantial risk", but omits, except in the

explanatory notes, to specify that it is not necessary that medical practitioners are of the opinion that the risk is immediate or inevitable.

The consequences could be extremely serious for women. Without clear reference to the X case criteria, doctors may believe that they can act only in circumstances of imminent or immediate risk, and may thereby endanger the life or health of a woman who does in fact fall within the X case criteria.

This is a real concern, as the case of Michelle Harte, which was reported in 2010 in The Irish Times, illustrates. Ms Harte had cancer and in the opinion of her doctors required a termination of pregnancy to avert the risk to her life. However, she was refused treatment by a hospital ethics committee on the grounds that the threat to life was not imminent. Ms Harte was obliged to travel to the UK for a termination at a time when she was seriously ill.

RECOMMENDATION *6*

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction (and Head 4)

The Heads of Bill create an unnecessary additional obstacle to access to appropriate care and could render the legislation impractical and ineffective. The legislation must give the woman a more active role in the decision making process.

Recommendation 6

Head 2, subhead 3 (a) and Head 4, subhead 2 (a) which require mandatory consultation with a woman's general practitioner must be **deleted and replaced with** a provision that a qualified doctor of the pregnant woman's choosing may, with the pregnant woman's consent, consult with the doctors who are empowered to certify that a risk to her life exists.

Supporting evidence

Head 2, subhead 3 (a) and also Head 4, subhead 2 (a) require that a woman's general practitioners "*shall*" be consulted by the medical practitioners who are empowered to certify that a real and substantial risk to her life exists.

The pregnant woman's wishes and views must be central to any decision-making about a pregnancy that involves risk to her life. This requirement overrides a woman's consent, which is not required for such consultation, is an invasion of her privacy.

The IFPA is of the view that this proposal has implications for the effectiveness of the proposed legislation. It unnecessarily places involves a **third** doctor in the decision-making process in relation to physical threat to life and a **fourth** doctor in the case of threat on mental health grounds. Such mandatory consultation has no precedent in medical practice or law and could cause additional delays in a woman's access to a lawful termination.

Moreover, this requirement does not reflect reality—many women who experience crisis pregnancy do not consult their GPs; nor is it the case that there is always a GP who can provide additional insight into a woman's medical history.

Rather than impose a mandatory additional layer of consultation, the legislation must give the woman a more active role in the decision making process and allow her, if she so wishes, to nominate a qualified doctor to be consulted by the medical practitioners who are empowered to certify that a risk to her life exists.

RECOMMENDATION 7

Head 4 Risk of Loss of Life from Self Destruction

The provisions of Head 4 place unjustifiable obstacles in the path of a woman in a situation where risk to her life arises because of threat of suicide.

Recommendation 7

Head 4 should be **amended** so that the number of doctors required to certify a risk to a pregnant woman's life should be the same as in Head 2. Recommendation 5 in relation to the requirement to consult a general practitioner also applies to Head 4.

Supporting evidence

In relation to the question of suicide, it is impossible to estimate the number of IFPA clients who fall within the provisions of Head 4. Not all women who attend for crisis pregnancy counselling chose to disclose all their reasons for considering abortion. In the past year, however, two clients have reported suicidal thoughts or have threatened suicide and one client followed through on those threats. Both clients were attending psychiatric services. This small, but significant number of clients

in this situation is consistent with the findings of the Irish Contraception and Crisis Pregnancy Survey 2010 (ICCP-2010): among the findings of this study of 3,002 adults aged 18 to 25 was that 26 women (less than 1%) reported that they had experience of suicidal ideation.
The expert group gave a great deal of consideration to the appropriate legislative and health service response to risk to a woman's life by threat of suicide. The expert group report is absolutely clear that termination of pregnancy is a lawful medical treatment regardless of whether the risk to the woman's life arises on physical or mental health grounds.
The Heads of Bill require that while two doctors can certify that a real and substantial risk exists in the case of physical threat to life, in the case of mental health grounds, three doctors must make the decision. The IFPA believes that the higher number of doctors and the requirement of unanimity place unwarranted obstacles in the path of a woman seeking life-saving medical care.
The diagnosis of expressed suicide intent is a routine process for psychiatrists and the requirement of a second psychiatrist when this does not occur when a pregnancy is not involved has no justification. Nor is there any justification for the mandatory involvement of an obstetrician in the determination of a question outside their field of clinical expertise.
The IFPA is of the view that this proposal would put an extra burden on a woman and her doctor(s) and could cause unnecessary delays in access to treatment, in particular because of the requirement in Head 4, subhead 2(a) that a general practitioner also be consulted.
Imposing a different standard of decision-making in cases where the risk arises from threat of suicide risks stigmatising mental health conditions. Moreover, the provisions of Head 4 also have the potential to reinforce the chilling effect, which was highlighted by the European Court of Human Rights in A, B and C v Ireland.

RECOMMENDATION 8
Head 6 Formal Medical Review Procedures
The timeframe specified in Head 6 in relation to formal medical review procedures is too lengthy and could unduly delay a woman's access to a lawful termination.
Recommendation 8
The legislation should provide that once an application for an appeal is made, a decision should be given within no more than 3 days. The review committee must be required to notify to the woman not only the outcome of the review, but also the reasons for the decision.
Supporting evidence
The judgment in A, B and C v Ireland requires a framework to examine and resolve differences of opinion between a woman and her doctor or between doctors.
The IFPA is of the view that the appeals procedure provided in the Heads of Bill is cumbersome, complex and that the maximum timeframe permitted could unduly delay women's access to the most appropriate and timely treatment.
This is of particular concern given the lack of timeframes and referral pathways already discussed under the recommendations relating to Head 2. Under the proposals as outlined, a woman may find herself in a situation where having already experienced delay in accessing an initial assessment, she is not informed of the result of a review of a decision in her case until the pregnancy has advanced beyond a point where the least invasive termination procedure is no longer an option.
A woman who has been refused a termination under the procedures proposed in Head 2 or Head 4 may be deterred from risking further delay, so that the provision as it is currently proposed may in practice act as a deterrent, rather than as a mechanism to facilitate access to the exercise of a right.
Best international practice in relation to appeals procedures is that a decision is made within 3 days of the receipt of an application.
The expert group gave considerable attention to the requirements for the composition of a review panel and committee. The expert group report outlines the attributes of an appeal process, including that it must be independent, competent and give written decisions in a timely manner, and that the procedures must include the possibility for the woman's voice to be heard.
The Heads of Bill as currently proposed require that the woman be notified of the outcome of the review, but omit to require that she be informed at the same time of the reasons for the decision.

RECOMMENDATION 9
Head 8 Review in case of risk of loss of life through self-destruction
The review process where risk to a woman's life arises because of threat of suicide is more onerous than in the case of physical threat to life.
Recommendation 9
The number of doctors required to review a refusal to certify a risk to a woman's life should be the same whether the risk arises from mental or physical health. The legislation should provide that once an application for an appeal is made, a decision should be given within no more than 3 days. The review committee must be required to notify to the woman not only the outcome of the review, but

also the reasons for the decision.

Supporting evidence

The Heads of Bill require that, in the case of risk to a woman's life when the risk arises because of mental health grounds, a review committee of three must be convened, rather than the two doctors involved in reviewing a case where the risk arises on physical health grounds. These doctors must be unanimous in their decision.

The IFPA is of the view that the appeals procedure proposed in the Heads of Bill is cumbersome, complex and that maximum timeframe specified could unduly delay women's access to the most appropriate and timely treatment.

The IFPA is of the view that there is no justification for the higher number of medical specialists. Moreover, the imposition of a more burdensome process in this case than in the case of physical threat risks the stigmatisation of mental health issues and appears to be informed by a distrust of women's veracity in such circumstances.

Further, the inclusion of two psychiatrists in the decision does not reflect the reality recognised by the Government's expert group that the diagnosis of expressed suicide intent is a routine process for psychiatrists and the requirement of a second psychiatrist when this does not occur when a pregnancy is not involved is not justified.

RECOMMENDATION 10

Head 9 General Provisions for Committee

The general provisions are insufficiently clear and do not include sufficient safeguards for a woman who makes an application for a review of a decision under Head 2 or Head 4.

Recommendation 10

The legislation must require that a woman who makes an application for a review of a decision under Head 2 or Head 4 is furnished with copies of any direction under this head and guaranteed access to any "document or thing" sought by the review committee by way of direction.

Supporting evidence

Head 9 subhead 1 authorises the review committee to "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".

The IFPA is concerned that this proposal is not reflective of fair procedures. The wording is unclear and places no restriction on the documents or things that may be requested, and this may amount to a breach of the woman's right to privacy and confidentiality.

The Heads of Bill must be amended to clarify that all directions by the review committee and all documents or other things produced to the committee will also be made available to the pregnant woman.

RECOMMENDATION 11

Head 12 Conscientious Objection

Conscientious objection has been used in many countries to frustrate, delay or refuse access to lawful abortion; in the case of life-saving treatment it is especially important that women are not refused care because of the exercise of conscientious objection.

Recommendation 11

Head 12 must be amended to ensure that doctors who have an objection to abortion must be under a duty of care to ensure that the woman is referred to another doctor who does not have such an objection.

Supporting evidence

In many countries where abortion is legal, the exercise of conscientious objection has frustrated and delayed women's access to lawful abortion, or women have been refused care. Because the issue in question is refusal of care where there is a risk to a woman's life, the legislation must provide adequate safeguards against refusal of care.

There are some necessary limits on refusal to care in the current proposals. However, subhead 4 does not place sufficient duty on a doctor who exercises conscientious objection to ensure timely referral and ensure access to a lawful termination.

Further, this language raises concerns about women being sent from doctor to doctor, a process which is likely to increase the delay in accessing a termination and exacerbate the stigma and stress that were recognised by the ECtHR as part of the experience of women in Ireland who seek to terminate pregnancies.

The IFPA is concerned at the language in subhead 4—the duty is to "ensure that another colleague takes over the care". Current medical guidelines stipulate that doctors have a duty of care to ensure after-care to women who have abortions.

RECOMMENDATION 12

Head 19 Offence

The IFPA is of the view that the retention of severe criminal penalties for both women and their doctors is ineffective, disproportionate and inconsistent with the State's obligations under the European Convention on Human Rights, and international human rights law generally. The inclusion of the very heavy maximum penalty of fourteen years will not only maintain, but substantially reinforce, the chilling effect.

Recommendation 12

The Oireachtas Health Committee must take into consideration the impact and appropriateness of criminal sanctions in relation to women and revisit the inclusion of pregnant women among those to whom criminal liability may apply.

Supporting evidence

The European Court of Human Rights considered that the existence of criminal penalties for having or assisting in an unlawful abortion constitutes a significant "chilling factor" for both women and their doctors.

The IFPA is concerned that the Heads of Bill do not adequately address the chilling effect highlighted by the European Court of Human Rights, and may, in fact, substantially reinforce it.

The IFPA is of the opinion that the public interest to protect women's health and ensure that vulnerable people are not exploited is not served by the prosecution of pregnant women. Nor is the constitutional protection of the unborn sufficient justification.

The UN Special Rapporteur on the Right to Health has stated, in his 2011 interim report, that the application of criminal and other legal restrictions on abortion is often ineffective and disproportionate.

The extremely high maximum sentence proposed in Head 19, which would apply to anyone who induced an abortion, including a pregnant woman who self-induces an abortion using medication, is neither proportionate nor effective.

The current criminal law does not deter the more than 4,000 women who travel to the UK for abortions each year. Nor does the criminal law deter many other women from resorting to the importation of medication which may then be used incorrectly and without medical supervision or prescription of antibiotics, as is protocol when this medication is used in countries where it is lawful. The law does, however, deter some women in such circumstances from seeking medical advice in cases of any post-abortion complications that arise. Delay in seeking medical advice may result in risk to women's health, or in certain circumstances, her life.

The UN Committee Against Torture in its 2011 report on Ireland noted that "the risk of criminal prosecution and imprisonment facing both the women concerned and their physicians, the Committee expresses concern that this may raise issues that constitute a breach of the Convention Against Torture".

RECOMMENDATION 13

Head 19 Offence

The IFPA is of the view that the phrase "destroying unborn human life" is open to interpretations which could have implications beyond the aim of the Heads of Bill.

Recommendation 13

The word "destroying" should be deleted and replaced with the word "ending".

Supporting evidence

The word "destroy" is potentially open to being interpreted to include actions affecting the development of the foetus in the womb, and as such could lead to the mistaken assumption that the Heads of Bill intend to criminalise certain conduct by a woman during pregnancy.

The UN Special Rapporteur on the Right to Health states in his 2011 interim report that that criminal and other legal restrictions on conduct during pregnancy violate women's right to bodily integrity.

Fiona Tierney <fidoonhop@gmail.com>
08/05/2013 13:53 To
healthandchildren@oireachtas.ie
cc

bcc

Subject

Mr. Kelly, My neighbour has not access to an email, and asked me to post this to you.

Dear Mr. Kelly,
We wish to state our opposition to this Human Life in Pregnancy Bill. In light of all the evidence shown that Ireland continues to be one of the safest places in the world for pregnant mothers and their unborn babies and in view that many psychiatrists have pointed out abortion is not a treatment for suicidal ideation, why then is the government persisting with this bill against the vast majority of views by the very people they are supposed to represent!
Thanking you,
Imelda Bowers,
c/o. The Immaculate Heart House of Prayer
Gurtavalla Sth,
Doon,
Co. Limerick.

"Ingrid Masterson" <ingridmasterson@gmail.com>
07/05/2013 06.43 p.m. To
      <Healthandchildren@oireachtas.ie>
      cc
      <Alex. White@oireachtas.ie>, <Kathleen.lynch@oireachtas.ie>,
<Olivia.Mitchell@oireachtas .ie>, <Alan Shatter
[Alan.Shatter@oireachtas.ie]>, <Shane.Ross@oireachtas.ie>,
<Peter.mathews@oireachtas.ie>
      bcc

      Subject
      Proposed Abortion Law apart from suidical ideation

Dear Committe members debating this new law,

Followng the theme I expressed in my letter below , I am amazed at the almost non-existent coverage of how the law may affect women in the future who find themselves in a postion similar to the late Savita Halapannavar. How will the proposed law promote? allow? timely intervention in the case of a currently healthy woman with certainty of life before her, against that of the extremely uncertain, very limited, or even doomed, life of an unviable or miscarrying foetus? which may be seriously and adversely affecting her health or her life? How will the law balance these incompatible lives?   Will the woman be allowed to die along with her foetus?
Yours sincerely,
Yours truly,

Ingrid Masterson
MSoc Sc; ICP Reg Psychotherapist

-----Original Message-----
From: Ingrid Masterson [mailto:ingridmasterson@gmail.com]
Sent: 19 April 2013 20:51
To: Alan Shatter
Cc: Alan Shatter [Alan.Shatter@oireachtas.ie]
Subject: RE: Abortion Lawa

Dear Minister,

Listening to the inquest findings on the Savita Halapannaver case, I find it incredible that the medical person responsible has to wait until the unfortunate mother is almost at death's door in such a situation, especially when the foetus is not considered to be viable. One of the consutlant witnesses spoke of his experiences of septic abortion where the foetus had in all cases died; ... after rupture of her membranes, Savita was told the pregnancy could not continue.
What kind of nit-picking attitude underpins a law where the mother must deteriorate in health to the point of near death, carrying a doomed baby who it seems must die in the womb rather than outside it, in order to fulfil some legal (Catholic?) logic of correctness? I would not wish such a fate on my daughter--or on any woman.

Please use a sense of proportion and balance in framing more flexible legislation, and trust attending practitioners to use their judgement in each case. I write this as someone who has doubts about the wisdom of abortion in suicidal cases, especially in our Irish context where fully functioning multidisciplinary mental health care is not available to young adults suffering emotional difficulties, thereby making the possiblility of a pregnancy exacerbating already existing fragile mental stability more likely.
[I have never been a midwife though was a former RGN ad RMN].

Yours truly,

Ingrid Masterson
MSoc Sc; ICP Reg Psychotherapist

-----Original Message-----
From: Alan Shatter [mailto:Alan.Shatter@oireachtas.ie]
Sent: 14 December 2012 11:58
To: Ingrid Masterson
Subject: Re: Mental health and A vision for Change

THE IONA INSTITUTE

Submission to the Oireachtas Health Committee concerning the Protection of Life during Pregnancy Bill 2013

May, 2013

The Iona Institute
23 Merrion Square
Dublin 2

info@ionainstitute.ie

www.ionainstitute.ie

t. 01 6619 204

Introduction and Executive Summary

1. The Iona Institute is concerned first and foremost with Head 4 of the Protection of Life during Pregnancy Bill 2013, dealing with the issue of suicide and abortion, and believes this should not be provided for, as direct abortion is a grave injustice.

2. However, as objections to Head 4 will be dealt with by other groups this submission concentrates on Head 12 concerning conscientious objection.

3. We believe Head 12's treatment of conscientious objection is unacceptably restrictive even by the standards of countries with more permissive abortion regimes than our own.

4. We object in particular to the requirement that "no institution, organisation or third party shall refuse to provide a lawful termination of pregnancy to a woman on grounds of conscientious objection."

5. We also object to the requirement that when a woman seeking an abortion presents herself to a pro-life doctor, that doctor will be obliged to refer her to a pro-choice colleague. Such referrals would be both unethical and practically unnecessary.

6. In the first case (point 4 above) the moral autonomy of institutions is being severely undermined. In the second case (point 5 above) freedom of conscience is being severely undermined. In both cases, people will be pressurised to carry out what they consider to be a grave injustice, to deliberately kill the innocent. This kind of pressure can never be acceptable in any decent and free society.

7. We believe that the proposed Bill must respect the ethos of medical institutions which believe that direct abortion is contrary to medical ethics, including institutions that are not religious. We also believe it must respect the consciences of doctors who do not want to facilitate abortion in any way, including by referring patients to pro-choice colleagues.

Freedom of conscience and religion in Irish and international law

Freedom of thought, conscience and religion is a "vital human right" and is protected in the domestic law of liberal democratic societies as well as in international law.

Freedom of conscience and religion are protected by Article 44 of Bunreacht na hEireann.

Article 44.2.1 says: "Freedom of conscience and free profession and practice of religion are, subject to public order and morality, guaranteed to every citizen".

Article 44.5 says: "Every religious denomination shall have the right to manage its own affairs, own acquire and administer property, movable and immovable, and maintain institutions for religious and charitable purposes."

Article 18 of the Universal Declaration of Human Rights 1948 states that: "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 teaching, practice, worship and observance."

This right was later declared in Article 1 of the UN's Declaration on the "Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief."

Article 18(1) of the International Protocol on Civil and Political Rights, ratified by Ireland on 8 December 1989 along with the Optional First Protocol, likewise states that: “Everyone shall have the right to freedom of thought, conscience and religion”, which includes the right to manifest one’s religion or belief in “observance [and] practice.”

The Human Rights Committee has commented on the “far-reaching and profound” nature of this right, as well as its “fundamental character”, reflected in the fact that “this provision cannot be derogated from, even in time of public emergency, as stated in article 4.2 of the Covenant.”

Article 18(3) does place limitations on Article 18(1) and states that: “Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.”

However, the Committee has noted that these restrictions are to be “strictly interpreted” and limitations “may be applied only for those purposes for which they were prescribed and must be directly related and proportionate to the specific need on which they are predicated. Restrictions may not be imposed for discriminatory purposes or applied in a discriminatory manner.”

Recognising the importance of protecting conscience (in the form of conscientious objection from military service), the Committee has stated that whilst “the Covenant does not explicitly refer to a right to conscientious objection...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.”

Freedom of thought, conscience and religion is also enshrined in the European Convention on Human Rights, with Article 9(1) stating that: “Everyone has the right to freedom of thought, conscience and religion”, which includes the right to manifest one’s religion or belief in “practice and observance.”

Once again, the right to manifest one’s religion or belief is qualified, but the limitations are narrow in scope. Indeed, it has been noted that when the Convention was being drafted, “the final draft of Article 9(2) was the narrowest of the proposed articles...”8 Article 9(2) states that: “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 freedom of others.”

The European Court of Human Rights declared in Kokkinakis v Greece that: “As enshrined in Article 9, freedom of thought, conscience and religion is one of the foundations of a “democratic society” within the meaning of the Convention” and “[t]he pluralism indissociable from a democratic society, which has been dearly won over the centuries, depends on it.” Furthermore, the Court considered that without the freedom to manifest one’s beliefs, “Article 9, would be likely to remain a dead letter.”

When can conscience and religious freedom be limited?

No-one is arguing that either freedom of conscience or religion is absolute. They are subject to certain limitations as outlined in the above section.

However, as the above section also makes clear such limitations require a high level of justification.

An interesting and relevant case in this regard came before the British courts recently which is relevant to individual medical practitioners. Called ‘Doogan & Anor v NHS Greater Glasgow & Clyde Health Board’, it involved

two Scottish midwives who argued that their right to conscientious objection should extend to refusing to delegate, supervise or support members of staff who were looking after women undergoing terminations.

The two women were only permitted by their hospital not to help perform the abortion itself.

Finding in favour of the two midwives, the court recognised that abortion is a uniquely controversial aspect of medical practice and that the right of conscientious objection is a right which hospitals have to accommodate.

The court also endorsed a South African Court decision, 'Christian Education SA v Minister of Education (2001) 9 BHRC53', where the Judge said:

"…believers cannot claim an automatic right to be exempted by their beliefs from the laws of the land. At the same time, the state should, wherever reasonably possible, seek to avoid putting believers to extremely painful and intensely burdensome choices of either being true to their faith or else respectful of the law. "

Reasonable accommodation

Head 12 of the proposed legislation is informed by a view which says that once something is declared to be a 'right' a person's ability to vindicate their right must have few if any limitations placed upon it.

Depending on the right in question, this view can easily come into direct conflict with the rights of people with contrary views.

Indeed it may be said that a new morality is being imposed in that a particular view of abortion rights is being endorsed with the full power of the State and those with a contrary view are obliged by law to vindicate that 'right' in almost all circumstances.

The one exemption allowed by Head 12 is that those with a conscientious objection do not have to actually perform an abortion unless it is a 'medical emergency'. This is an extremely limited exemption.

It is more limited than the exemptions which exist in many other Western countries with far more permissive abortion regimes than our own, and it is vastly more restrictive than the expansive view of religious freedom found in a resolution passed by the Parliamentary Assembly of the Council of Europe in 2010.

The European Court of Human Rights is also part of the Council of Europe and is, of course, the court which told us to clarify our law on abortion.

The resolution in question is called, 'The right to conscientious objection in lawful medical care'.

Paragraph one of the resolution reads: "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 or embryo, for any reason."

It should be noted that the above paragraph covers both individuals and institutions, whether religious or not.

To repeat, Head 12 of the proposed law has a far more restrictive view of institutional autonomy and conscientious objection than the above quoted resolution.

Even those who believe abortion is a 'right' should be willing to accommodate in a reasonable manner those who take a contrary view.

It is unreasonable to ask any pro-life medical institution or pro-life medical personnel to facilitate direct abortion in any way.

Conclusion

In view of the above admittedly brief discussion of freedom of conscience and religion, we ask that the proposed Protection of Life during Pregnancy Bill 2013 be amended so as to adopt a more expansive view of freedom of religion and conscientious objection.

We ask that the Bill adopt the view of the court in Doogan & Anor v NHS Greater Glasgow & Clyde Health Board', and by the Parliamentary Assembly in the resolution, 'The right to conscientious objection in lawful medical care.'

Specifically we ask that pro-life doctors not be required to refer women seeking abortions to pro-choice colleagues, as this is both unethical and practically unnecessary. We also ask that medical institutions, whether religious or not, which object to direct abortion be exempted from having to carry out direct abortions, including on the grounds of threat of suicide, as this would be considered a very grave injustice by such institutions. If the law in Ireland is unfortunately changed to allow the deliberate killing of the innocent unborn child, at the very least no person or institution should be pressurised or forced to cooperate directly in this injustice and to compromise their moral, personal and professional integrity.

Submission

on

The Protection of Life during Pregnancy Bill 2013

by

Ireland Stand Up

Ireland Stand Up

www.irelandstandup.org

Submission Closing Date 8th May 2013 @ 5pm

‘Caring for life, from the beginning, to the end,

What a simple thing, what a beautiful thing.

So, go forth and don't be discouraged.

Care for life.

It's worth it!’

(Pope Francis)

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Ireland Stand Up is a voluntary national lay initiative that was founded to defend our Christian Faith and Heritage and to campaign for the reinstatement of Villa Spada, Ireland's Embassy to the Holy See/Vatican Embassy. The initiative is entrusted to Our Lady of Knock, Queen of Ireland. Support for this initiative is spread across the 32 counties of Ireland and among the Irish Diaspora. The closure of our Embassy is seen as part of a secular and ideological agenda that has no mandate. The agenda seeks to remove the status of the Vatican as an independent state, to legalise abortion and euthanasia, to redefine marriage, to undermine faith schools and ultimately religious freedom.

A briefing on our links with the Holy See was attended by 83 politicians on 18th Jan 2012. They were overwhelming in their support for reinstatement of our Embassy. We continue to lobby our public representatives to respect our Christian faith and heritage, to defend and uphold the dignity of life from conception to natural death, to protect the definition of marriage between one man and one woman, to safeguard faith schools and our right to religious freedom.

IrelandStandUp@gmail.com Tel: 087 7678040

Several supporters have contributed to this submission.

If members of the Committee wish to contact the contributors or our spokesperson Mary E. Fitzgibbon you may do so via email or by phone.

Comment:

Ireland Stand Up, in line with the Fine Gael Party commitment given in Feb 2011**(8)** is opposed to the legalisation of abortion. The clarity required by the ECHR ruling can be fulfilled by the introduction of medical guidelines. Ireland is not required by the ECHR to legislate for abortion despite the Tánaiste Eamon Gilmore's erroneous assertion that our government must legislate. International medical evidence now shows that abortion is not a treatment for suicide and thus negates the 1992 Supreme Court Ruling in relation to the x case which did not hear expert psychiatric evidence.

Introduction

Ireland Stand Up fully supports all necessary medical intervention and/or treatment required to save the life of a mother with due consideration given to the equal right to life of the innocent unborn child. Abortion, the result of which is the direct intentional killing of an innocent human being, is distinct from the necessity to intervene to save lives in the course of which it may not be possible to save both the mother and her unborn child.

> *"The fundamental human right, the presupposition of every other right, is the right to life itself. This is true of life from the moment of conception until its natural end. Abortion, consequently, cannot be a human right—it is the very opposite. It is a deep wound in society (Pope Benedict Emeritus XVI)."*

This bill, the title of which is a misnomer, concedes the principle that it is lawful to end the life of an innocent unborn child in the case of suicide which is morally unacceptable. The Bill as outlined represents a dramatic and morally unacceptable change to Irish law and is unnecessary to ensure that women receive the life-saving treatment they need during pregnancy. It is a tragic moment for Irish society when we regard the deliberate destruction of a completely innocent person as an acceptable response to the threat of the preventable death of another person **(1).**

Ireland Stand Up supporters are constituents who come from a variety of professions, legal, medical, health, teaching and engineering who have been involved in life issues for many decades either in respect of our professions or in a voluntary capacity. We would welcome an opportunity to address the Committee in respect of the concerns raised in our submission.

Signed:

Mary E. Fitzgibbon (Spokesperson)

(Contributors: Mary E. Fitzgibbon, Jim O'Sullivan, John Walsh, Anne Doyle, Margaret Hickey, Elaine Carey)

8th May 2013

Executive Summary (includes recommendations for consideration by the Committee and summarised in the concluding remarks)

Definition of unborn

- In the bill a definition of the unborn is determined as being from implantation. In an article by Dr. Dianne Irving a bioethicist **(2)** she states that the "formal definitions used in this new Irish abortion bill are scientifically false," Specifically, the bill defines the term "unborn" "as it relates to human life" to mean "following implantation until such time as it has completely proceeded in a living state from the body of the woman."

  This definition, Irving says, defies the "accurate objective facts of human embryology, known internationally for over 125 years." Quoting the findings of human embryologists, Irving says that what implants into the uterus is not the single-cell embryo – inaccurately called a "fertilized egg" – but an older embryo consisting of about 100 cells.

  "Implantation (5-7 days post-fertilization) is not when the sexually reproduced unborn child begins to exist. That new human being begins to exist at the beginning of the process of fertilization," she said.

- We are concerned that this opens the possibility that embryo stem cell research will be legalised.

  - **The term medical procedure** is being used in several sections of the Bill. The medical procedure in the case of a threat of suicide is being used instead of the term 'abortion'

e.g. (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,

This issue requires clarification in respect of what the intention of the 'medical procedure' is i.e. is it the intention of the medical procedure to result in the killing of the unborn child in the womb, what implications specifically does this term 'medical procedure' have for the unborn child, what duty of care is afforded the unborn child and who will vindicate the right to life of the unborn?

Head 3

- We request clarification in respect of the following which relates to location and circumstances i.e. 'Because of its emergency nature, this termination may be carried out in a location other than a public obstetric unit.'
- What safeguards are there to ensure that private abortion clinics cannot open in the Republic as has happened in the North of Ireland? Will these be unlawful and will immediate legal action be taken to prevent them operating here? There is considerable concern that there may be a conflict of interest for the former head of the Irish Family Planning Association now Director General Designate and Deputy (Acting) CEO of the HSE in respect of his role in relation to the Bill.

Head 4

- (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.

- This action is not supported as an-evidence based intervention for the management of suicidal ideation. It concedes the principle that an innocent human life may be ended which is immoral and unacceptable. The evidence does not support this practice and may predispose the woman to an increase in mental health problems post abortion. This situation does not allow for legal representation for the unborn child. These parts of the bill should be removed, and a commitment given to provide the most effective, evidence-based treatments for pregnant women with suicidal ideation. That would better serve the health and rights of pregnant women and their unborn children **(3, 6).**

- 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 4 requires deletion to come in line with evidence based medicine. The Supreme Court Judgement now 21 years old is outdated.

- If the Oireachtas produced legislation that was consistent with best medical practice omitting suicide as grounds for abortion wouldn't the current Supreme Court find it difficult not to defer to that decision on the grounds that the Oireachtas is in possession of expert knowledge that the Supreme Court in 1992 was denied access to? **(4)**

Head 12

(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.

- Sections 3 and 4 raise serious concerns over religious freedom and freedom of conscience and the requirement to ensure that another colleague takes over care involves formal co-operation in an action that is considered immoral on the part of the health professional. Refusing to take part is legitimate but to have an obligation imposed on the health professional or institution to find a replacement is unacceptable.
  E.g. I don't agree with or participate in abortions but I will hand you over to the care of people who do agree with and facilitate abortions. This is particularly relevant in the case of suicidal ideation. Procurement of abortion is forbidden by the Roman Catholic Church.

  What is most worrying is that a medical practitioner who objects to abortion is required to engage another medical practitioner who does not object to abortion to carry out assessments. This in effect could mean that no woman will ever be denied an abortion as there are health professionals who hold the belief that abortion is a matter of choice.

  - The reality is that there is little that any law framed like the Act can do to provide significant safeguards once the concept of abortion becomes acceptable. Even within the first few years of passing the law in the UK, obstacles were placed in the path of those who wished to progress in Obstetrics and Gynaecology, but who were not prepared to perform abortions. **One promising candidate for a consultant post was turned down in the early seventies, with advice from a professor on the Appointments Committee telling him that there was no place in Britain for a Roman Catholic gynaecologist.** He emigrated to Canada, was subsequently appointed an associate professor and wrote to the BMJ (1976 (i); 1456-8) expressing his dismay at the road that the profession is taking in the UK. The Lane commission which looked at the working of the Abortion Act were sent a dossier of some 8 cases of similar discrimination, but they argued that "the needs of the many must take priority" **(7).**

Two weeks ago the appeal court in Edinburgh overturned a ruling against two catholic Labour Ward Midwifery Sisters and said the UK Abortion Act 1967 gave medical staff wide-ranging protection against taking part in abortions on religious and conscience grounds **(5).**

Lady Dorrian, sitting with Lord Mackay of Drumadoon and Lord McEwan, said: "In our view the right of conscientious objection extends not only to the actual medical or surgical termination but to the whole process of treatment given for that purpose."

The midwives' lawyer, Gerry Moynihan QC, had said it was up to staff rather than their managers to decide what was morally or ethically objectionable to them. Their employers were saying that their administrative convenience over-rode the midwives' right to conscience, he argued.

Moynihan said the right to object covered all their duties, with the exception of helping in life-saving treatments. There was clear legal authority that the right to conscientious objection extended to all the staff involved in preparing or planning for a procedure, he said.

"The administrative convenience of the health board is irrelevant because the right is a balance between facilitating abortion while respecting the genuine conscientious objection of medical, nursing and ancillary staff," he told the court.

- There are voluntary maternity hospitals in Ireland and some have a Catholic ethos, Section 3 of Head 12 constitutes a direct attack on religious freedom.

Concluding remarks

- In our submission due to the extremely short deadline we have raised several but not all of the issues of concern. Our concerns relate to the legalisation of abortion despite a commitment to the contrary by Fine Gael and also clarified in a letter from Joe Costello TD (**8, 9**), the definition of the unborn as being from implantation and implications arising from this i.e. embryo stem cell research, the use of the term **'medical procedure'** as opposed to **abortion** specifically when there is a threat of suicide and what this implies for the unborn child and the duty of care to the unborn, the inclusion of suicide as grounds for abortion which concedes the principle that an innocent human life may be ended up to birth, the need for legal constitutional protection for the unborn in cases of threatened suicide, the necessity to remove this section from the bill, issues related to religious freedom and conscientious objection and matters arising in relation to the views of doctors who do not condone abortion and referral to colleagues who are prepared to co-operate with abortion procedures.

- **We request that our legislators consider the grave and serious nature and consequences of this Bill.**

- **We sincerely hope that they will take into account the common good, and uphold a culture of life with due regard to the equal right to life of the mother and baby.**

References

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2. Dianne Irving, Irish abortion bill would enshrine erroneous definition of life in law: ethicist 6th May 2013 http://www.lifesitenews.com/news/irish-abortion-bill-would-enshrine-erroneous-definition-of-life-in-law

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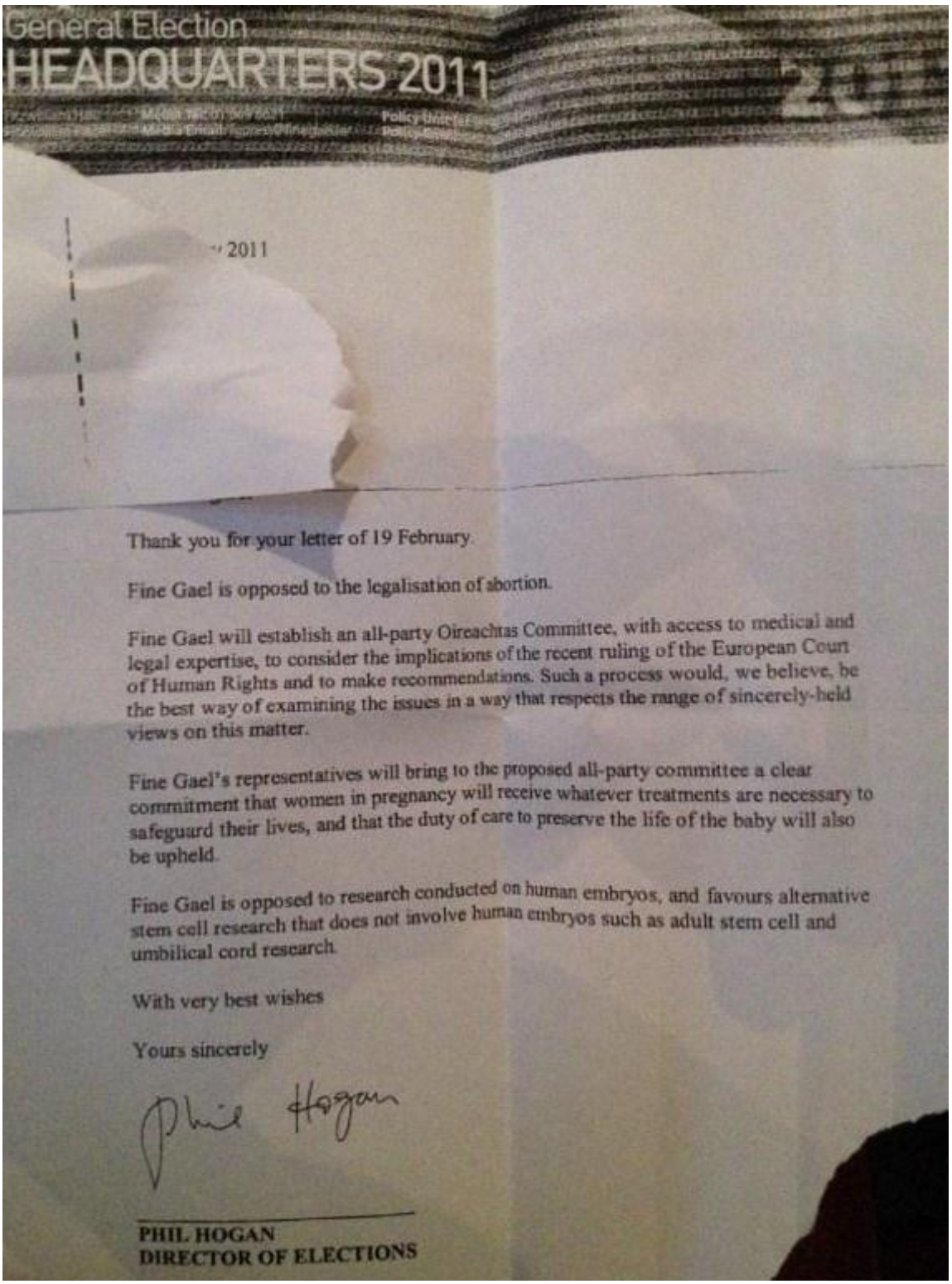
General Election
HEADQUARTERS 2011

2011

Thank you for your letter of 19 February.

Fine Gael is opposed to the legalisation of abortion.

Fine Gael will establish an all-party Oireachtas Committee, with access to medical and legal expertise, to consider the implications of the recent ruling of the European Court of Human Rights and to make recommendations. Such a process would, we believe, be the best way of examining the issues in a way that respects the range of sincerely-held views on this matter.

Fine Gael's representatives will bring to the proposed all-party committee a clear commitment that women in pregnancy will receive whatever treatments are necessary to safeguard their lives, and that the duty of care to preserve the life of the baby will also be upheld.

Fine Gael is opposed to research conducted on human embryos, and favours alternative stem cell research that does not involve human embryos such as adult stem cell and umbilical cord research.

With very best wishes

Yours sincerely

Phil Hogan

PHIL HOGAN
DIRECTOR OF ELECTIONS

9. **Letter from Joe Costello 8 March 2013**

Labour

Dáil Office:
Dáil Éireann,
Kildare Street,
Dublin 2
Tel: 01 6183896 Fax: 01 6184596
Email: joe.costello@oireachtas.ie
Web: www.labour.ie/joecostello

Joe Costello TD
Spokesperson on European Affairs and Human Rights

8 March 2011

Dear Mary

Thank you for your postcard which was forwarded to me by Eamon Gilmore for reply.
Our programme for Government has no mention of abortion.

Yours sincerely

JOE COSTELLO TD

10.

10 Chestnut Hill,

Naas,

Co.Kildare.

086-8841836

8th May 2013

Mr Paul Kelly,

Principal Clerk,

Joint Committee on Health and Children,

healthandchildren@oireachtas.ie

Dear Mr Kelly,

On behalf of the Irish Catholic Doctors Association I attach out submission to the Committee on the Protection of Life in Pregnancy Bill 2013.

I can be contacted at this email or above telephone number or address if necessary.

Further information about our organisation can be found at www.irishcatholicdoctors.com.

Yours sincerely,

Dr John Kehoe,

Chairman ICDA.

Submission on the Outline Heads of the

'Protection of Life During Pregnancy Bill 2013'

To: The Oireachtas Joint Committee on Health and Children
By: The Irish Catholic Doctors Association (ICDA)

Brief introduction to ICDA
The Irish Catholic Doctors Association (ICDA) is a group of physicians from a variety of specialties including but not limited to Obstetrics, Psychiatry, and General Practice, who strive to live the fullness of the Catholic faith through our daily medical practice. We hope to enable other Catholic doctors to do the same through organising meetings with speakers and social meetings also. We are the successors to the Guild of Cosmas and Damian which was established about 70 years ago. In 2012 we hosted the FEAMC Annual Conference in Dublin, *(Federation Européen des Associations Medicales Catholiques/European Federation of Catholic Medical Associations)*.

Submission Summary

1. Doctors are healers.
2. Doctors in treating their patients must always adhere to the principle that it is always and everywhere morally illicit to directly and intentionally kill innocent human life.
3. Heads 4 and 8 which deal with abortion as a treatment for a threat of suicide by the mother must be deleted from the Bill as there is no medical evidence to support abortion as a treatment for suicide.
4. It is a strange paradox that while our modern medicine emphasises the need for evidence of benefit of treatment, that we are now prepared to use abortion a totally unproven remedy for suicide threat.
5. It is very disturbing that the Legal Profession and the Government should dictate to the Medical Profession on clinical decisions and the care of their patients.

.....

Observations on Head 1 Interpretation

'Termination of Pregnancy' is a term that is frequently used in the subsequent Bill and Notes but this term is not included in the 'Glossary of Terms' e.g. a pregnancy can be terminated in a number of different ways, including:

- spontaneous natural miscarriage or spontaneous abortion,
- delivery at term or prematurely,
- by induced early delivery,
- by direct intentional killing of the unborn, which we refer to as **'procured abortion'**.

Suggestion:

We suggest that when referring to 'direct intentional killing of the unborn', the term **'procured abortion'** be used for the sake of clarity and accuracy.

Observations on Head 2 Risk of Loss of Life from physical illness, not being the risk of self-destruction

Subhead 5 in Head 2 of the Bill reads as follows:

"(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."

Suggestion:

Under sub-head (5) we suggest that the word *'termination'* be substituted with the phrase *'medical procedure that may as an unintended consequence result in the demise of the unborn child'.*

Suggestion:

We suggest that a **sub-head 6** be added, stating, that during all emergency medical procedures performed in line with this Bill, every effort must be made to preserve the life of the baby, and that under no circumstances will the life of the baby be directly and intentionally terminated.

It should also quote the following statement from the current Medical Council's, **'Guide to Professional Conduct and Ethics for Registered Medical Practitioners',** *(7th ed., 2009, Section B, Page 21, under the heading 'Abortion')*:

> "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".

This point would preserve in the doctor's actions the principle, that it is always and everywhere morally illicit to directly and intentionally kill innocent human life, and that the value and integrity of human life is not based on age, desirability, sex, status, consciousness, awareness, or any other accidental criteria, but

simply and solely on the dignity of the human person, which can only be found in the human body, is found in every human organism, and cannot be separated from it except by death.

2.

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

Our observation is, that this is what currently happens in obstetrical practice.

Suggestion:

A phrase similar to our suggestion under Head 2 be inserted to ensure that every effort must always be made to save the life of the baby, as per current Medical Council Guidelines.

> We suggest that a **sub-head (3)** be added, stating, that during all emergency medical procedures performed in line with this bill, every effort must be made to preserve the life of the baby, and that under no circumstances will the life of the baby be directly and intentionally terminated.

It should also quote the current Medical Council's **'Guide to Professional Conduct and Ethics for Registered Medical Practitioners',** *(7th ed., 2009, Section B, Page 21, under the heading 'Abortion')*, is the following statement:

> "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".

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

This Bill allows Abortion

This Bill allows any pregnant woman to have an abortion if she claims that she is suicidal, once her claims have been confirmed by three Consultants, one Consultant Obstetrician and two Consultant Psychiatrists. But any woman can claim that she is suicidal in order to get an abortion.

We find Head 4 can never be accepted because there is no medical evidence that abortion is a treatment for suicide. Given that abortion is not indicated in the treatment of suicide threat, we suggest that Head 4 be omitted, as it is medically erroneous.

Head 4 will eventually lead to abortion on demand

We believe that Head 4 could and will eventually be interpreted as allowing for direct intentional killing of the unborn child at any stage, as doctors who support liberal abortion would eventually fill the panel suggested in this Bill. This is what is referred to commonly as *'abortion on demand'* and the unfortunate innocent unborn child is the victim. Let anyone who states that '*abortion on demand'* would not happen in Ireland, let them quote any State in the world where having started as limited 'therapeutic abortion' did not soon end up in fact as '*abortion on demand'* however well dressed up.

Allowing someone to kill someone else on the threat of self-destruction is illogical

It must be pointed out that, even in these exceedingly rare cases (1/500000) where a pregnant mother is suicidal, it is not the baby that is a threat to her life, but she is a threat to her own life (even if based on the baby's existence). The logic of this is that, should she form the opinion that the existence of another person, born or unborn, was also

a threat to her life, then there should be legislation to terminate that life. This of course would be preposterous, but the logic is identical to that used in this bill. Indeed, the above scenario would also have to apply to any citizen regarding any other citizen. In the cases envisioned and defended by this bill, the baby literally is a person whose right to life is defended under article 40.3.3 of the Constitution, but who happens to be in the wrong place (the womb), at the wrong time (when unfortunately his or her mother is threatening suicide).

3.

Head 4 is contrary to the majority pro-life view in Ireland

We contend that this State must reflect in its laws the contention of the overwhelming majority of the Irish people that the taking of innocent human life is wrong always and everywhere, and we contend that the unborn child scientifically and morally constitutes innocent human life, and that there are no circumstances where only the direct intentional killing of the unborn child can be the treatment for a medical or psychiatric crisis. We furthermore contend that previous administrations (composed incidentally of both parties of the current government, and others) have prudently and legitimately refrained from proposing legislation based to the extraordinarily flawed X-case Judgement which was made in the absence of expert medical opinion.

Suggestion:

Given that abortion is not indicated as a treatment for suicide ideation, we advise that Head 4 be omitted from the Bill as it is medically erroneous.

It is a strange paradox that while our modern medicine emphasises the need for evidence of benefit of treatment, that we are now prepared to use abortion, a totally unproven remedy for suicide threat.

It is very disturbing that the Legal Profession and the Government should dictate to the Medical Profession on clinical decisions and the care of their patients.

Observation on Head 5 Medical opinion to be in the form and manner prescribed by the Minister
Observation on Head 6 Formal Medical Review Procedures
Observation on Head 7 Review where risk arises from physical illness, not being a risk of self destruction

We have no observations on Heads 5, 6, 7.

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

Abortion as a treatment for suicide threat by the mother is not in accordance with evidenced based medicine. Head 8 of the Bill should therefore be deleted.

Observation on Head 9 General provisions for Committee

Penalty or refusing to attend – No comment

Observation on Head 10 Formal medical review reports to Minister & Head 11 Notifications

We welcome medical and statistical reviews and transparency on this life-and death matter.

4.

Observations on Head 12 Conscientious Objection

We welcome (1) and (2)

Is 'Conscientious Objection' an issue when the mother's life is at risk

Dr Sam Coulter-Smith, Master, Rotunda Hospital made a very important point at the debate on Medical Ethics at the recent IMO Conference in Killarney when he said:

> "*Conscientious objection* is **never an issue** in hospitals when the baby has to be delivered early in order to save the mother's life even if the death of the baby is inevitable due to immaturity, although every effort is made to save the baby's life in such circumstance."

Hospital staff know this and can readily differentiate between this and a 'procured abortion' which is the direct intentional killing of the baby in the womb.

Abortion is not the treatment for suicide and in fact may make the patient's mental state worse. Therefore the Medical and Nursing staff know that to terminate the pregnancy on the grounds of suicidal ideation is direct intentional killing of the unborn baby because the mother does not want to be pregnant. This is not the proper treatment for such a mother but is in fact a 'procured abortion' and on conscience grounds medical personnel will not want to be part of this evil.

Those drafting this Bill also acknowledge this difference by inserting a 'limited' conscientious objection clause into the Bill.

Sections (3) and (4)
There are difficulties with sections (3) and (4) of the 'conscientious objection' clause in the Bill for example:

Conscientious Objection clause and Institutions : Section (3)
Section (3) inherently contradicts (1) and (2). Should it arise, for example, that an institution recognised by the State for the purposes of this act was composed entirely of members and executives who had conscientious objections to abortion, however unlikely, this act would force someone to perform abortions in that institution, or else be punished. This does not respect conscience.

Similarly, the Notes state that the right to conscientious objection is a human right and applies only to individuals and not institutions. There appears to us to be an absurdity in this contention, as all institutions are composed of individuals, and institutions are set up by individuals to partake in them so as to be able to practice their arts, professions, or trades for the good of others and their own selves. Institutions are always composed of individuals, all of whom have the right to conscientious objection, even if they all hold the same convictions.

Conscientious objection is absolute for the individual
The Notes erroneously state that the right to conscientious objection is not absolute. We contend that it is absolute for the individual holder of this objection.

Conscientious Objection and section (4):

Section (4) reads as follows: 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.

Section 4 as quoted above, demanding that that you recommend someone else to carry out the procedure would of course nullify one's right of 'conscientious objection' and such direction does not respect 'conscientious objection' in reality even though it is stated by the Irish Medical Council.

5.

Suggestion:

We therefore advise that sections (3) and (4) be omitted from the Bill.

Observations on Head 13 'Travel and Information'

No comments.

Observations on Head 14 – 17 deal with Regulations

No comments.

Observations on Head 18 'Repeal and Consequential Amendments' & Head 19 'Offence'

No comment

Observation on Head 20 Commencement – with short title

No observations.

Insert Irish Feminist Network Here

"Clinch" <clinch@eircom.net>
Sent by: "clinch@eircom.net" <clinchtaney
08/05/2013 01.39 p.m. To
"Kelly, Paul" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
protection of life during pregnancy Bill

History:
This message has been forwarded.

Dear Mr Kelly,

I assume your committee will be discussing the above bill in the near future. I would be grateful if I could appear before it at some stage even if only for a short time.

I am an ex-Master of the Coombe Hospital so I have extensive experience in the management of pregnant women and their babies.

I also worked in the UK, in Cardiff and Aberdeen where I had insight into the provision of abortion services in those cities.

I have been a member of the Medical Council and contributed to the compilation of its Ethical Guide to Conduct and Behaviour.

In 2000, I gave evidence before the Oireachtas all-party Committee on the Constitution chaired by the late Brian Lenihan T.D. into the problem of abortion.

My e-mail address is as above and my direct telephone line is 01 298-2026.

I look forward to hearing from you,

Yours sincerely,

James Clinch, MA, MD, FRCOG.

From: "James and Ruth Foley" [jrfoley@eircom.net]
Sent: 05/05/2013 17:55 CET
To: Jerry Buttimer; Paul Kelly; Ciara Conway
Subject: For Health Committee meeting

Hello to you both.

My name is James Foley I am a psychiatric nurse with a degree in Nursing. I am currently studying to be a counsellor. I am writing to request that you consider the following statement for the health committee re their preparation for the public hearings on the recently published heads of the bill on protecting life in pregnancy.

Many points have been made for and against this. There has been one common thread through the points that have being made to promote this bill, the fact that the unborn is a human being with the constitutional right to live is ignored. There is also a presumption made that the woman in crisis pregnancy is better off for having an abortion when she says she is suicidal.
Re the unborn being a human being. To be pro-abortion choice it means you have to degrade the truth of unborn life. If you believe the unborn child is a human being with the right to life but are still prepared to vote for its destruction you are contradicting yourself. To draw a line in the sand defining when humanity starts is at best a very crude and at worst blatantly illogical. The need to define humanity is been forced by those whose agenda has been made clear, abortion on demand. Life only having value on the basis of being wanted. For our government and society to go down the route of destroying life on this basis is horrific, where will such a mind-set lead us? What will it take for such a mind-set to be satisfied? How many lives will be lost before we and you realise the wrong that has been done?
Re the needs of a woman in crisis pregnancy. Is it the pregnancy that is the crisis or the circumstances around the pregnancy? I propose that an unborn child does not make a woman suicidal. The Labour Party's core values says, "Poverty, homelessness, unemployment and ignorance are the enemies of freedom". In research commissioned by Planned Parenthood in America these were the very factors that were found to be why women believed they had no choice but to have an abortion.
http://www.feministsforlife.org/Q&A/index.htm This should be the focus of government action. If the government changed its focus from blaming the unborn for the woman's pain and looked at the pressures that she is under instead they would have a totally different outlook. Indeed it would mean that the government would truly have to prioritise care provision and lead society to practice love towards both women in crisis and the children they don't want who would be put up for adoption. Is our government prepared to do that, are you?
Some observations about the bill. It gives no legal voice to the unborn. Who is going to appeal on behalf of the baby if the decision goes against her? Due to the conscientious objection clause it is likely that all the psychiatrists involved would be pro-abortion choice and the results will show this. Psychiatrists the same as all other people work out of their beliefs, so whether they are pro-life or not does matter and the proof is on the side of the pro-life psychiatrist. I have professionally

witnessed where a woman claimed suicidality in a psychiatric setting and was given no care for same by her psychiatrist or the nurses because she simply wanted an abortion, so they left her to her own devices. This bill comes across as being the result of abortion fatigue at the political level, what a poor reason for introducing a bad law. The bill gives no time limits as to when an abortion will happen, and the controls in it are less rigorous than the Californian law stating a woman must be so ill as to warrant involuntary psychiatric admission. This law was quickly abused by those who believed abortion was a human right.

Those who say we must implement the X case because of the ECHR ruling are only presenting their view. There is considerable legal opinion that disagrees with them. You can't just ignore this. The Labour Party and others are just using these cases to force their own agenda. For what aim? A process of eradicating moral standards they find abhorrent because of their connection to traditional Irish religious values. This is called Theophobia. The psychologist who gave testimony at the X case was asked at the 2000 Oireachtas hearings his opinion on the considerable medical evidence that did not support abortion in circumstances of the x-case. His reply,

"To broaden it out into a discussion about suicide is irrelevant. This is about the right to choose..."

He had obviously no concern for medical facts re how to care for women or for the life of unborn children.

In a culture where abortion is considered a woman's right and therefore the unborn is a nothing it would seem illogical and cruel to tell a woman requesting abortion that no you can't have one. In a culture where the two patient model pertains there is true hope. Mother and child can go on to live successful lives yes with elements of regret but much less so than if abortion had been chosen. Ireland is presently having a battle over these two mind-sets. May life win out over death. You have a crucial part to play in this.

Also there is the equality of father's rights. It may be a minority of fathers who would be prepared to parent the child alone but shouldn't their willingness to do this not be accounted for.

You may ask, "But haven't the Irish people accepted the suicide grounds in rejecting two previous referenda? The first referenda was rejected by pro-life groups who felt it was too vague and open to abusive interpretation. The second referenda saw a split in the pro-life side. Research conducted by the Pro-life Campaign found that 5% of the no vote was pro-life who held to the belief that life starts at conception not implantation. That vote was lost by less than 5%. A simple straight referendum outlawing abortion on suicide grounds while supporting the current practice based on medical council guidelines has never been put to the people. Also the recent opinion polls asked very simple questions, without incorporating current medical practice of the two patient model.

May I finish with the question pro-abortion choice advocates put to pro-lifers like me, "What would you do if your daughter was suicidal looking for an abortion?" Would you tell her to undergo a serious medical procedure that has been proven to not make any difference to her emotional well-being? Would you tell her that there is the proven possibility that she will suffer long term pain over her choice? Would you love her? Would you hold her in your arms and let her cry as she seeks your comfort

and your reassurance? Would you encourage her to get appropriate medical treatment, psychiatric if necessary? Would you tell her, "We'll get through this together. This will not last forever." "Abortion is repeatedly sold as a "safe and simple" solution. Routinely, no information is given about alternatives, foetal development or procedure risks." Women Hurt

I hope that some of what I have said will influence you positively as you consider the final preparations for the public hearings.

Yours Most Sincerely

James Kevin Foley

School of Law
University of Limerick
Castletroy
Limerick
8 May 2013
Dear Paul,
Please find attached a joint submission to the Joint Oireachtas Committee on Health and Children on the Heads of the Protection of Life in Pregnancy Bill from myself, Jennifer Schweppe, and Dr Eimear Spain of the University of Limerick. As you are aware, I was invited to give an oral presentation to the Committee in January, and I have worked with Dr Spain responding to the Heads of the Bill here.
The University postal address is above, and further details are:
Jennifer Schweppe Dr Eimear Spain
"Ard Aoibheann", 47 Cairnsfort,
Ballybricken, Golf Links Road,
Grange, Limerick.
Co Limerick.
Jennifer.Schweppe@ul.ie Eimear.Spain@ul.ie
087 7667103 086 8678850
Please feel free to contact either of us if you require any other information, or further clarification on any issue contained in our submission.
Best wishes,
Jennifer Schweppe and Dr Eimear Spain

Submission
to the
Joint Oireachtas Committee
on
Heads of the Protection of Life During Pregnancy Bill 2013

Jennifer Schweppe and Dr Eimear Spain
Centre for Criminal Justice,
University of Limerick
8 May 2013

Table of Contents

Introduction

Jennifer Schweppe and Eimear Spain are lecturers in law at the University of Limerick with a strong research interest in right to life issues and the scope of Article 40.3.3°, both having published extensively on the topic in both academic and media contexts.

Jennifer Schweppe

Jennifer Schweppe is a Lecturer in Law at the University of Limerick, and has published extensively on the issue of abortion law in Ireland. Having graduated with a BCL from University College Dublin, she was awarded an Open Post Graduate Scholarship while completing her LLM by research. As part of this LLM, she examined the scope of Article 40.3.3° with particular emphasis on *in utero* drug exposure and third party foetal assault. Based on her expertise in the area of abortion law, Jennifer was invited to make a submission to the Joint Committee on Health and Children on the issue of legislating for Article 40.3.3 in January 2013.

Dr. Eimear Spain

Eimear Spain is a Lecturer in the School of Law who has published extensively in criminal and constitutional law, particularly on the right to life and end of life decision making. Eimear graduated with a BA in Law and Accounting from the University of Limerick in 2003 and with a PhD in 2008. Dr Spain's research interest lies in the interaction between criminal law and psychology, particularly the role of emotions in criminal behaviour and the criminal justice system. Her current research is centred on the role of emotions (including fear, anger and love) in criminal behaviour and their consequential importance for the attribution of moral and criminal responsibility. She has published numerous books, book chapters and articles in the areas of criminal, constitutional and administrative law both nationally and internationally

Relevant Publications include:

Books and Edited Collections

Catherine O'Sullivan, Jennifer Schweppe and Eimear Spain (eds), Legislating for Article 40.3.3: Abortion Law in Ireland (Special Issue of the Irish Journal of Legal Studies) (Forthcoming 2013)

E Spain, The Role of Emotions in Criminal Law Defences; Duress, Necessity and Lesser Evils (Cambridge University Press, Cambridge 2011)

Jennifer Schweppe, *The Unborn Child, Article 40.3.3° and Abortion in Ireland: 25 Years of Protection?* (The Liffey Press 2008) (Editor)

Journal Articles and Book Chapters

Jennifer Schweppe and Eimear Spain, 'Article 40.3.3 and the Capacity to Survive Outside the Womb' (2013) Irish Journal of Legal Studies (Forthcoming)

Eimear Spain, 'Love in Life and Death' (2013) 64 (1) NILQ 91-109

Jennifer Schweppe 'Taking Responsibility for the "Abortion Issue": Thoughts on Legislative Reform in the Aftermath of *A, B and C'* (2011) 14(2) *Irish Journal of Family Law* 50
Eimear Spain, "Pregnancy and Unwanted Third Party Interference: A Woman's Rights" in Jennifer Schweppe (ed), The Unborn Child, Art 40.3.3, and Abortion in Ireland: 25 Years of Protection? (Liffey Press 2008), 113-129
Jennifer Schweppe '"A Constitutionally Permissible Abortion?" The Right to Travel, the Role of the Medical Profession and the Duty of the HSE' in Jennifer Schweppe (ed), *The Unborn Child, Article 40.3.3° and Abortion in Ireland: 25 Years of Protection?* (The Liffey Press 2008)
Eimear Spain, "Vo v France: Reasonable Settlement or Missed Opportunity?" (2006) 2 IFLJ 16-20
Jennifer Schweppe'Revisiting Article 40.3.3°: Part Two: Pregnant Women and Unborn Children: An Irreconcilable Conflict?' (2006) 1 *Irish Journal of Family Law* 19
Jennifer Schweppe 'Revisiting Article 40.3.3°: Part One: Third Party Foetal Assault' (2005) 4 *Irish Journal of Family Law* 19
'Mothers, Fathers, Children and the Unborn: The Twenty-Fifth Amendment to the Constitution Bill' [2001] *Irish Student Law Review* 136

Executive Summary

While the introduction of the Heads of the Protection of Life During Pregnancy Bill 2013 is an important step towards clarifying the right to life of pregnant women in Ireland, there are some important issues which need to be clarified and important gaps which we believe should be addressed before this Bill passes through the Houses of the Oireachtas.

The ambit of the Heads of the Bill are narrow, focusing only on the Supreme Court decision in X, not addressing situations of inevitable miscarriage or foetuses with fatal abnormalities. Heads of Bills are, of course, simply a draft outline of the proposed legislation: we would argue that the Heads should be considered a work in progress, and attention paid to some of the significant issues with its contents and the gaps left in it. There are two key concerns we have with the Heads: first, issues concerning those issues which are contained in the text or the explanatory memorandum; second, some issues which are not in the Heads which we believe deserve closer attention. Part of this Submission is based on the contents of the Submission made by Jennifer Schweppe to the Committee in its oral hearings in January 2013.

In this submission, we highlight some concerns we have with the text of the Heads. We do not comment on each Head, but rather have chosen to highlight some of the key issues we believe should be dealt with prior to the Bill being finalised. We also include a lengthy analysis of the issue of fatal foetal abnormality and inevitable miscarriage. While these two issues are outside the ambit of the Heads, we believe that they should be considered in any forthcoming legislation.

Recommendations

Head 1: Interpretation

Recommendation 1

The Heads should be clear that where a medical practitioner treats a woman in good faith, subjectively assessed, that medical practitioner cannot be prosecuted for terminating the pregnancy. It is suggested that the terminology found in Head 5 should be adopted throughout any proposed legislation replacing the term "reasonable opinion" with the term "medical opinion" in the definition section and throughout the proposed legislation

Recommendation 2

We would recommend that legislators take cognisance of the recommendations of the Law Reform Commission in its series of Consultation Papers and Reports on proxy consent. This could usefully be done by way of the introduction of a parallel piece of legislation which incorporates those recommendations made by the Law Reform Commission contained in the draft bill appended to its Report, *Children and the Law: Medical Treatment*, whilst simultaneously providing for proxy consent for incapacitated adults. The Bill should be clear as to the circumstances in which a doctor can treat a young woman or minor in the absence of parental knowledge or consent. The Bill should be equally clear as to the role of the Court in the context of the travel amendment, outlining clearly that where anyone wishes to travel to terminate a pregnancy, that woman cannot be prevented from travelling in any circumstances.

Head 2: Risk of loss of life from physical illness

Recommendation 3

It is submitted that Heads two, three and four should provide that is is not an offence for a medical practitioner to carry out a termination where a doctor/doctors (as appropriate) certifies that in their medical opinion formed in good faith that (i) a real and substantial risk exists and (ii) that a termination is the only means of averting such a risk. Requirements in relation to the number of doctors and the location etc must still be complied with.

Recommendation 4

Doctors should be under a legal obligation to make a determination on the availability of a termination once a request has been made and to inform the woman of that decision.

Recommendation 5

Where a medical practitioner is faced with a request for a termination, he or she should be under an obligation under the Heads to consult with another doctor to determine whether the termination should occur under Head 2, 3 or 4.

Recommendation 6

The Head should include a time limit for medical practitioners, requiring a decision be made within 24 hours of the initial request.

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

Recommendation 7

Where a request to terminate under Head 3 is refused, the situation should automatically become a request for a termination under Head 2 of the Act. For this reason, we would suggest that the order of the Heads be altered slightly, with Heads 2 and 3 being reversed in order.

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

Recommendation 8

We recommend that the requirement of unanimity be considered in conjunction with the concerns outlined in Head 12 in relation to conscientious objections and medical opinion and the possibility of allowing a woman to request that particular medical practitioners involved in the decision making process at every level in her case be replaced.

Head 6: Formal medical review procedures

Recommendation 9

Legislation should impose an obligation on medical practitioners who receive a request for a termination to consult another suitable medical practitioner, to provide a response to that request and to notify the minister of the request and the reasons for the refusal.

Recommendation 10

Given the urgency and, by definition, life-threatening nature of the conditions involved, we recommend that the Committee stage should be complete within two days, with the final decision of that Committee being made within three days.

Head 9: General provisions for Committee

Recommendation 11

Consideration should be given to the desirability of providing free legal representation to all women in cases of this nature.

Head 12: Conscientious Objection

Recommendation 12

Given the complexity of the task involved in making a distinction between conscientious objection and medical opinion we recommend that this issue be given more consideration, including the possibility of allowing a woman to request that particular medical practitioners involved in the decision making process at every level in her case be replaced.

Head 20: Commencement

Recommendation 13

We recommend that the Minister is given a time limit in which to commence the entirety of the Bill to avoid a situation where the bill is enacted but not commenced for an extended period.

Issues not considered

Recommendation 14

The Heads of the Bill do not attempt to go further than what is strictly necessary under the terms of the ECHR decision, and there are sound political and legal reasons for this. We would recommend that during the drafting process, two Amendment Bills should be drafted simultaneously, one which deals with each of the two concerns highlighted here.

Recommendation: 15

We recommend that the legislature include a provision authorising a termination in cases of inevitable miscarriage within the Protection of Life During Pregnancy Bill 2013.

Submission

Head 1: Interpretation

Head one provides definitions of the various terms found in the Heads of the Bill. The clarity provided in the interpretation section is to be welcomed, particularly the inclusion of a definition of the term "unborn" for the first time in Irish Law.

Reasonable Opinion

Reasonable opinion is defined in head one as ""an opinion formed in good faith which has regard to the need to preserve unborn human life as far as practicable", a definition which is likely to cause confusion. The inclusion of the word reasonable in the proposed legislation suggests that a doctor must form an opinion in good faith that the risk can only be averted by termination which is *objectively judged as "reasonable".* However, the definition of reasonable opinion contains no objective element and implies that an opinion formed in good faith having regard to the need to preserve unborn human life as far as practicable is sufficient. That is, it need not be objectively reasonable.

This distinction has important consequences as should heads 2, 3 and 4 contain an objective element, a doctor would be liable to conviction and imprisonment for 14 years should he or she honestly and in good faith form the opinion that there was a real and substantial risk the life of the woman which could only be averted by termination *which is subsequently judged to be unreasonable.* This distinction is of great importance for doctors as the presence of an objective element may have a "chilling effect" on doctors who despite honestly believing that a termination is the only means of avoiding a real and substantial risk to a woman's life exists *may withhold treatment until the threat becomes absolutely clear so that they do not risk criminal sanction* for performing a termination in circumstances where it is subsequently judged not to have been reasonably necessary. This requires further clarification in the Bill proper.

Recommendation 1

The Heads should be clear that where a medical practitioner treats a woman in good faith, subjectively assessed, that medical practitioner cannot be prosecuted for terminating the pregnancy. It is suggested that the terminology found in Head 5 should be adopted throughout any proposed legislation replacing the term "reasonable opinion" with the term "medical opinion" in the definition section and throughout the proposed legislation

"Unborn"

"Unborn" is defined as human life "following implantation until such time as it has completely proceeded in a living state from the body of the woman". This definition is expansive providing protection from the moment of implantation in the womb but excluding fertilised eggs pre-implantation, including in vitero, as decided in the Supreme Court judgment in *Roche v Roche & Others*. It is also intended to exclude emergency contraceptives and the treatment of ectopic pregnancies. The inclusion of foetuses within the course of being born is also to be welcomed, thus ensuring that the current lacuna in the law identified by numerous commentators, including the Expert Group on abortion, has been filled.

"Woman"

The Heads of the Bill define 'woman' as 'any female person'. On a simplistic level, this makes sense: the Heads allow a medical practitioner to treat any female including those under the age of 16, based on current medical practice, and will refer to third parties, such as parents or the husband of the woman based on the Medical Council Guidelines. However, as a study has recently shown, medical practitioners are not uniform in the manner in which they understand the current legal position which will lead to ambiguity and uncertainty in the manner in which the legislation operates.

However, not all 'female persons' are capable at law of consenting to a medical procedure without referral to another person or body. Three scenarios arise here: that of young women and minors; those in the care of the HSE; and those individuals who by reason of mental incapacity cannot consent to medical procedures. In terms of the operation of the Bill itself, questions arise as to whether a doctor is obligated to inform parents that their daughter is seeking a termination of her pregnancy. Further issues arise then in the context of the right to travel based on decisions of the High Court; what role the HSE has in facilitating terminations, whether they arise in the context of the legislation or not; and

whether a court can sanction any woman, in care or through its wardship jurisdiction, to travel to terminate a pregnancy which does not fall within the terms of the Heads of the Bill.

According to section 23 of the 1997 Act, where a young person is in the care of her parents, a doctor cannot be held criminally liable for providing medical treatment to her in the absence of parental knowledge or consent. For those under the age of 16, as the Law Reform Commission notes, 'the "usual" position is that parents should be asked for their consent, but that in "exceptional circumstances" the doctor would "encourage" the under 16 year old to involve their parents, bearing in mind the doctor's "paramount responsibility" to act in the patient's best interests.' *The Heads are silent on whether a medical practitioner is under an obligation to inform parents of the procedure in question.* Theoretically, a doctor could treat a minor under Heads 2, 3 or 4 of the Heads without ensuring that her parents either knew or consented to the procedure. This may, of course, be the intention of the framers: there are certainly circumstances in which it would be inappropriate for such consultation. However, given the ambiguity of the law in this area, the Heads should be clear on this issue.

Regarding those in care, depending on the type of care order made under the Child Care Act 1991, either the District Court Judge (in the case of emergency care orders, interim care orders and interim special care orders) or the HSE (in the case of care orders and special care orders) can consent on behalf of the young person or minor, or give directions in relation to their treatment. Generally speaking, these provisions will apply where the medical treatment in question is a life-saving termination of pregnancy and of course the Court should consent to the procedure if the young woman is in a situation envisaged by Heads 2, 3 or 4 of the Bill. If the procedure is considered life-saving, as the Heads require, it is undoubtedly in the best interests of the young woman to terminate the pregnancy, and one would assume that no court would second-guess the decision of the medical practitioners involved. The Heads do seem to envisage a situation where a third party could apply to the Court to prevent a termination occurring. It is not clear on what basis the Court would make this decision – again, presumably the terms of the Child Care Act 1991 would apply, and it would be certainly unusual to deprive a Court of the ability to overturn the decision of medical practitioners.

The ambiguity in the law resulting from the C case and the Miss D case on the question of whether a young person in the care of the HSE, or indeed, any other person who requires Court approval for medical treatment, such as a ward of court, can travel to terminate their pregnancy in circumstances which do not fall within the terms of the Heads remains. In the Miss D case, McKechnie J held that Miss D's right to travel took precedence over the right to life of the unborn. There was a shift from Geoghegan J's position in the C case, where he believed that the State, and the courts, were under an obligation to protect the right to life of the unborn to the point that the court could not positively sanction travel for an unconstitutional abortion, to McKechnie J's decision, where the right to travel was paramount, trumping the right to life of the unborn. It could be argued that *Miss D* was decided on the basis of capacity to consent to treatment, rather than Article 40.3.3°, but this issue requires resolution. Where the case concerns, for example, a Ward of Court, capacity does not resolve the question. The Heads do not pretend to resolve this ambiguity.

Recommendation 2

We would recommend that legislators take cognisance of the recommendations of the Law Reform Commission in its series of Consultation Papers and Reports on proxy consent. This could usefully be done by way of the introduction of a parallel piece of legislation which incorporates those recommendations made by the Law Reform Commission contained in the draft bill appended to its Report, *Children and the Law: Medical Treatment*, whilst simultaneously providing for proxy consent for incapacitated adults. The Bill should be clear as to the circumstances in which a doctor can treat a young woman or minor in the absence of parental knowledge or consent. The Bill should be equally clear as to the role of the Court in the context of the travel amendment, outlining clearly that where anyone wishes to travel to terminate a pregnancy, that woman cannot be prevented from travelling in any circumstances.

Head 2: Risk of loss of life from physical illness

Head two provides that a termination may be provided in non-emergency situations, where there is a real and substantial risk to the life of the woman, a risk which in the reasonable opinion of two medical practitioners can only be averted by terminating the pregnancy.

Real and Substantial Risk

The decision not to define the term 'real and substantial risk', is to be welcomed as in the absence of a legislative definition, it is left to medical practitioners, those most qualified, to make the decision. However, this freedom for medical practitioners to assess whether in their professional opinion a risk is "real and substantial" can only work if the professional opinion formed in good faith is respected and doctors are not concerned with how others would assess the risk, a factor which will be considered below.

Reasonable Opinion

An important element of the general scheme is the requirement that the decision made by the medical practitioners in question is one which must be made 'in good faith'. This means that the medical practitioners involved must be of the opinion that there is a real and substantial risk to the life of the woman and that this risk may only be averted through termination. This requirement of acting in good faith is supplemented by a requirement that "[i]n their reasonable opinion this risk can be averted only by that medical Procedure". As discussed in Head one, while the definition contained therein implies that an opinion formed in good faith is sufficient, the inclusion of the word reasonable suggests that a doctor must form an opinion in good faith that the risk can only be averted by termination which is *objectively judged as "reasonable"*. Similarly the Committee undertaking a review of an earlier refusal of a termination or a refusal to give an opinion on the availability of a termination, must "form an opinion in good faith"; the requirement that the opinion be reasonable as to the necessity of the termination is not to be found.

This distinction is of great importance for doctors and requires further clarification in the Bill proper.

Recommendation 3

It is submitted that Heads two, three and four should provide that is is not an offence for a medical practitioner to carry out a termination where a doctor/doctors (as appropriate) certifies that in their medical opinion formed in good faith that (i) a real and substantial risk exists and (ii) that a termination is the only means of averting such a risk. Requirements in relation to the number of doctors and the location etc must still be complied with.

Obligation to come to a determination

Heads 2, 3 or 4 of the Bill place no obligation on medical practitioners who have been faced with a request for an abortion to provide a determination on the issue, indeed Head 6, subhead 2 expressly acknowledges a right of appeal where a woman has requested a termination and the medical practitioner concerned has "has not given an opinion in relation to the matter." The option to ignore a request places women in life threatening situations at risk and should removed.

Recommendation 4

Doctors should be under a legal obligation to make a determination on the availability of a termination once a request has been made and to inform the woman of that decision.

Unilateral decision making

It is clear that doctors who receive a request for a termination may unilaterally refuse that request with no obligation to consult another suitably qualified medical practitioner to discuss the case or to submit any record of the refusal under the law. Given the requirement for unanimity, a requirement to consult in coming to the initial decision would provide a level of transparency, particularly important in this troubled area. In any event, certification requirements should be extended to require documentation (beyond that contained in the individual patient's medical record) and notification of the refusal to a central authority.

Recommendation 5

Where a medical practitioner is faced with a request for a termination, he or she should be under an obligation under the Heads to consult with another doctor to determine whether the termination should occur under Head 2, 3 or 4.

A Timely Decision

There are no time limits in place for medical practitioners who are faced a request for a termination under Head 2. Given the urgency and, by definition, life-threatening situations involved here, we would recommend that where such a request is made, a decision must be made within 24 hours of that initial request.

Recommendation 6

The Head should include a time limit for medical practitioners, requiring a decision be made within 24 hours of the initial request.

Joint certification

Under Heads Two and Four medical practitioners involved in a decision on the availability of a termination (the number and specialization of which is dependent on the form of the threat to the woman's life) must jointly certify their opinion, that is, the decision must be unanimous. While this provides a degree of protection, it also raises the possibility of one doctor being in a position to block a termination, a concern if done on ideological grounds. Given this, it is of vital importance that the process of appeal is robust and accessible.

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

Head three provides that a termination of a pregnancy is permissible in emergency situations, where there is an immediate risk to the life of the woman and where, in the reasonable opinion of one medical practitioner, a termination of pregnancy is immediately necessary to save her life. The acknowledgment that the reasonable opinion of one doctor, formed in good faith, that a termination is necessary to save the life of a woman is to be welcomed as ensuring that women receive life saving medical treatment in emergency situation. However, under the Heads of the Bill, suicide risk cannot be considered an emergency situation.

Recommendation 7

Where a request to terminate under Head 3 is refused, the situation should automatically become a request for a termination under Head 2 of the Act. For this reason, we would suggest that the order of the Heads be altered slightly, with Heads 2 and 3 being reversed in order.

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

Head four provides that a termination is permissible where there is a real and substantial risk of loss of the life of the woman by way of self-destruction, which in the reasonable opinion of three medical practitioners (one obstetrician/gynaecologist and two psychiatrists) can only be averted by terminating the pregnancy.

While some people have suggested that there is no need to legislate for a risk of self-destruction, or that, as the decision in the X case was wrongly decided, we should not legislate for this risk, this is a misunderstanding of the legal situation. It is important to note that the ECtHR did not require a change of the law on abortion in Ireland, rather, it placed an obligation on the State to give effect to the existing law, that is, Art 40.3.3 as interpreted in the X Case. Should the Oireachtas reject the risk of self-destruction, a referendum would be required to change Art 40.3.3, a proposal previously rejected by the people. As this issue is debated in the media and in the Oireachtas over the coming days and weeks it should be remembered that any legislation which fails to include this risk in the absence of a referendum, would not be in compliance with the terms of the A, B and C judgment.

Separate process

The creation of a separate process for dealing with threats arising from self-destruction rather than physical ailments can be criticised as inherently discriminatory placing an extra burden on women suffering from mental health difficulties and stigmatising those with mental health issues once again. Despite these concerns, the proposed scheme may offer a pragmatic solution recognising the political realities.

Unanimity

As noted in the discussion of head 2, the requirement that the doctors involved in the certification process come to a unanimous decision on the availability of a termination means that one doctor will be in the position to block a termination. Given the obligation on the doctors involved to give an opinion not only on whether the threat to a woman's life is real and substantial but also whether a termination is the only means of averting that risk, the ability of one doctor to block a termination becomes particularly significant in cases where the risk to the woman's life is in the form of suicidal ideation. Based on testimony before the All Party Oireachtas Committee and the recent statement signed by 113 psychiatrists[1] there appears to be a view among a significant number of medical practitioners that termination is never a treatment for suicidal ideation. The requirement of unanimity therefore makes it very difficult for a woman with suicidal ideation will receive a termination in this jurisdiction.

[1] http://www.independent.ie/irish-news/more-than-100-psychiatrists-disagree-with-abortion-proposal-29222046.html; http://www.irishtimes.com/news/social-affairs/evidence-showing-no-mental-health-benefit-to-abortion-cannot-be-ignored-1.1374415

Medical Expertise

On its face, it difficult to see what expertise an obstetrician would have in this context, and why their presence is required on the assessing team. The medical condition in question is a psychiatric one: an obstetrician will have no qualification in this area and will have little to add to the question as to whether a termination is justified in the circumstances. Criticisms that have been leveled at this section are thus compelling. Presumably, the inclusion of an obstetrician is to ensure that a member of the medical team is capable of performing the termination if required: no medical practitioner can be compelled to carry out a medical procedure against their will. However, as the legislation currently stands, with the requirement of unanimity, an obstetrician could prevent a termination occurring where those with the relevant expertise believe that it is necessary. There is no easy solution to this question.

Recommendation 8

We recommend a reconsideration of the requirement of an obstetrician on the review panel.

Head 6: Formal medical review procedures

Head 6 puts in place a formal mechanism to allow a woman to request a review of a refusal of a termination or to ensure her case is considered in circumstances where she has been unable to obtain an opinion on the availability of a termination. Given the requirement for unanimous decision making and the ability of a doctor to unilaterally refuse a termination, it is very important that any review procedure is robust and accessible.

Heads two, three and four place no obligation on medical practitioners to provide women with a decision on the availability of a termination or to seek a second opinion when a request for a termination is made, and a doctor may refuse to respond to a request or refuse that request for a termination without consulting any other doctors. The obligation on the doctor who forms the view that a termination is not legally permissible to inform the woman of the possibility to review that decision is therefore particularly important in this regard in protecting women. However, we have suggested that this does not go far enough and there should be an obligation on medical practitioners who receive a request for a termination to consult another suitable medical practitioner, to provide a response to that request and to notify the minister of the request and the reasons for the refusal.

Recommendation 9:

Legislation should impose an obligation on medical practitioners who receive a request for a termination to consult another suitable medical practitioner, to provide a response to that request and to notify the minister of the request and the reasons for the refusal.

Timing

Strict control must be maintained on the timing of the review procedure. If a woman is refused a termination or is unable to access a determination of her case, she must request a review in writing, a committee is then to be formed as soon as possible or within seven days, and once formed have up to seven days in which to review and determine the case. The European Court of Human Rights requires that the procedures outlined in the legislation both accessible and effective. Heads six, seven, and eight of the Bill sets out a procedure in which, following the initial refusal to treat (for which there are currently no time limits set), a woman may be left without a final decision for two weeks following her decision to review the initial refusal. Given the urgency and, by definition, life-threatening nature of the conditions involved, we believe that a shorter timeframe should be in place in this Head. We would recommend that the Committee stage should be complete within two days, with the final decision of that Committee being made within three days.

***Recommendation 10*:**
Given the urgency and, by definition, life-threatening nature of the conditions involved, we recommend that the Committee stage should be complete within two days, with the final decision of that Committee being made within three days.

Head 9: General provisions for Committee

Head 9 is to be commended for providing a voice for the pregnant woman, ensuring that she or her representative is heard in any review procedure. It also provides the committee with the authority to call relevant witnesses and to obtain relevant clinical evidence and creates an offence of non-compliance with the direction of the committee, significantly strengthening the power of the committee.

Recommendation 11

Consideration should be given to the desirability of providing free legal representation to all women in cases of this nature.

Head 12: Conscientious Objection

The Heads of Bill contain a conscientious objection clause, allowing a health professional to excuse him or herself from a case if he or she has difficulty in undertaking or assisting a termination. However, he or she still has a duty to ensure the patient is being taken care of by another health professional who does not have the same difficulty. This head is to be welcome in ensuring that no doctor is forced to be involved in a termination procedure.

No requirement to remove self from team

However, the head is framed to protect health care professionals rather than women and there is *no requirement that doctors with a conscientious objection remove themselves from the certifying team*. Given the requirement of unanimity, this raises the possibility of a doctor who is ideologically opposed to abortion blocking the provision of a termination in circumstances which fulfill the X case criteria. There is no procedure for challenging the inclusion of a specific doctor on a certifying team. While it is to be hoped that any doctor who is ideologically opposed to termination will step back on the grounds of conscientious objection rather than staying on board and blocking a termination using the requirement for unanimity, any request on the part of the woman to have any doctor replaced should be respected and provided for in the legislation.

Conscientious objections and medical opinions

The Heads do not distinguish between an individual who may refuse to perform a termination for moral or ethical reasons, and those who honestly believe that there are no medical conditions which would justify a termination of pregnancy. The former is a matter of conscience; the latter is a matter of professional medical opinion. This is particularly the case in the context of Head 4 of the Bill, where psychiatrists have publically stated that they believe that suicide in pregnancy will never justify a termination. This is not an issue of conscience; it is a medical opinion. If such medical practitioners are members of a certifying team, a woman will be effectively denied an effective decision-making process. It is difficult to see how such a problem can be resolved through legislation: is it possible for a doctor to be summarily removed from a panel because of their stated medical opinion? That said, if the medical practitioner has publically stated their opinion, a woman will be denied an effective remedy due to objective bias on the part of that doctor.

***Recommendation 12*:**

Given the complexity of the task involved in making a distinction between conscientious objection and medical opinion we recommend that this issue be given more consideration, including the possibility of allowing a woman to request that particular medical practitioners involved in the decision making process at every level in her case be replaced.

Head 19: Offence

Head 18 of the Bill repeals the relevant sections of the 1861 Act replacing them with Head 19 which makes it an offence to "to do any act with the intent to destroy unborn human life", an offence punishable by up to 14 years in prison or an unlimited fine. This offence may be committed by companies or individuals, including pregnant women. In reading this provision, the impact of criminalising pregnant women must be considered. It is likely to reduce the number of women who seek follow up medical care following back street abortions, or as is becoming increasingly common, those who use abortifacient pills purchased online. Given the poor level of medical care received by these women in the first place, the availability of medical care should things go wrong becomes even more important. The potential harshness of this measure is recognised in the explanatory notes which accompany the Heads of the Bill where it is noted that the sentence to be handed down in these circumstances is at the discretion of the Courts.

The Heads confirm that the consent of the DPP is required before any prosecution can be brought, preventing "frivolous or mischievous cases" being brought before the Courts. This implies that the discretion of the DPP will be applied in the most difficult cases.

Head 20: Commencement

Head 20 provides that the Act will come into force when appointed by the Minister.

Recommendation 13:

We recommend that the Minister is given a time limit in which to commence the entirety of the Bill to avoid a situation where the bill is enacted but not commenced for an extended period.

Issues not considered by the Heads: Inevitable Miscarriages and Fatal Foetal Abnormalities

While we accept that the legislature has framed this legislation narrowly in order to fulfil the requirements of the A, B and C case, it is submitted that there are other circumstances in which termination should be lawfully permitted in this jurisdiction under Art 40.3.3.

Fatal Foetal Abnormalities

Heads 2-4 of this Bill attempt to satisfy the EctHR decision in the A, B and C case by dealing with the narrow test laid down in the X case, the assumption being that the only circumstances in which an abortion is permissible in the jurisdiction is when there is a real and substantial risk to the life of the mother. However, it is arguable that the category of terminations permissible under Art 40.3.3. is wider, particularly in the case of women carrying foetuses which are "incompatible with life" or suffering from "lethal foetal abnormalities". We would suggest that this issue should be addressed by the Oireachtas in this legislation.

From a legal perspective the question is the extent of the protection afforded to the unborn under Art 40.3.3° and this enquiry may be broken down into three constituent parts. The first question to be addressed is whether the definition of the unborn includes a foetus which does not have the capacity to survive outside the womb where such incapacity is not exclusively due to extreme immaturity.[2] Should the definition of the unborn extend to cover unviable foetuses, a related enquiry must be made into whether the right to life is in fact engaged in circumstances where there is no capacity to survive outside the womb. Finally, the extent of the shift in the balancing of rights between the right to life of the mother and the unborn in circumstances where the foetus lacks the capacity to survive must be examined, including whether it is practicable to defend the right to life of the unborn in these circumstances.

[2] The constitutional protection afforded the unborn must cover those foetuses which have the capacity to be carried to term and to be born alive, subject to the exceptions laid out in Attorney General v X…

[3] [2009] IESC 82, [2010] 2 IR 321.

Unborn

It is arguable that a foetus suffering from a fatal foetal abnormality does not fall within the term "unborn" and Art 40.3.3. "Unborn" is defined in the Heads of the Bill as human life "following implantation until such time as it has completely proceeded in a living state from the body of the woman". In *Roche v Roche*[3] Denham J stated, 'The concept of unborn envisages a state of being born, the potential to be born, the capacity to be born…" and two interpretations of this authority are possible. The first suggests that the term unborn encompasses all foetuses in the womb which necessarily have the capacity to be born, irrespective of whether they can achieve life outside the womb or not. The second possible interpretation would suggests that life, for the purposes of the Constitution, may be interpreted as constituting *viable* life: that is, life which has the capacity to exist independently of the woman if brought to term. That is, a right to be born inherently implies a capacity to be born alive. This interpretation would suggest that a foetus which does not have the capacity to be born alive does not attract constitutional protection. It is suggested that this interpretation is preferable, recognising a harsh and sad reality. It is supported by the authority of *D v Ireland*[4] where it was found that if it had been established that there was no realistic prospect of the foetus being born alive:

[4] *D v Ireland* App No 26499/02 (ECHR 28 June 2006)

[5] *D v Ireland* App No 26499/02 (ECHR 28 June 2006)

[6] *D v Ireland* App No 26499/02 (ECHR 28 June 2006)

"there was 'at least a tenable' argument which would be seriously considered by the domestic courts to the effect that the foetus 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."

Right to life not engaged

If the court were to accept that a foetus with a fatal foetal abnormality is an "unborn" under Art 40.3.3, it is still open to the court to find that the right to life of the "unborn" is not engaged in circumstances where a foetus is not capable of surviving outside the womb. In D v Ireland[5] it was found

"there was 'at least a tenable' argument which would be seriously considered by the domestic courts to the effect 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."

This argument was accepted by the Court in deciding that the case was inadmissible due to the fact that the applicant had not exhausted all domestic remedies.

Balancing rights

A third argument for the inclusion of foetus suffering from fatal foetal abnormalities as an exception to the prohibition on termination of pregnancy under Art 40.3.3 is the suggestion that in these circumstances the balance between the right to life of a woman and the unborn shifts in favour of the woman. In D v Ireland[6] the ECtHR particularly stated:

"There is … 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 an abnormality incompatible with life."

Given the nature of the relationship between a woman and her foetus, addressing the balance is a complex task and does not involve balancing the life of the unborn against the life of the woman in isolation.[7] The constitution requires that the life of the unborn be defended "as far as practicable" and this may not be possible to defend and vindicate that right in every case.[8]

[7] *Attorney General v X* [1992] IESC 1; [1992] 1 IR 1, per McCarthy J., p81.

[8] Ibid

[9] *D v Ireland* App No 26499/02 (ECHR 28 June 2006), [90]

It is certainly arguable that should a case involving a foetus suffering from a fatal foetal abnormality that the fact of incompatibility with life would be a factor which would influence the court in its decision on where the balance lay. The government argued in D v Ireland that the X case;

"illustrated the potential of the constitutional courts to develop the protection of individual rights by way of interpretation and the consequent importance of providing those courts with the opportunity to do so"[9]

Conclusion

While it has yet to be conclusively established through the courts whether a termination is permissible where a foetus will not survive outside the womb, it is certainly arguable that a termination would be permissible under Art 40.3.3 on the basis of the arguments outlined. Of course, the only way to guarantee protection for women and families in this situation would be to hold a constitutional referendum, however, it is argued that this is not necessary particularly given that any legislation giving effect to this would be subject to a presumption of constitutionality, strengthening the view that any such legislation would survive constitutional challenge. We would urge the Oireachtas to move beyond the narrow confines of the decision in the X case, which was after all, a decision made based on very specific facts, to consider the full extent of Art 40.3.3 and to use this opportunity to consider cases of fatal foetal abnormality.

Recommendation 14

The Heads of the Bill do not attempt to go further than what is strictly necessary under the terms of the ECHR decision, and there are sound political and legal reasons for this. We would recommend that during the drafting process, two Amendment Bills should be drafted simultaneously, one which deals with each of the two concerns highlighted here.

Inevitable Miscarriages

As this legislation is framed to deal with the narrow circumstances laid down in the X case, it also fails to deal with situations of where a woman is suffering from an inevitable miscarriage. We are adopting the definition of "inevitable miscarriage" put forward by Dr. Simon Mills in his written submission to the Joint Committee on Health and Children as "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".[10] As an inevitable miscarriage will not necessarily constitute a real and substantial risk to the life of a woman, such circumstances will not necessarily come within the narrow test laid down in X. However, it is argued that should the courts be called upon to decide on such a case that Art 40.3.3. could nonetheless be interpreted as allowing a termination of such a pregnancy and the legislature should take this opportunity to include cases of inevitable miscarriage within the legislative framework.

[10] Dr Simon Mills, Written Submissions, Joint Oireachtas Committee on Health and Children

9 January 2013, p18

It is arguable that a foetus which cannot be brought to term and has no prospect of life outside the womb does not come within the definition of unborn under Art 40.3.3 or that the right to life of the unborn is not engaged in these circumstances. Similarly, it is arguable that in circumstances where a pregnancy cannot be brought to term the balance again shifts in favour of the woman and a termination would be permissible under Art 40.3.3. The grounds for such a determination echo those outlined above in relation to foetuses suffering from fatal foetal abnormalities and therefore will not be expanded upon in this section.

Recommendation: 15

We recommend that the legislature include a provision authorising a termination in cases of inevitable miscarriage within the Protection of Life During Pregnancy Bill 2013.

"Jim O'Sullivan" <1926jos@gmail.com>
08/05/2013 12.04 p.m. To
<healthandchildren@oireachtas.ie>
cc

bcc

Subject
Protection of Life during Pregnancy Bill

For the attention of Mr Paul Ryan.

The proposed legislation is medicalising the crime of abortion. Abortion cannot be legal in certain circumstances .Abortion is a criminal offence and has nothing to do with medical treatment.It must be borne in mind that the direct targetting the life of a preborn baby has always been a criminal offence under Sections 58/59 of The Offences Against the Persons Act 1861.No Irish doctor has been charged under that legislation, as they always do their best to save both mother and baby. The Act was primarily intended to prosecute back street abortionists, so I am requesting that this legislation be kept on the statute books.It is ironic that if the 1861 Act is abolished in the Republic, it will still be the legal in the Six Counties.

The argument for abortion being used to address suicide ideation, has been thoroughly demolished at the hearings of the Oireacthtas Committee on Health, and subsequent interviews with persons on both sides of the abortion debate. Legislating on on the flawed Supreme Court judgment on X is absolutely a retrograde step, which will help to widen an abortion culture here. Please set aside this faulty Supreme Court ruling. The Irish people do not want abortion to be legalised, even in the narrowest of circumstances. With regard to the two Referendums to remove the suicide clause the Irish people rightly rejected both, because both were deeply flawed. It is time for an honest referendum to settle the matter once and for all.

Jim O'Sullivan
Newtown
Bantry.

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Submission to The Joint Committee on Health and Children on The Heads of Bill-
Protection of Life During Pregnancy 2013

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Submission to The Joint Committee on Health and Children on The Heads of Bill-Protection of Life during Pregnancy 2013

On behalf of: **Professor Joan Lalor**
Associate Professor of Midwifery
Trinity College Dublin.

1. Introduction

I have been invited to make a written submission in respect of the forthcoming consideration of the Protection of Life During Pregnancy (Heads of) Bill 2013 by the Oireachtas Joint Committee on Health and Children. This document summarises my comments on the proposed Bill and the limitations that, in my judgement, exist in the current draft.

2. Professional expertise of Professor Lalor as relevant to this submission

I have worked clinically and in a research capacity within the area of prenatal diagnosis since 1995 and I have undertaken an extensive study for my Doctoral research (funded by the Health Research Board) on women's experiences of and adaptation to a diagnosis of fetal anomaly. Although the majority of women choose to continue the pregnancy, the distress at the point of diagnosis is no less significant for women who choose the alternative, which is to travel to terminate a much wanted pregnancy. Women who choose to leave the jurisdiction often do so in secret, and are forced to grieve silently when they return. This has consequences for how they resolve their grief and the potential impact on their mental health into the future. I have also recently received funding from the Health Research Board (with doctoral student Ms. Sylvia Murphy Tighe) to undertake a study to explore

why women who continue feel the need to conceal their pregnancy, and the links between concealed
pregnancy and maternal and neonatal outcomes such as abandonment and infanticide. My ongoing
work with women directly affected by distress in pregnancy and significant experience in clinical
practice place me in an excellent position to comment on the Heads of the Protection of Life During
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Pregnancy Bill, 2013. Many of my comments relate to the implementation of what is proposed in
relation to the potential for psychological distress in those women seeking to access termination of
pregnancy through the mechanisms proposed. I also raise concerns regarding the monitoring of cases
that will result from this legislation, in particular, those cases that are unsuccessful or where women
seek to appeal the decision based on the initial assessment. Additionally, I have concerns regarding
the wording, intention and interpretation of several sections. . Clarification is required to ascertain
how this Bill will apply to clinical practice in other complex clinical situations. This is because of the
potential for this Bill to valorise the life of the unborn above that of the mother, leading to the
potential for clinicians to access the Courts to enforce a caesarean section order on a woman in order
to protect the life that exists (as currently drafted).
A detailed list of current publications and current projects can be accessed at http://people.tcd.ie/lalorj1. Selected references to publications deemed to be most relevant to this
submission are listed below.

1. **LALOR**, JG, Thirty years after Article 40.3.3: Ireland is to legislate finally for termination of pregnancy,
MIDIRS Digest, June , 2013
2. **LALOR**, J, Begley, C, Galavan, E, Termination of pregnancy for Fetal Abnormality: challenges faced by
women living in Ireland opting to travel and their experiences of care in the UK, *ICM 29th Triennial*
Congress, *Durban, South Africa*, *19-23 June*, 2011
3. **LALOR,** J, Begley, C & Galavan, E, Recasting hope: A process of adaptation following fetal anomaly
diagnosis, *Social Science and Medicine*, 68, (3), 2009, p462 – 472
4. **LALOR**, J. & DEVANE, D, Information, knowledge and expectations of the routine ultrasound scan.,
Midwifery, 23, 2007, p13 – 22
5. **LALOR,** J., DEVANE, D. & MC PARLAND, P, Ultrasound screening for fetal abnormality in Ireland: A
national survey, *Irish Journal of Medical Science*, 176, (3), 2007, p175 – 179
6. **LALOR**, J., Devane, D. & Begley, C., Unexpected diagnosis of fetal abnormality: Women's encounters

with caregivers, *Birth*, 34, (1), 2007, p80 – 88
7. **LALOR,** J., DEVANE, D. & MC PARLAND, P, Ultrasound screening in Ireland: How effective is the
service?, *Irish Medical Journal*, 99, (9), 2006, p264 – 266
8. **LALOR,** J. & BEGLEY, C, Fetal anomaly screening: what do women want to know? Journal of Advanced Nursing, *Journal of Advanced Nursing*, 55, (1), 2006, p11 - 19
9. **LALOR,** J, Begley, C & Galavan, E, Peripheral fatherhood: Men's experiences of adverse prenatal
diagnosis , *ICM*, *Glasgow*, *5th June*, 2008
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3. Executive summary of key comments on the Heads of Bill

I. Title

1. Return to original title proposed Protection of **Maternal** Life in Pregnancy Bill.

II. Head 1-

1. Error: Nurses and Midwives Act 2011, not Nurses Act 2011
2. Clarification is needed re term 'unborn'- is there a requirement to have capacity to live outside the womb? This is critical in terms of the presence of a lethal anomaly, as the distress women experience following such a diagnosis renders most so grief stricken as to be temporarily unable to negotiate a complex and additionally stressful legal quagmire. Clarification must be given with regard to the extent to which it is practicable to protect the life of the unborn if this Bill is to echo the position given in defence of the State by the AG in the D v Ireland case i.e. 'that remorseless logic would not apply when the facts are exceptional'. The evidence is convincing that the emotions women feel when facing the loss of a child can be simultaneously paralysing, chaotic and overwhelming (Lalor 2009). Yet in spite of this more often than not they also have the capacity to worry about the impact on their family as their partners fear strongly the additional loss a much loved woman and mother. In other equally complex medical situations, the time taken to make a decision in the context of the risk of loss of life from a physical illness is equally important. The stage of gestation at which the request for termination occurs, and the impact that any delay in completing the medical assessment and reviewing any appeals might have on viability, however limited is critical. Although internationally most neonatologists will attempt to sustain extra-uterine life following 23 completed weeks of gestation, the outcome for neonates born at the limits of viability is grim. Is the State to allocate resources to support critically ill infants and children with significant disability and health care requirements? Will this Bill impact on the clinical decision making on neonatologists in terms of when to resuscitate (or not) under the requirement to sustain life? Is the primary intention of the Bill to further protect the

unborn or actually the pregnant woman? Without such clarity (and given the change in the title of the Bill through the omission of the word maternal) it behoves one to question whether in the context of a medical condition affecting the wellbeing of the fetus if a women may be subject to a Court enforced caesarean section also to sustain life? This also links to Head 18 and any repeal or consequential amendments to the Offences Against the Person Act 1861. The protection here is in favour of the fetus.

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3. Concerns exist regarding the potential for a fetus to be eligible to legal representation. If this is the case, does the fetus need to be viable with a realistic prospect of extra-uterine life to avail of such representation?

III. Head 2

1. It is crucial that viability is considered when the risk to the mother's life is being considered and that decisions to act in the interest of the mother are not subject to undue delay.

2. Subheading 2 also relates to II.2 above: if there is a responsibility to sustain life after delivery does this extend to before delivery?

3. No consideration has been given to the risk to life that might exist following a termination of pregnancy or perceived coercion to continue the pregnancy against one's preference and the right a woman should have to appropriate and ongoing care for her physical or mental health. Please note a death occurring during pregnancy and up to one year following the birth is classified as a maternal death.

4. Provision for the protection of whistleblowers (Similar to Children First Guidelines) is not made within the current draft should concerns be raised by healthcare professionals or members of the public with regard to how the provisions of the Bill are being implemented in practice. A mechanism to report such concerns is also absent.

IV. Head 3

1. Consultation and consensus should be reached in advance with clinical and statistical experts on a minimum dataset of outcomes to be recorded in terms of the report on cases where by a termination is performed, or is sought and refused under the provisions of the Bill.

2. Statutory reporting should be required, and clarification made as to whether there are to be implications for how cases resulting in termination of pregnancy such as ectopic

pregnancy, oncological, haematological, and other life threatening illnesses (Multiple Sclerosis etc) affected by pregnancy or requiring treatment harmful to the fetus are to be
reported, by whom, to whom. At present there is a gross lack of clarity regarding the reporting and monitoring of maternal deaths and the associated provision of inquiry into such deaths under the terms of the Coroner's Act 1962. The Maternal Death Enquiry
(MDE) report identified that many maternity units are uncertain where divisions of responsibility lie and the nature of the data to be reported. The same must not be allowed to occur in relation to the provisions of this Bill.
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V. Heads 5-7
1. Precision is required in terms of the time frames involved in initiating the process, receiving a decision, proceeding to appeal (if necessary), and receiving a decision.
2. Should an unreasonable delay occur, a clear mechanism should be in place for the woman or her advocate to invoke to accelerate matters.
3. It is wholly unsatisfactory to place a distressed woman in a position of having to apply
in writing to the HSE to have her case reviewed. It should be sufficient that a named person within the maternity care setting can be contacted and is available within 24 hours to support the woman and her advocate in initiating the appeal process. Standards
must be enshrined in law as to the maximum amount of time allowable between notification of the appeal and the sitting of the committee, and subsequent notification of
the decision to the woman. This is essential as the stage of gestation is critical to the procedure required to perform the termination and the consequent risk to the woman
both mental and physical. The State has obligations under ABC v Ireland ECHR ruling to ensure through the enactment of this Bill that the process is both effective and timely.
VI. Heads 9-11
1. The provisions as written are grossly insufficient. For example, the procedure should
include a copy of all case notes for consideration as the notes are the property of the
health service provider and the woman. The sanction for any medical practitioner withholding information (non-compliance) should include the penalty of imprisonment
as is the case in the Offences Against the person Act 1861. All breaches should be reported to the DPP; it should not be left to the HSE to choose whether to initiate proceedings against what are in effect its own staff and service providers.
2. It is critical that the original medical practitioner should not be permitted to contact the
committee and should any breach occur the consequences should carry legal sanction.
3. Procedures of the appeal committee should include a provision for the woman or her
advocate to present the case to the committee members only, and it should be

guaranteed that they are not be required to do so in the presence of the original medical
practitioner who refused the request for fear the process becomes adversarial like a civil
case.
4. The issue of remuneration should not be considered for salaried employees of the HSE.
5. All reviews should be undertaken by an external body such as CEMACH (or equivalent) and all applications to include outcomes up to six months following the delivery should be analysed. It is critical that all reviews are undertaken by an external
independent body in order to identify patterns in practice, deviations from the provisions of the Bill and variability in practice across the 19 maternity units. Such variation must be kept to a minimum to ensure women receive the best standard of care
7
irrespective of the health care provider and geographical location.
VII. Heads 12-13 and 18-19.
1. A mapping exercise to investigate the extent to which all health staff involved (medical,
nursing and allied health) would exercise their right to conscientious objection should
be undertaken to pre-empt where services might not be staffed sufficiently to enact the
provisions in the Bill.
2. The legal right to refuse treatment should be maintained to ensure that women are not
forced to leave the state in order to maintain their bodily integrity; again this point is
linked to II.3 against the potential for legal representation to be available to the fetus.
3. An opportunity presents itself here to add additional clarity on whether healthcare
personnel in Ireland can make a direct referral to an appropriate specialist in another jurisdiction when termination of pregnancy is being considered in the context of a medical condition (fetal or maternal in origin) which is not covered by the provisions of
the Bill. Given the lack of clarity in terms of whether the presence of a life threatening
event for the fetus, as opposed to the woman, there is no room for ambiguity as to whether a woman can under the provisions of the Information Act leave the State without interference in order to protect her bodily integrity from a Court enforced procedure being undertaken against her will.
Signed:
Date: 7th May 2013.

Fw: Abortion Bill
Paul Kelly
to:
C-Health
08/05/2013 10.51 a.m.
Show Details

Submissions
----- Forwarded by Paul Kelly/Office/Oireachtas on 08/05/2013 10:52 -----
Joe Varley <mjoseph.varley@gmail.com>
08/05/2013 10:52

To
paul.kelly@oireachtas.ie
cc
jerry.buttimer@oireachtas.ie
Subject
Abortion Bill

Dear Mr. Buttimer,

Under existing medical practice doctors treat two patients, the mother and the child, and make every effort to save both. Any treatment required by the mother to save her life is given to her, even if this will result in the death of her unborn child.

The result of our current medical practice is that Ireland is one of the safest places in the world for a pregnant woman and her unborn baby. However, those who want abortion to be made available in Ireland are misleadingly promoting this bill as legislation which is necessary to save the life of the mother.

The proposal to include a threat of suicide as a ground for abortion in this bill flies in the face of ALL of the expert psychiatric evidence given to this committee earlier this year. ALL of those psychiatrists told this committee that abortion is not a treatment for suicide. In addition, in a recent survey of psychiatrists in Ireland over 90% of respondents opposed the inclusion of suicide as a ground for abortion. The Government is purporting to be acting on the recommendation of the expert group assembled to consider the ABC decision but is refusing to take on board the expert testimony of Irish psychiatrists who will be asked to certify abortions if this legislation goes ahead. It is clear from this that the proposed legislation is not about women's health. It is about an ideological position that a woman should be entitled to take the life of her unborn child which should be unacceptable, indeed unthinkable, in any society which considers itself to be civilised.

At present in the UK, where abortion is effectively on-demand, approximately 200,000 unborn babies lose their lives every year. The vast majority of those abortions are carried out on the ground of protection of mental health – the very same issue we are considering here . If the bill goes ahead in Ireland with a threat of suicide as a ground for abortion then we will end up in the same situation as the

UK. It does not matter how restrictive the legislation is initially. Once the principle is established that a child's life can be taken following a threat of suicide it will become acceptable to do so and the legislation will, bit by bit, be amended to make it easier and easier to have the abortion certified as necessary, resulting in abortion on-demand.

The Irish people amended our Constitution to specifically acknowledge the right to life of the unborn. If this bill goes ahead then, due to the decisions of a handful of judges and politicians, that protection will be effectively set aside. This is a matter for the people to decide in a referendum.

For these reasons I am opposed to the propose abortion bill.

Yours sincerely,

Joe Varley

9, Terenure Rd. West,

Dublin 6w

Dympna Clancy <careerguidance11@gmail.com>
08/05/2013 16:05 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
NEW MATERNITY BILL - Written Submission. Attention: Mr Paul Kelly

ATTENTION: MR PAUL KELLY

Re: Written Submissions from an Interested Individual on the New Maternity Bill

Knockainey
Hospital
Co Limerick

8 May 2013

Dear Mr Kelly,

I do not want to see abortion brought into Ireland.

John Bruton said that our constitution provides that the baby is separate to the mother and has rights of its own. From what he said, this new legislation is against the constitution because it will be giving all the rights to the mother. I do not want abortion in Ireland.

I understand that in England 97% of abortions are obtained on mental health grounds and in Canada this is a figure of 98%. To put that in context, it means that out of approximately 180,000 abortions in the UK last year some 174,600 abortions out of 180,000 were performed because of mental health issues. People will do the same in Ireland once the barriers to abortion are opened. I do not want abortion in Ireland.

As far as I am aware, there is a lack of medical evidence to support the notion that abortion is a treatment for suicidal mothers. Doctors, and in particular, psychiatrists have come out in recent weeks stressing that abortion is not the way to treat a suicidal patient. I do not want abortion in Ireland.

Many people in Ireland believe in the Fifth Commandment: thou shall not kill. Many of those that do not hold a religious faith also believe it is morally wrong to take the life of a child. Others recognise that abortion is against the laws of nature. I do not want abortion in Ireland.

Lastly, I believe life begins at conception. We all have the potential to "be" – regardless of our location and the stage of our development. A child is a child whether it is in the womb or born, whether it is zygote

or a foetus or a “baby”. For this reason, I do not want abortion in Ireland.

If abortion is allowed into Ireland, it will become the norm. It will do nothing to enhance our society. Professionals in the UK already put huge pressure on pregnant women by suggesting abortion – even where the mother is initially happy to have her child. These women are vulnerable – often finding themselves in very difficult situations. What they do not need is a quick fix that many live to regret for the rest of their lives. I do not want abortion in Ireland.

I would like to stress that I believe no politician – who has the opportunity to vote on this legislation – should be coerced into voting for abortion… coerced into voting for abortion because they fear that by not voting for it will jeopardise their career prospects.

I understand that legislation is not an EU requirement and that improved guidelines for medical and nursing staff is all that is needed. I do not want abortion in Ireland.

Thank you for considering my views.

I would be grateful to hear back from you.

Yours sincerely,
John Clancy
(sent from gmail account belonging to my daughter, Dympna Clancy)

John M Cooney

Protection of Life During Pregnancy 2013

Liaison Psychiatry is a speciality delivering care to patients with an overlap between physical and psychological illness. Liaison psychiatrists work in general medical hospitals. Part of our work load is the assessment of patients who present to the Emergency Department either having harmed themselves or threatening to harm/self-destruct. Psychiatrists are the most experienced group in the evaluation of risk of self-destruction but it is important to clarify the extent of the validity of such clinical evaluations

Patients who threaten to harm themselves generally fall into a number of groups.

- Patients who are threatening self-harm with severe mental illness such as depression. These patients, often overwhelmed with (transient) sadness and pessimism have beliefs which they do not hold when they recover. Severe depression in this form is rare in pregnancy, but would be managed as any patient presenting with mental illness, with treatment of the mental illness

- Patients without formal mental illness who are threatening self harm. These represent a mixed group. Many of these patients are responding to significant psycho-social stressors such as relationship difficulties, lack of housing or substance dependence. In these circumstances, people will naturally seek whatever means they can to resolve their distress - some are seeking admission to psychiatric units or access to medication. In this context, threats of self-harm/self-destruction (so called suicidal ideation or intent) are not in themselves a psychiatric illness or diagnosis and do not immediately place the person under a medical as opposed to a social rubric. It is in this area that the proposed legislation, which asks psychiatrists to arbitrate on threats of self-harm in a woman with an unwanted pregnancy and with a pre-ordained intervention, namely termination of that pregnancy is unworkable and, for psychiatrists, clinically invalid.

- It is of concern that women with an excruciating & distressing dilemma may have to additionally represent themselves as being suicidal and be subject to an evaluation process that is significantly clinically suspect because of the basis it is predicated on.

22, Sandford Avenue
S.C.R. Dublin 8

6 May 2013

The Chairman
Oireachtas Health Committee
Dáil Éireann, D. 2.

Re: Proposal to Legislate for Abortion in Ireland

Dear Chairman,

It is morally wrong and legally impossible for the Irish government to legislate for the deliberate killing of an unborn child, in light of the following facts:

- God–given inalienable rights cannot be given away or taken away by man
- Natural Law has supremacy over the Irish Constitution
- The rights of the people (including the unborn), under God, are inalienable, indefeasible and sovereign. Any attempt to change this would be invalid.
- The inalienable right to life of the unborn child is equal to that of the mother
- In Ireland, Bunreacht na hEireann trumps the ECHR (a provision can be applied by the people in a referendum, provided it does not conflict with Natural Law)

- 'All powers of government, legislative, executive and judicial, derive, under God, from the people.'
- ' It follows; that every act, whether legislative or judicial in order to be lawful under the Constitution, must be capable of being justified under the authority thereby declared to be derived from God' (item 22 * see note below)
- Any legislation repugnant to Natural Law would be necessarily unconstitutional and invalid. (item 23.)
- The family (including the unborn child) possesses 'inalienable and imprescriptible rights, antecedent and superior to all positive law'

On health grounds alone, deliberate abortion is unconstitutional and in breach of the ECHR - it kills the child and *increases* the mother's risk of suicide. It fails to secure the right to life, conflicts with Natural Law and is not in the interest of the common good.

Yours Sincerely,

John O'Farrell

C.C. President Michael D. Higgins, TD, Cardinal Sean Brady, An Taoiseach Enda Kenny, TD, Attorney General Maire Whelan, Ms. Caroline Simons, Pro-Life Campaign, Family & Life, et al.

Note: * Please see letter of 15 August 2009, addressed to former Taoiseach Brian Cowen TD, items 1 – 47. Copy enclosed. My letters contain no accusations.

Annette Green <asbgreen@yahoo.co.uk>
08/05/2013 07:40
Please respond to
Annette Green <asbgreen@yahoo.co.uk>

To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Mew maternity bill - urgent

Dear Mr Paul Kelly,
i am writing to you to express my deep concern at the proposed legislation on abortion.
I work currently for the HSE and for many years also worked for the NHS in England.
The course of action proposed by the government is unnecessary, the X case issue requires clarification rather than legislation.
The unfortunate Galway death occurred due to a lack of timely medical intervention and a lack of periodic monitoring of vital signs by the nursing staff.
Life is precious and once we arbitrarily decide on a time when we consider that life begins we begin to make a judgement on the value of life. Life begins at conception so abortion is the deliberate taking of a life. in the case of maternal danger the existing guidelines though perhaps requiring clarification do adequately provide for the protection of the maternal life.
Once the concept that abortion is permissible outside of the existing provision enters into legislation, It allows for the wanton killing of innocents. A premise that quickly unravels and poisons all of society.
The legislation in England was introduced for extreme, emergency cases but now is a form of contraception, there is the recent case of the consultant using abortion for sex selection purposes.
I urge you to protect life and value the stance of this country and it's constitution and reject the proposed legislation on the basis that it is wrong and does not introduce a good either intentionally or unintentionally into our society.

Your sincerely
Mr Joseph Green MSc BSc
Ballycasheen Heights
Upper Park Rd.,
Killarney
Co Kerry
087 121 9083

To Paul Kelly,

healthandchildren@oireachtas.ie

The mantra is that we must legislate for abortion because the Supreme Court decision was given **21 years ago**.

But is this not the **very reason for not legislating? I. E. because it is so old.** Science is always updating itself. New conclusions are coming out every day.

In this regard, Eilis O'Regan reported in the Irish Independent of 25.4.2013 that **113 psychiatrists** had signed a statement that "legislation allowing abortion as a treatment for a threat of suicide, has no basis in medical evidence". **So they are saying that there is no evidence that killing the baby would cure the pregnant girl of her idea of suicide**.

So why are we going illogically for legislation? If there were a Supreme Court case right now, and that conclusion was submitted, would the Judges not **give a ruling contrary to the 1992 decision?**

Mrs K Cronin

14 Glandore Park

Dun Laoghaire

Submission: The Heads of the Protection of Life during Pregnancy Bill 2013

Introduction:

My name is Kathleen Farrell and I lecture in Dublin Institute of Technology. I am very interested in the well-being of the family for the greater good of society. I strongly believe that the right to life of the unborn child underpins all other rights and is an essential premise going forward for the healthy functioning of society. I have a PhD in the area of work-family balance from the Smurfit Business School and I have contributed at international conferences on this topic.

Executive summary:

In relation to Head 4 abortion is the direct killing of an unborn child and is not a remedy for suicide ideation. Suicidal intent is never a justification for the killing of an innocent human being. A threat of suicide does not justify abortion and there is no medical evidence that abortion is a treatment for su icide as outlined by psychiatrists at the recent Oireachtas committee meetings. Furthermore, in a nationwide survey of psychiatrists almost 90% of respondents have expressed concern over the governments' plan to include the risk of suicide as grounds for an abortion (Http:Uwww.thejournal.ie/psychiatrists-abortion-legislation). The recommendation is to remove the threat of suicide as grounds for abortion.

Regarding Head 12 it is recommended to consider the right to conscientious objection in lawful medical care as outlined by the Parliamentary Assembly of the Council of Europe 2010. In light of this resolution it is recommended to take into account the religious freedom and conscientious beliefs of any citizens who do not wish to participate or cooperate in any way with an abortion. The legitimate autonomy and religious ethos of faith-based institutions needs to be respected. They should not be obliged to perform abortions when it goes against their ethos.

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

The proposed bill proposes abortion when there is a real and substantial risk to the life of the mother ariSing from suicide intent and this risk can only be averted by the termination of her pregnancy.

Abortion is the direct killing of an unborn child and is not a remedy for suicide ideation. Suicidal intent is never a justification for the killing of an innocent human being. A threat of suicide does not

justify abortion and there is no medical evidence that abortion is a treatment for suicide as outlined by psychiatrists at the recent Oireachtas committee meetings. Furthermore, in a nationwide survey of psychiatrists almost 90% of respondents have expressed concern over the governments' plan to include the risk of suicide as grounds for an abortion (Http:Uwww.thejournaLie/psychiatristsabortion-legislation).

Recommendations:

Remove the threat of suicide as grounds for abortion.

Head 12: Conscientious objection

The proposed abortion bill is an attack on the right to life of unborn children and an attack on freedom of conscience and re ligion.

The proposed bill will limit the conscience right of pro-life doctors who if approached for an abortion by a woman is obliged to refer her to a pro-choice colleague.

Hospitals with maternity units will have to carry out "lawful terminations" regardless of ethos.

Recommendations:

The resolution passed by the Parliamentary Assembly of the Council of Europe 2010 should be considered here. The resolut ion is ca lled "The right to conscientious objection in lawful medical ca re". Paragraph one is a statement of the rights of conscientious objection both of individuals and institutions. It reads "No person, hospital or institution sha ll be coerced, 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 or embryo, for any reason" (http://www.sba-list.org!suzy-b-blog!european-union-protects-doctors-freedom-conscience).

The bill should be amended to take into account the religious freedom and conscientious beliefs of any citizens who do not wish to participate or cooperate in any way with an abortion.

The legitimate autonomy and religious ethos of faith-based institutions needs to be respected. They should not be obliged to perform abortions when it goes against their ethos.

Dr. Kathleen Farrell

6·5·'13

PROTECTION OF LIFE DURING PREGNANCY (HEADS Of) BILL 2013

SUBMISSION

Keelin O'Donoghue PhD FRCOG
Clinical Director, Women and Children, Cork University Hospital
Senior Lecturer, Department of Obstetrics and Gynaecology, University College Cork
Consultant Obstetrician and Gynaecologist, Sub-Specialist in Maternal and Fetal Medicine,
Cork University Maternity Hospital,

Cork University Maternity Hospital (CUMH) is a large tertiary-referral hospital, which opened in 2007. We deliver about 8,600 babies annually, and over 17,000 women are seen annually in our Emergency Department. All sub-specialties in Obstetrics and Gynaecology are represented at CUMH. We are also the only Irish maternity hospital of this size co-located with an acute general hospital, Cork University Hospital, facilitating access to medical, surgical and radiological specialities.

In 2012, 8,366 women delivered 8,563 infants, of whom 32 were stillborn. In addition, there were 54 late miscarriages (pregnancy loss between 14 and 22 weeks) and over 1,700 women were diagnosed with early pregnancy miscarriage in our early pregnancy clinic.

CUMH has 4-6 cases per year where a decision is made to terminate the pregnancy prior to viability, on the grounds of saving the mother's life. Such decisions at CUMH are currently made by two Consultant Obstetricians, with additional reference to the Clinical Director, and involving other medical specialists as the scenario dictates.

Comments:

The views of any Obstetrician do not necessary reflect those of their consultant group or hospital. Clinical opinions can vary according to the level of training, sub-specialisation, familiarity and involvement with complex pregnancies, and number of cases encountered throughout the working life.

It is important that Obstetricians have legal clarity when making decisions to end pregnancy – be that termination of pregnancy pre-viability or preterm delivery.

The proposed Legislation needs to be backed up by Guidelines, which should also delineate referral pathways and review processes.

These should facilitate some flexibility of decision-making to allow for clinical judgement.

Consultants making these decisions should largely be on the Specialist Register; however it is acknowledged there are Consultants in permanent posts in large units, who are not on the Register. Locum consultant staff should not be rostered in isolation without a mechanism of without senior support. Perhaps these issues can be best set out in the guidelines – there needs to be a compromise between making emergency procedures in expected obstetric complications safe, feasible and legal in

all units, with access to the facilities and expertise of larger more-specialised units in rarer situations where complex medical issues arise.

Two obstetricians should be involved in making the decision, with due recourse to other medical specialities as the clinical situation demands. The support of a second obstetrical (consultant) opinion should be sought in all but the most extreme circumstances.

As pregnant women with severe illness requiring specialised in-patient treatment may be in a general hospital, all general hospitals need to be involved in these procedures, but with involvement of the appropriate specialists (i.e. Obstetricians should still be involved in decision-making and procedures). This is not a major issue for those hospitals co-located with adult facilities.

Obstetricians have to rely on Psychiatrists to determine whether suicide ideation is true intent and poses a real and substantive risk to the life of the woman.

SUBMISSION

PROTECTION OF LIFE DURING PREGNANCY BILL 2013

OIREACHTAS HEALTH COMMITTEE 20th May 2013

By Dr. Keith Holmes

Consultant Child & Adolescent Psychiatrist

Summary

As legislation that purportedly addresses issues pertaining to the X Case, the proposed Heads of Bill not alone struggles to deal with the issue of pregnant minors seeking a termination of pregnancy, there is in fact no mention whatsoever of children within the Heads of Bill, effectively making it unworkable with regard to pregnant minors. Parenthetically, in my experience working as a Consultant Child and Adolescent Psychiatrist, I have yet to come across a situation where an abortion is the treatment for suicidal ideation in pregnancy.

Introduction

It is assumed that the proposed legislation is intended to apply to all pregnant women, not just those who are adult. However, the utter absence of any mention of pregnant minors, and the unworkability of the proposals in the case of pregnant minors, while on the one hand reassuring to those of us whose first instinct is to "do no harm" and who feel that there is no role for Psychiatrists in adjudicating over the permissibility of abortion in those who do not have mental illness, nonetheless does lead to concerns that there may be, at some point, an introduction of an "in exceptional circumstances", or "emergency" clause which may in fact override much of what has been laid down in the Bill.

In particular I will look at Head 1, Head 4, and Head 6.

Head 1

Within the interpretation, there is a definition of "Psychiatrist" as a medical practitioner who is registered in the Specialist division of the Register of Medical Practitioners. Nonetheless, there is no mention of which specialties are in fact involved in the working of the Bill. For example, might one wish to have a pregnant thirteen year old girl assessed for suicidality by an Old Age Psychiatrist? If it is the case that this law is to apply to minors, then it should be clearly stated that a minor should be seen and assessed by a Child and Adolescent Psychiatrist. Furthermore should it also suggest that a pregnant woman who has a significant intellectual disability must also be seen and assessed by a Psychiatrist who is a specialist in Intellectual Disability? This is of more than just academic importance, as will be addressed in Head 4.

Head 4

If we look first at the criteria that the Psychiatrist must fulfil in order to be considered suitable under Head 4, it states that "both of these Psychiatrists must be employed in a hospital or other inpatient facility…….registered by the Mental Health Commission under the Mental Health Act 2001" and furthermore mentions "one of these should be attached to the institution where such a procedure is carried out".

With respect to a pregnant minor, there are approximately six Consultant Child and Adolescent Psychiatrists in the country who are attached to publicly funded Approved Centre registered by the Mental Health Commission under the Mental Health Act 2001, as the great majority of the remainder are employed in Community based outpatient teams. To the best of my knowledge, there are no Intellectual Disability Consultants attached to Approved Centres. Furthermore, to the best of my knowledge, there are no Child and Adolescent Psychiatrists attached to "any such institution where such a procedure is carried out".

Therefore, from the very beginning, with respect to the X Case, we have an effectively unworkable Act. If the pool of Psychiatrists from which the two are drawn to partake in a Panel is six, and none of these are attached to an obstetric unit, how can this Act proceed?

Furthermore, if this law in invoked on more than a small number of occasions, it would become very clear very quickly which Psychiatrists hold which views with regard to the permissibility of abortion in non mental health-related issues regarding suicidality. It is unclear if there is a proposal whereby a woman can effectively ask that a Psychiatrist (or an Obstetrician) be appealed against because of their previous record, but given the paucity of numbers that can be involved of Psychiatrists, it leads to significant problems.

Notwithstanding these problems, the glaring omission in Head 4 is looking at the issue of Consent in those who are still children. The law in this matter is the "1968 Non Fatal Offences Against the Person Act", whereby it allows that a sixteen year old has the capacity to consent to medical dental or surgical procedures, but not to refuse lifesaving treatment. Because the law is silent on mental health assessment, the common practice is that

those who are under the age of eighteen require consent from their guardians in order to proceed for a Mental Health Assessment. Therefore, it would be up to the minor's guardians to consent to the initial mental health assessment on behalf of their child. In some cases this may be straightforward, but in cases where guardians disagree, recourse to the Courts is often sought, and this will clearly complicate matters. Furthermore, in cases where the HSE, acting for the State is acting in loco parentis, the problem is compounded. Therefore, when one speaks of the notion of "informed consent" under the terms of this Act, it is the informed consent of a parent/guardian rather than the young pregnant girl. In the eyes of the law the girl herself is not a fit person to consent.

Among my colleagues, there is a degree of confusion about Sub Heading 4 under Head 4, stating that it will be a matter for the patient to decide if she wished to proceed with the termination following a decision that it is permissible under this Act. If, in the wisdom of the Panel, it is agreed that a minor can proceed with a termination, it can only be if this is seen as "lifesaving". However, the 1968 Non Fatal Offences Against the Person Act makes it quite clear that that those who have yet to reach the age of majority cannot refuse lifesaving treatment, and therefore there is a real question of whether or not they are in fact in a position to refuse this treatment. If the treatment were not lifesaving, the Panel would not agree to it, and if the treatment is lifesaving, the young person cannot refuse it. If, on the other hand, there is a way in which this is not seen to be lifesaving, and further consent is required for a termination of pregnancy, we are then faced with a somewhat puzzling situation where a pregnant sixteen year old requires parental consent to be seen by a Psychiatrist but can consent to an abortion herself.

It appears, from this arrangement that a psychiatric assessment is of a higher order of impact to the young person thereby requiring parental consent when compared to an abortion.

Head 4 also outlines the wish that the young person's General Practitioner be involved, and that is certainly sensible. However, given the likelihood that if the young person has previously required psychiatric input, given the virtual stipulation whereby the treating Psychiatrist cannot be part of the Panel unless they work in an approved centre, there should also be clarity that the young persons treating Psychiatrist, be consulted if indeed they have one.

<u>Head 6</u>

In Head 6, which deals with Formal Medical Review Procedures, grounds are laid out whereby an appeal can be made to review a case. What has not been envisaged by those who drafted the legislation is the possibility of an appeal against an agreement to permit a termination. While this is unlikely to happen in a case where an adult woman is seeking a termination, it is quite likely in a case where a minor is seeking a termination, and represented by one guardian, but with disagreement from another. It is quite likely that one parent may wish their child to receive a termination whereas the other may not, and the law does not allow this difference of opinion to be addressed. It is also unclear who can appeal on behalf of the minor, irrespective of the finding, whether it can be the minor herself, or whether it has to be her guardians who do it on her behalf.

Confidentiality

What has not been addressed at any point in this Bill is the relationship between this Bill and Minister Fitzgerald's proposed Bill regarding Children First Guidance, placing it on a Statutory footing. This will also ensure that any minor who is pregnant before the age of seventeen, or who is likely to have become pregnant before the age of seventeen, must have their details passed on to the HSE for further investigation, as it is implicit that transgression of the law has taken place because of the age of consent for sexual activity being seventeen years old, and it is unclear from the Heads of Bill who in fact should carry this out, if it has not already been done.

In Summary:

This Bill fails to address the complexity of the X Case, fails to address the possibility that a minor may be pregnant and seeking an abortion, fails to address the complexities of Consent, and is essentially unworkable when looked at with respect to Psychiatrists who can appropriately form a view in line with this legislation. While this may act as a deterrent, one fears that an exclusionary clause may be inserted which will effectively open the flood gates.

Signed:

_____

Dr. Keith Holmes

Consultant Child & Adolescent Psychiatrist

Submission on the Protection of Life During Pregnancy (Heads Of) Bill 2013

Author: Ken Igoe
Address: 34 Coil! Beag, Ratoath, Co Meath
Mob: +353 (0) 87 644 5398; Email: ken.igoe@gmail.com

In reference to Heads 2, 3 and 4 of the proposed Protection of Life During Pregnancy (Heads Of) Bill 2013, concerns relating to the moral authority regarding the proposed bill and its constitutional compatibility
5/7/2013 Cover Note

Introduction
As a citizen of Ireland, husband, and parent I am writing this submission to highlight the concerns that I have with the proposed bill, in the hope that it will help guide the committee in its ultimate decision making process.
I am not a member of any lobby or activist group but base my moral guidance on my Roman Catholic religion which has driven the basis of our own constitution particularly pertaining to the section on Fundamental Rights. I believe there are elements in this bill which directly threaten the fundamental rights outlined in Article 40.3.3°: *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.*

Executive Summary
Head 2:
This section attempt to clarify the decision making process regarding the determination of *"a* real and substantial risk of loss ofthe pregnant woman's life". It fails to go far enough in defining a real and substantial risk and also fails to qualify the equal human rights status ofthe life of both the unborn child and the mother.
Recommendation - A clearer definition of *"a* real and substantial risk of loss of the pregnant woman's life", and based on the equal human rights status of both the life of the unborn child and the mother.
Head 3:
This section attempts to define the course of action a medical practitioner is authorized to take in cases of medical emergency, where the sole responsibility for determining *"a* real and substantial risk of loss of the pregnant woman's life" is with the medical practitioner. The level of entrusted power on the medical practitioner, while understandable, lacks the oversight and accountability to ensure such decision making processes are fundamentally compatible with Article 40.3.3 of our constitution.
Recommendation - An after action review commission as opposed to a letter to the Minister is required to fully determine whether appropriate and reasonable decision making processes are followed in cases where termination is enacted as a result of a medical emergency.
Head 4:
This section legislates for termination of the unborn child in cases where there is a risk of the mother committing suicide. This cannot be legislated for constitutionally and is in direct conflict not only with Article 40.3.3 but also Article 40.3.2.
Recommendation - Head 4 should be removed from the proposed bill
1

Details

HEAD 2:

The State is required to provide a duty of care to both the life ofthe unborn child and mother and to treat the right to life of both as equal. There are particular lIuncertainties" in Head 2 which have potential to directly impact this equal rights status.

1.b.i States: *lIa* real and substantial risk of loss of the pregnant woman's life". The vagueness of this statement makes it difficul~ to ascertain how this decision making process is executed.

For example it is unclear:

Ql) whether all options have been exhausted regarding saving both the life of the mother and the life of the unborn child?

Al) The bill should state explicitly that all options to save both the life of the mother and the life ofthe unborn child must be followed before arriving at a decision to terminate.

Q2) in situations where the unborn child's life is viable but the life of the mother is at threat?

A2) This is a particularly difficult situation to define, constitutionally both lives should be regarded as equal, and as such prioritization of one life over another is morally difficult to define. Timing of risk to life during the pregnancy is a key consideration here. If risk to life is likely to occur beforethe unborn child can viably survive outside the womb then the mother's life should be prioritized. After this period it becomes a matter of debate, and perhaps in such situations final decision should be left with the mother and / or close family.

Q3) how the decision is arrived at during different stages through the term of the pregnancy?

A3) The definition of unborn child needs to be explicitly defined in this bill. By definition the classification of an unborn child should be from time of egg fertilization as this initiates the process of life. Any attempt to de-prioritize the life ofthe unborn at any stage in the mothers pregnancy (outside of the situation highlighted above in A2) should be regarded as in direct conflict with Article 40.3.3° of our constitution.

HEAD 3:

In the case of the decision making process to terminate the unborn child resulting from a medical emergency, it is obviously impractical to form a €Ommittee to define *lIa* real and substantial risk of loss of the pregnant woman's life". Such situations entrusts significant power on the medical practitioner to make this decision and as such there must be a defined process for accountability. In these situations an after action review of the decision process must be significant and thorough and conducted by an appropriately qualified committee (akin to the committee review process proposed in Head 2 of the

2

bill). The committee must be charged with investigating whether due process and consideration was applied in the decision making process by the medical practitioner and also define guidelines for medical practitioners with the intent of influencing their decision making process in such ways that are compatible with Article 40.3.3° of our constitution. Any emergency decision made which is deemed to violate Article 40.3.3° of our constitution should be followed up with the appropriate level of disciplinary action.

HEAD 4:

This section of the bill legislates directly for cases where the mother of the unborn child is considered suicidal and as a result, both lives are at risk. This situation cannot be legislated for under our current constitution and I believe it is not possible to categorically determine the true nature of a mothers "state of mind" regarding potential to self harm or threat to self harm. This legislation is entirely anti life in its intent and has the effect of removing the moral responsibility of the mother to protect the life of the unborn child.

Any attempt by a mother to take her own life along with the life of her unborn child should be considered legally as murder, and any attempt to legislate for self destruction is morally akin to

facilitation of infanticide. As such this legislation is in direct conflict not only with Article 40.3.3° of the constitution but also Article 40.3.2°: *The State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen.*

Constitutionally the state is obliged to directly protect and legislate to protect the life of every citizen including the unborn child. Any attempt to facilitate termination based on a risk of self destruction is unconstitutional and morally reprehensible.

Signed:

Ken Igoe

Kevin Mulcahy <kevmulcahy@gmail.com>
08/05/2013 02.19 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Maternity Bill 2013

Dear Sir/Madam,
I wish to make a submission regarding the government'rg proposed abortion legislation. I believe this legislation will pave the way for abortion on demand and I believe that there is no justification, moral or otherwise for the deliberate and intentional killing of an unborn child in the womb.
Whilst the recent case of Savita Halappanavar, was extremely sad and very tragic, I believe system errors and failure to provide appropriate medications and the failure to monitor her condition ultimately led to this tragic outcome.
Whilst the irish media and pro abortion groups, believe that a termination would have saved this woman's life, alluding to the x case in 1992, I believe medical errors and system failures were ultimately responsible.
This debate has been totally one sided and no one has stopped to consider for a moment the physical and emotional harm that a termination can do to a woman. This harm is irreversible and has lifelong consequences not only for the person, but their families and friends.
Abortion destroys our hopes our dreams, our future. It is not the solution that media and pro abortion groups make it out to be. It is murder in every sense of the word.
We cannot say in ireland, that we have respect for human life, and abhor situations when somebody is gunned down and yet we are prepared to countenance legislation which will facilitate the deliberate and intentional killing of an on born child. This is not respect for human life.
The government will say it is legislation is restrictive and will only allow termination where there is a substantial risk to the mother's life including suicide.
I believe however, this will open the floodgates and lead to a liberal abortion regime in ireland. I am not arguing from any moral or religious point of view, but believe that abortion in any circumstance is completely wrong, inherently evil and can never be condoned.
If we could see how abortions are carried out, I'm sure each of us would be totally shocked and repulsed. Yet no television station in ireland will show this because it is too graphic. How then can we have an informed debate, without seeing abortion for what it really is, a form of extermination.
In drafting this legislation, Irish society is going beyond a pint from which there is no return. I believe in God and I also believe that He has the right to give life and also to take life. I also believe in judgement. Make no mistake about this, those who draft and support this evil legislation will be held accountable by Him.
Yours sincerely,
Kevin Mulcahy.

Kieran Troy <kierantroy@gmail.com>
08/05/2013 04.12 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Submission on the protetion on life during pregnancy bill

Newtown, Rahan, Tullamore, Co. Offaly
May 8th 2013

Dear Paul,
this is a submission on the proposed bill. Please acknowledge receipt of same.
Best wishes,
Kieran Troy (086 3256639)

Submission
Before considering the merits of the proposed legislation, it is essential that we ask why the government feels bound to introduce the legislation at this particular time. There are two possible (and very different) reasons why one might wish to legislate for X:

1. The X-case judgement protects the lives of expectant mothers because it makes legal certain courses of action that will avert grave dangers to their lives during pregnancy. The courses of action allowed by the X judgement must be codified into law so that the medical profession will be free to pursue these courses of action when the particular risk conditions arise.

2. When judgements of a certain sort are made by the Supreme Court, the government has a solemn duty to codify those judgements into law.
1. X legislation is good law that safeguards the lives of expectant mothersLet us consider the first motivation for legislating for X. In cases where there is a substantial risk to the life of the mother, and where the termination of the pregnancy is the only way to avert that danger, then it is right and proper that the government should clarify the legal status of the termination of the pregnancy under these conditions. It is clear that such termination in the case of grave risk to the life of the mother is qualitatively different to what is usually meant by the term “abortion”. If termination is the only reliable way to safeguard the life of the mother, then such termination qualifies as being a genuine treatment for the mother’s condition. This is the crucial acid-test of the rightness or wrongness of a termination of pregnancy in the light of article 40.3.3 of

the Constitution. If other credible and viable treatments of the mother's condition are available, then the decision to effect a termination goes against the right to life of the unborn as protected by article 40.3.3.

In the case of an expectant mother with suicide ideation, there is an overwhelming consensus among the professionals that termination of the pregnancy cannot be identified as being either the only, or an appropriate, treatment for the mother's condition. In the first place, it is impossible to establish that the termination of the pregnancy might be the sole course of treatment for the suicide ideation. Other forms of treatment are proven to be effective for averting suicide. Secondly, there is a general consensus in the psychiatric profession that abortion is not
a sure treatment at all for suicide ideation. There is no evidence whatsoever that it reduces the risk of suicide. Thirdly, to undergo an abortion in such a mental state has potentially damaging consequences for the mother. At the Oireachtas hearings, medical professionals stated clearly that a woman who is suicidal is in no mental condition for the
life-changing and irreversible procedure that is abortion. Fourthly, to those who claim that abortion "can't do any harm" in the case of suicide ideation because - they claim - it has no long-term damaging consequences for the mother, it would be a moral outrage of the highest order to permit the termination of a human life for a speculative course of treatment
whose efficacy has no basis in the evidence whatsoever.

Is the government then justified in introducing the segment of the legislation that permits termination in the case of suicidality on the grounds that such legislation safeguards the life of the mother? Clearly not. Such legislation has no grounding in medical evidence. We have no legitimate reason whatsoever for believing that such legislation would do anything to safeguard the lives of expectant mothers.

2. The government has a solemn duty to legislate for XThe X-judgement was made by the highest court of the land. Does that mean that the government must act upon it even if it (the government) agrees that the judgement has no basis in medical evidence? Is the government duty-bound to introduce a law that purports to safeguard the life of the mother even if there is overwhelming consensus among the professionals that there is no evidence that such a law will safeguard the life of the mother? Surely the government is also duty-bound by the Constitution to
protect the life of the unborn child except in circumstances where there is no other remaining option but to take that life in order to protect the life of the mother? This clash between the Constitution, the X-judgement, and the medical evidence can be put in stark terms as follows:

i) The Constitution guarantees the right to life of the mother and her unborn child.
ii) The X-judgement states that the termination of the pregnancy is permitted if such action is necessary to save the life of the mother.
iii) There is no medical evidence to show that termination in the case of suicidality is an action that safeguards the life of the mother.
iv) Therefore abortion as a response to suicidality cannot be permitted under the Constitution.

There is a general consensus that there is a serious clash between the X-judgement and the medical evidence. Is the government still duty-bound to act on X? Abraham Lincoln's great contribution to history was the stand he took against the U.S. Supreme Court decision of 1857. This decision stripped the most vulnerable segment of American society - the black
population - of the rights accorded to citizens under the constitution. The X-case judgement has much in common with the U.S. decision of 1857. The U.S. decision infringed on the rights of the black population because of a flawed conception of what it is that constitutes an American citizen. The court in the X-case infringes on the right to life of the
child in the womb because of a flawed conception of what constitutes appropriate "treatment" for suicidality. The Irish court heard no medical evidence regarding the suitability or efficacy of abortion as a

solution for suicidality, yet decreed that the direct killing of the life in the womb was an appropriate course of treatment. In making this judgement, the
court stripped the most vulnerable members of our society of their most fundamental and basic human right – the right to life. And it did so by making that right subordinate to a "treatment" that no credible medical professional accepts as being appropriate or effective in the first place. Many of the most prominent figures in the American establishment derided and condemned Lincoln for defying the authority of the U.S. Supreme Court.

The pro-life movement in Ireland is being subjected to derision at the moment for questioning the decision to legislate for X. Crusades to legislate for court judgements need not always be noble in spirit. Indeed, as the American case shows, a crusade to reject a court decision can sometimes be the most noble thing of all. Truly noble crusades are those that are driven by a concern for the rights of the most vulnerable.

Is the government compelled to legislate for X by the A, B and C ruling of the European Court of Human Rights? No. The court decreed that Ireland must clarify whether and under which circumstances a termination may be performed to save the life of a pregnant woman. Evidently, this can be achieved without permitting abortion as a response to suicidality.

The statute books of most states have obsolete laws that no-one would consider trying to enforce. It would be inappropriate to try to enforce these laws because they refer to archaic conditions that no longer arise.

Enforcing such laws would not bring about the good that the original law was introduced to procure. These laws were originally passed in order to protect the lives, or rights, of citizens in particular circumstances. The circumstances have changed, however, and the implementation of these laws would do nothing now to safeguard the rights of citizens. The premises on which these laws are based no longer have a basis in everyday life. The X judgement is based on the premise that abortion can avert the risk of suicide. This premise has no basis in the medical evidence. Just like the many obsolete laws on the statute books that no one would dream of
enforcing, the X judgement (as far as suicidality is concerned) does nothing to safeguard the lives or rights of citizens. Enforcing the X judgement would not bring about the good that the original decision was intended to procure. The government is aware of this fact, so why is there such a headlong rush to enforce it legally? If the government's haste is
derived from ideological or political motives, then that would be a moral outrage of shocking proportions. Bad laws are often enforced for political motives, but the government's proposed legislation is no ordinary law because it permits the killing of innocent human beings as a medical "treatment" that has no basis in medical evidence.

Based on the above considerations, I ask that the segment regarding suicidality (Head 4) be omitted from the proposed legislation. It has no basis in medical evidence and is extremely vulnerable to abuse, as the situation in other countries testifies unambiguously. I ask that the government initiate a transparent and open debate about the rightness or wrongness of the X-case interpretation of the constitution. Despite the passage of more than twenty years, we have never been permitted this debate by the general tendency of the media to confuse the X-case with the completely different issue of whether broader abortion rights should be allowed. The way that the Savita story was handled by the media illustrates clearly how this deliberate campaign of
confusion and manipulation operates. I am not asking that the government ignore the X-case insofar as it touches on the issue of suicide ideation. But it would seem wise to consider first the X-case on its own and with the kind of mature attention that it deserves. The growing accumulation of medical evidence, and new testimonies from women who have had abortions
(for example the lady involved in the 1997 C case) can only assist us in coming to a proper decision as to how to act on X. The wellbeing and safety of pregnant women and their unborn babies must be our priority, not a sense of obligation to transform court decisions (that are not based on credible premises)

into law.

Yours sincerely,
Kieran Troy

Submission in relation to the Outline Heads of the

Protection of Life during Pregnancy Bill 2013

Brief Introduction: Since 1983 I have been involved in the pro-life movement in Ireland, in various ways.

Executive summary of submission : The proposal – as outlined in the Outline Heads of the *Protection of Life During Pregnancy Bill 2013* – appears to be totally contradictory, and is based on the false premise that it is required to legalise the practice of abortion, i.e., the killing of unborn children, in order to safeguard the lives of pregnant women. The ECHR judgment does not require Ireland to legalise the killing of unborn children – it merely laid down that Ireland should clarify matters surrounding the X case (see below, at Head 4).

List of recommendations for consideration by the Committee:

1. Abandon the present proposal.

2. Replace with explicit guidelines for the care of women in pregnancy, such as those that have been in place up until now, and which are deemed internationally to be providing maternal care of the very highest order for both mothers and their unborn babies.

Head 1 –

'Appropriate location' – locations approved by the HSE, except in the case of emergencies (see Head 3)?

'Implantation' – the newly-created human being comes into being at the moment of fertilisation, therefore the right to life is being denied to a human being before 'implantation'.

'Medical procedure' – i.e., abortion, which is the killing of an unborn child.

'Unborn' – *Bunreacht na hÉireann* refers to the unborn child as *beo gan breith*, that is, 'the living not having been born'. How can an implanted embryo be alive if he or she has not already been alive?

There is a reference to *Roche v Roche & Others*. However, this particular case is not the end of the matter, and there is the possibility of other cases cancelling out *RvR*, in time.

Head 2 –

Reference is made to a 'medical procedure' – 'in the course of which … unborn human life is ended.' Why not say 'abortion'. Why is there reference also to 'termination', when what is intended and meant is 'abortion'.

Abortion is the killing of the unborn child, carried out in various ways. Why are the various methods of abortion not listed here? (Or under Head 1?)

Head 3 –

See comments at Head 2. The final paragraph under this Head demonstrates the farcical nature of the proposed Bill. In 'emergencies', the 'conditions' presented do not apply. What else is this but abortion on demand.

Head 4 –

The X case judgment was made with no medical evidence, and no psychiatric evidence having been made available to the Supreme Court judges. In the intervening time since then, and particularly arising from the expert evidence presented in the January 2013 Hearings before the Oireachtas Committee on Health and Children, it is immoral, unethical and wrong to accept that abortion is a treatment for suicidal ideation.

It is constantly put forward, particularly in the media, that the people – in the 2002 abortion referendum – wished to retain the threat of suicide as it arose in X. This is totally untrue and misrepresents the wishes of the majority of Irish people. Pro-life people throughout Ireland – myself included – voted NO in the 2002 referendum because of the fact that many safeguards for unborn human life would have been removed had the referendum passed. Similarly in the 1992 referendum, to which I also voted NO.

Head 5 –

Words with no meaning.

Head 6 –

‘ … a medical procedure in the course of which or as result of which unborn human life may be terminated/ended …’. What is meant here is ‘ … an abortion, killing the unborn child …’.

Why hide the truth?

Head 7 –

A term of 14 days could be involved here.

It reminds one of Wannsee, and the deliberations at that location.

Head 8 –

See above, at Head 4

Head 9 –

Words. . .

Head 10 –

What does this Head mean, other than that the Bill is providing for the provision of abortion – the killing of unborn children.

Head 11 –

See above, at Head 10.

Head 12 –

This does ***not*** provide for conscientious objection.

Head 13 –

These two provisions are already included in the Constitution of Ireland.

Head 14 –

This gives *carte blanche* to the Minister for Health, or any future Minister, to make any regulations that he or she wishes, at the behest of Europe, or international abortion providers.

Head 15 –

See above, at Head 14.

Head 16 –

See above, at Head 14.

Head 17 –

See above, at Head 14.

Head 18 –

This is a most outrageous suggestion, and it is totally unnecessary. If implemented, it would remove the current legislation prohibiting abortion in Ireland (and elsewhere) in one fell swoop. The proposal, if proof were needed, indicates the true purpose of the so-called *Protection of Life during Pregnancy Bill 2013*, which is to legalise the killing of unborn children in Ireland.

Head 19 –

Meaningless, in the context of the remainder of the Bill proposals.

Head 20 –

Of little importance.

Lelia O'Flaherty

8 May 2013

Leonard Coughlan <leonardcoughlan36@gmail.com>
08/05/2013 04.52 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Heads of Protection of Life during Pregnancy Bill for Mr Paul Kelly

Leonard Coughlan,
6 Grosvenor Place,
Wellington Road,
Cork City,
Ireland

Leonardcoughlan36@gmail.com

(085) 1124293

Dear Committee,

There is absolutely no need for this head of bill to be legislated and passed. Doctors always do a sterling job and there is no legal ambiguity in relation to this matter.

It angers me that the Minister sees a need to legislate for abortion. It will never be morally justified nor is medically necessary which results in the tragic loss of a dead unborn baby.

It wouldn't matter if two or twenty medical practitioners were involved in the service of referring and carrying out of abortion on a suicidal pregnant woman as they only have a 2% accuracy rate of predicting if they are truly suicidal or not. All they would do is tick the boxes to cover themselves from being sued. Even if the woman was truly suicidal, the right course of treatment is psychiatric care and medication. Suicidal thinking will eventually go away over time.

I dislike the terminology that is used in this Bill. What "a lawful termination of pregnancy" really means is abortion.

One of the greatest lies being told about abortion in this Bill is the claim that there is a need for abortion when there is a real and substantial risk to the life of the mother. This is nonsense. It is medically necessary treatments that save mothers and babies during emergency pregnancies.

Contrary to what politicians have been saying about this matter, the Court of Human Rights never obliged Ireland to legislate for the X case. They asked that Ireland clarify their position and it is a scandalous that the people are not being allowed another referendum. Abortion has reared its ugly head for 40+ years in this country and the majority of the Irish people have made their feelings known that they will not tolerate abortion in this country.

It is awful to put medical professionals in a moral dilemma by introducing abortion here. Conscientious objection only shares the sin because one

medic will be passing the buck to another to carry out the dreadful deed.

Your Sincerely,

Leonard Coughlan

Covering Note:
Name: Liam & Attracta Coleman
Postal Address: 7 Rock Court, Blackrock, Dundalk, Co. Louth.
E-mail address: =~:c. ===
Telephone No: 087-2339902
Why we are making a submission:
As citizens of Ireland, we consider the introduction of abortion legislation in Ireland to be:
1. A grievous wrong to be perpetrated against the weakest and most defenceless of our fellow human beings;
2. Contrary to the wishes of the Irish people as expressed in referenda and national elections. The mandate of this government has been misrepresented as being elected to introduce this legislation - this government did not seek a mandate to introduce abortion in this country and indeed Fine Gael (the major party in this government) promised that it would not introduce legislation to gi ve effect to the X Case;
3. Contrary to the aspirations of the founding fathers of this State and of the fundamental principle underlying the Irish Constitution as set out in its Preamble - ' ... to promote the common good, with due observance of Prudence, Justice and Charity'.
Our submission is being made by us as citizens of Ireland. However, it has been reviewed and approved by fellow citizens who hold similar views to ours. We set out the names and e-mail addresses of those who have also approved of this submission. However as there was insufficient time to obtain and include their hand-written consent, if necessary, this submission should be considered to be that of Liam & Attracta Coleman only.
While we consider that our submission speaks for itself, Liam Coleman, will, if required, be willing to meet with the Committee to discuss this submission.

Executive Summary and Recommendations:
The Irish Constitution in its preamble, its overriding objective and fundamental basis, commits the people of Ireland to " .... 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, true social order attained ..... "
Our concern with the proposed legislation is that it does not reflect this fundamental principle to which the Constitution commits the people of Ireland - including the legislature.
The Supreme Court decision in the X Case has been shown to be deeply flawed as witnessed by the compelling evidence given by psychiatrists to the January 2013 Oireachtas Hearings. Therefore any legislation giving effect to this decision cannot meet the fundamental principle upon which our Constitution is based: Prudence, Justice and Charity.
Based on our personal deeply held fundamental principle of Love - for all beings and for our environment including our culture, we consider that:
1. as a fundamental principle, everyone has the equal right to life - from conception to natural death;
2. laws shape publicly held values and the proposed introduction of abortion legislation will cause a fundamental shift away from consideration of the good of society as a whole to the growing culture of the supremacy of one's personal rights over the equal rights of othersa shift away from the 'common good' as set out in the Irish Constitution;
3. from the moment of conception, there are 2 lives and every possible effort should be taken to preserve the lives of both mother and child as is the current medical practice in the Republic of Ireland.
Recommendations:
As the basis for this proposed legislation is flawed, it is not appropriate to make recommendations on a "Head by Head" basis as requested in the notes on making a submission.
We recommend that:
1. this proposed legislation not be enacted;
2. the Irish Government enter into a period of consultation with all interested parties to seek

to and bring forward proposals to redress the unsafe precedent established by the Supreme Court in the X Case so as to ensure that Ireland's safety for her expectant mothers and babies is enhanced;
3. this area of medicine be regulated by medical guidelines which reflect best practice internationally and are updated and enhanced as medical knowledge and practice continues to develop in obstetrics.

List of Approvers of Submission of Liam & Attracta Coleman:
From: Peter Rust [mailto:peterrust@eircom.net]
Sent: 07 May 2013 19:26
To: Attracta Coleman
Subject: Re: Submission to Oireachtas Committee
Hi Liam,
Please include me my e-mail ispeterrust@eircom.net
regards
Peter [Rust]
From: oonagh meeartney [mailto:oonaghmeeartney@hotmail.eom]
Sent: 06 May 2013 22:11
To: Attracta Coleman
Subject: RE: Submission to Oireaehtas Committee
Hi Liam,
Very good letter, I would be happy to put my name on the list
Oonagh McCartney
From: Edward Donaghy [mailto:edwardjdonaghy@eircom.net]
Sent: 06 May 2013 20:04
To: Attracta Coleman
Subject: Re: Submission to Oireachtas Committee
DEAR LIAM,
PLEASE PUT FORWARD MY NAME.
GOD BLESS
CARMEL [Donaghy]
From: martin me guill [mailto:mmeguill@hotmail.eom]
Sent: 06 May 2013 17:39
To: Attracta Coleman
Cc: oonaghmeeartney@hotmail.eom
Subject: RE: Submission to Oireaehtas Committee
1
..... I would be pleased to include my name on this letter
Martin McGuili
From: "gerry"
To: "Edward Donaghy"
Sent: Monday, 6 May, 2013 8:38:34 PM
Subject: Re: Fwd: Submission to Oireachtas Committee
Hi Carmel
Please include our names to your submission to the oireachtas committee.
Gerry Carroll
From: "Monica Gahan" –, :, . :. . : ; : : :. . !. !. : ˜–=˜˜˜˜. !. !. . !. :. ˜
To: "Edward Donaghy"
Sent: Monday, 6 May, 2013 9:33:50 PM
Subject: RE: Submission to Oireachtas Committee
Thank you. Yes I do want my name and email address added to this.
Monica {Gahan]
Subject: Re: Submission to Oireachtas Committee
..... Please include my name and email on the submission.
From: "Sheila's Email"
To: "Edward Donaghy" <edwardidonaghy@eircom.net>
Sent: Monday, 6 May, 2013 11:10:04 PM
Subject: Re: Submission to Oireachtas Committee
..... please include my name and tonys and my email address.
Sheila [& Tony Murphy]

From: =====:. . . : : : :. : : : :~: : :. . :. !. :.
To: orH"""-'"
Sent: Tuesday, 7 May, 2013 8:06:00 AM
Subject: Re: Submission to Oireachtas Committee
Catherine Spillane
Certainly use my name
2
From: =. . :. . :. . !. . . :=: : :. :. . . :. : :=-″″' –' : : :. !. :–. :=: : :. : :. :. :. . :. :~
To: "Edward Donaghy" ' ==:. :. : : : : J=~:›. :. :. 1–=' : : : :' :' :″: :~. !. !. !. . !. ='
Sent: Tuesday, 7 May, 2013 8:40:05 AM
Subject: Re: Fwd: Submission to Oireachtas Committee
..... I am happy if you could include my name and email address **in** the submissions to the Oireachtas Committee.
Tom Rice
From: "Deirdre Lonergan" <deirdre!onergan@hotmaiLcom>
To: "Edward Donaghy" <edwardjdonaghy@eircom.net>
Sent: Tuesday, 7 May, 2013 12:28:54 PM
Subject: RE: Submission to Oireachtas Committee
yes please include my name and email address
[Deirdre Lonergan]
From: Margaret McNamara [mailto:kevinandmargaret@gmail.com]
Sent: 07 May 2013 21:04
To: info@dsoe.ie
Subject: SUBMISSION TO OIREACHTAS COMMITTEE
Kevin McNamara
Margaret McNamara
email address =..:..::.====::::=..:;;;:.".====
To: "Carmel Donaghy"
Sent: Tuesday, 7 May, 2013 7:28:36 PM
Subject: RE: Submission to Oireachtas Committee
Marga ret Doyle email: =″–' =' –=' ~″––' –=:. . :. . :. . : : :=. : : :. =
3

This submission is s'
Liam Coleman:
Attracta Coleman:
Date: 07-05-13
As the basis for the proposed legislation "Protection of Life during Pregnancy" is flawed, it is not appropriate to formulate our submission on a "Head by Head" basis as requested in the notes on making a submission. Instead this submission is made on Heads 1 *to 20 inclusive.*
Dear Oireachtas Committee Members,
We write to you as an Oireachtas Committee member and public representative as we believe that it incumbent on us (as citizens of Ireland) to advise you of our views on the matter of the proposed abortion legislation.
The founding fathers of the Irish Republic proclaimed that "The Republic guarantees equal rights and equal opportunities to all its citizens, and declares its resolve to pursue the happiness and prosperity of the whole nation and of all its parts, cherishing all the children of the nation equally ... " *(Proclamation of the Provisional Government of the Irish Republic)*
Our Irish Constitution in its preamble (its overriding objective and basis) commits the people of Ireland to " .... seeking to promote the common good, with due observance of Prudence, Justice and Charity, so that the dignity and freedom ofthe individual may be assured, true

social order attained ..... "
Article 40.3.3 of that Constitution clearly and unambiguously (as approved by the Irish People in 1993) requires that "The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right."
Our concern is the fruit of our fundamental principle of Love - for all beings and for our environment including our culture.
We consider that:
1. as a fundamental principle that everyone has the equal right to life - from conception to natural death;
2. laws shape publicly held values and the proposed introduction of abortion legislation will cause a fundamental shift away from consideration of the good of society as a who Ie to the growing culture of the supremacy of one's personal rights over the equal rights of othersa shift away from the 'common good' as set out in the Irish Constitution;
3. from the moment of conception, there are 2 lives and every possible effort should be taken to preserve the lives of both mother and child as is the current medical practice in the
1
Republic of Ireland.
The following points (by way of some examples) demonstrate the rationale underpinning our view that the proposed introduction of legislation to legalise abortion (the direct and intentional killing of a child in the womb) is wrong and should be opposed:
i. The current medical practices have served this country well notwithstanding the attempt by some to use the unexpected and sad death of Savita Halappanavar to misguide us as citizens and you as legislators. Where doctors require further clarity and assurance regarding the permissibility of medical interventions to save the life of the mother, these can be best be provided from revised and augmented medical guidelines I. The tragic death of Savita demonstrates the extreme rarity of such an event. Her death highlights the need for the Irish Medical Profession to examine, amend and publish its revised Guidance to medical practitioners in this medical area. The Medical Profession are best placed to identify appropriate guidance which should be reviewed and updated at least every five years to allow for continuing developments in obstetrics. The Irish Government should take this opportunity to ensure that Ireland's safety for the expectant mother and baby is enhanced. Legislation should not be introduced based on the flawed X Case (see below) or because of the unfortunate death of Savita. "Great cases like hard cases make bad law. For great cases are called great, not by reason of their importance ... but because of some accident of immediate overwhelming interest which appeals to the feelings and distorts the judgment,,2 The European Court of Human Rights judgment in A, C and C v Ireland requires only that clarity be provided to Irish citizens regarding the correct legal position on abortion, not the right to abortion;
ii. The Oireachtas Hearings earlier this year clearly established that abortion is not a solution to the threat of suicide. Indeed Irish psychiatrists are fundamentally opposed, arguing that in such situations, "permanent and irrevocable,,3 decisions are not appropriate when a pregnant woman is suicidal. The evidence provided by the psychiatrists at the Hearings is at variance with the legal finding in the X case and with the current Government's own Expert Group recommendation. Based on the Oireachtas Hearings' evidence, it would clearly be unsafe and inappropriate to legislate to give effect to the legal decision in the X case which failed to adduce appropriate medical evidence before making its decision. The Supreme Court decision is clearly flawed. To legislate on that basis is contrary to the Irish Constitution (its Preamble) which sets out the purpose of the following Constitution " .. to promote the common good, with due observance of Prudence, Justice .. "
Where is the Prudence and Justice is legislating for something which has been clearly shown to be wrong? Indeed as a legislator, it may be appropriate for you to consider the need for a Referendum to redress this unsafe precedent established by the Supreme Court;
111. There is no evidence that abortion reduces mental health risks.4 By contrast,

there is some evidence to indicate that women who have abortions may be more likely to commit suicide than women who continued with their pregnancies.[5]

iv. Abortion legislation williegalise the killing of the child in the womb. On the other hand, medical guidelines currently in place allow for medical interventions to save the life of the mother which regrettably may expose the child in the womb to risk of death due to the termination of the pregnancy. It is estimated that up to 30 such terminations may be occurring each year in Ireland[6], thereby proving conclusively that all medical assistance is provided to safeguard the life of the mother in the Republic of Ireland. The Savita

Halappanavar report and inquest clearly showed the criticality of many factors in her untimely and sad death, primarily the management of sepsis which is now the leading cause of maternal deaths in the UK. It should also be noted that 'there are many well-documented fatalities from sepsis in women following termination of pregnancy' [7];

v. The introduction of legislation to allow abortion is not a legal codification of the current medical practice guidelines. Abortion is the intentional killing of the child in the womb and is therefore not analogous to the current medical practice of safeguarding the life of the mother. Unlike legislation, medical guidelines can be readily updated and enhanced as medical knowledge and practice continues to develop. Medical guidelines are therefore far superior to lerislation in that they represent best practice and support a doctor's 'first law .. do no harm." They do not depend on the legal interpretation of legislation in the Irish Four Courts but on best medical practice worldwide.

vi. While legislative safeguards may be introduced to attempt to minimize the volume of abortions, anyone deemed to meet the criteria for a legislatively approved abortion will be facilitated by the State (all of us, its citizens) to have one. We have only to consider the experience of our nearest neighbour, the UK, since the introduction of the 1967 Abortion Act. Mr. David Steel (now Lord) who introduced it as a Private Member's **Bill** has admitted that he "never envisaged there would be so many abortions,,9. There are now almost 190,000 abortions in the UK annually (of which approximately 3,000 are to women providing Republic of Ireland addresses). 97% of UK abortions are performed on mental health grounds [10].

vii. Dr A. Clare (psychiatrist - RIP) stated in evidence to the previous Oireachtas Hearings on Abortion and the Constitution (2000) that in his experience the threat of suicide grounds for an abortion was widely exploited. He considered that this placed the psychiatrist in an impossible position. Legislation for abortion on grounds of suicidal feelings would require psychiatrists to practice defensive medicine - with the best will in the world, how many psychiatrists will risk confirming that the woman in front of them claiming to be suicidal, is not suicidal when, if wrong, they will be liable to litigation and claims of clinical malpractice.

vll1. With the passage of Abortion legislation, medical staff with pro-life views will find it increasingly difficult to practice their profession in medical areas where they will be required to assist in the abortion process. When new medical positions become available preference will be given to medical staff who are prepared to assist in the abortion process - this will inculcate the acceptability of abortion into publicly held values.

We ask you as legislators to take our views on this matter into account and act as required by the Irish Constitution with Prudence, Justice and Charity in the common good - not the good of individuals as individuals but as individuals as part of a just and caring society.

1: The suggestion Dr. R. Mahony that she felt threatened by the current legal position (1861 Offences the Person Act) was countered Dr. S. Smith who stated "I am not aware of any situation in which the lack of prevented care" A doctor who acts in faith in conformity with the current medical guidelines will not be exposed to prosecution. In any event the continuation of Sections 58 and 59 of the 1861 Act (still operative in the UK) or alternative would

still be to a breach of any new fear on the part of Dr. Mahony will not be eliminated by the introduction of abortion

Oliver Wendell Holmes Jr., Associate Justice of the United States Supreme Court for over 30 years;
. Dr. J. Sheehan, evidence to Oireachtas
. Professor D. British journal of Psychiatry (2008);
M. eta!., Journal of Public Health Vo 15, Issue 5,
6: calculated from evidence by Masters of Dublin Maternity
7: The Irish Times 01-05-13 referring to a letter from a group of obstetricians to the newpaper;
8: Irish Independent
9: Irish Independent 21-12-12;
10: Abortion England & Wales: 2011, National Statistics, Department of Health, May 2012 pp8-9;
4

LIFE INSTITUTE

Life Institute Submission to

THE JOINT OIREACHTAS COMMITTEE ON HEALTH AND CHILDREN

on Outline Heads of

THE PROTECTION OF LIFE DURING PREGNANCY BILL 2013

OPENING COMMENTS

The draft Protection of Life during Pregnancy Bill aims to allow the direct and intentional killing of unborn children to take place in Irish hospitals for the first time - and no time limits will apply.

This is a travesty.

Despite the protestations of an Taoiseach regarding the scope of the proposal, the Committee must know that the legislation seeks to dramatically change current medical practice in Ireland.

It would be possible for the first time to carry out a termination of pregnancy as a treatment for suicidality.

The duty of care that doctors have towards the unborn child is also undermined by

The government has taken this decision in the face of all the best medical evidence. In fact, given that this Committee has already heard considerable evidence from leading medical practitioners on abortion and suicidality, and that the government then proceeded to ignore that evidence, public confidence in this process is now at serious risk.

There is a public perception that this government wishes to ignore evidence when it doesn't suit political ideology; that it shares the disparaging view of voters expressed in recent recorded conversations with Labour Party TDs; and that it views the European Court as being superior to the people, whose right it is, under Article 6 of the Constitution to decide all questions of national policy, according to the requirements of the common good.

LEGAL REQUIREMENTS

The draft Bill seeks to implement the ruling in the X case. But the X case ruling is fundamentally flawed since a) it heard no medical evidence and b) it held the threat of suicide superseded the equal right to life of the unborn child. if the Government wishes to move positively to protect mother and baby, it should review the X case, and hold a referendum restoring protection to both.

Neither did the European Court require that Ireland legalise abortion or legislate for the X case. Instead it sought clarity for women regarding the availability of medical treatment which may be required in pregnancy to safeguard lives. This clarity can be provided by guidelines reflecting the duty of care to both mother and baby as provided in the Medical Council guidelines.

Finally, the ruling from the European Court of Human Rights is persuasive rather than binding, and should not be used to deny the people their constitutional right to decide on this issue. Opinion polls have shown that, while people are confused on the issue, more than 60% back a ban on abortion once necessary life-saving medical treatments can continue.

OBSERVATIONS ON THE PROTECTION OF LIFE DURING PREGNANCY BILL

Terms appearing in the Bill:

The Bill states that '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. Has the Committee considered that General Practitioners are currently seeking to have General Practice recognised as a speciality by the Medical Council. Could GPs assume the role of specialists within the wording of the Bill?

Why does 'medical procedure' include the provision of any drug? Is this to facilitate chemical abortions?

The 'unborn' is defined as human life following implantation until such time as it has completely proceeded in a living state from the body of the woman. There is no scientific basis for this definition, and it seems to be contradicted in recent rulings from the High Court on surrogacy.

'Termination of pregnancy' is not defined in the Bill

'Emergency situation' is not defined in the Bill

Observations on the Heads of the Bill

HEAD 2

The Life Institute upholds the right of every Irish woman to access life-saving medical treatment in pregnancy, while also obliging medical practitioners to preserve the life of the unborn as far as practicable.

This is current medical practise in Ireland and has served mother and baby well for many years.

The Bill says that it shall not be an offence to carry out a medical procedure in the course of which or as a result of which unborn human life is ended. However, the notes refer to the termination of pregnancy as if it were, in itself, a necessary medical procedure. The distinction between an unintended consequence and a direct action seems to be blurred in the Bill.

The Bill states that 'except in emergency circumstances, an obstetrician/ gynaecologist will always be one of the certifying medical practitioners.' Can the Committee clarify what emergency situations are likely to arise that would allow anyone else to certify someone as requiring a life-saving intervention? What type of registered medical practitioner is being foreseen as being appropriate in this imagined scenario?

HEAD 3

All women should be able to access any emergency treatment required during pregnancy. Again, the Bill does not make clear the

distinction between a life saving intervention which results in the loss of the life of the baby and a direct action to end the life of the child.

'Emergency situations is not defined in the Bill.

The notes state that 'Because of its emergency nature, this termination may be carried out in a location other than a public obstetric unit'. In what circumstances does the Committee envisage that arising.

HEAD 4

We have attached the evidence from the previous Oireachtas Committee hearings on the issue of suicidality arising in pregnancy.

Suffice it to say that if the Government chooses to ignore such expert evidence then the consultative process is a sham.

Furthermore, 113 psychiatrists have since told the government that the new legislation would require doctors to "participate in a process that is not evidence-based" and said that should not be asked of the profession.

Despite that, this Bill allows for an unborn child to be deliberately killed, in circumstances where no physical threat to a mother's life exists, through all nine months of pregnancy,

Minister of State, Alex White, has confirmed that there will be 'no time limits' in the legislation.

This Bill would authorise the intentional killing of an innocent human being in Ireland for the first time.

Ireland, long a light to the world for her exemplary protection of mothers and babies, is now to legalise late term abortions.

Think about what that means. Consider what science tells us about that child in the womb.

The baby is perfectly formed at eight weeks. Every day after that, muscle gets stronger, bones get denser, and the baby gets bigger.

What are Irish doctors going to do? What methods are they going to use? Will the Commitee address this issue?

If a baby's life is to be ended 5 months into the pregnancy for example, what method of termination will be used?

In order to distract from the horror of late term abortion, Health Minister James Reilly is suggesting that, after 6 months, the baby could be delivered prematurely and kept alive. That would deliberately inflict all the serious problems of extreme prematurity on a physically healthy baby – being born to a physically healthy mother.

All decent doctors would be appalled at this prospect.

Neither does the prospect of legal liability does not seem to have been given due consideration in this instance.

CONCLUSION

Instead of ensuring that both mother and baby are safe, this Bill wants to begin the medieval practise of offering the violence of abortion as a solution to a woman in crisis. Where mental health issues arise in pregnancy, the answer must be to offer support, compassion and professional assistance. This Bill seeks to end the life of a baby instead.

This is a cruel, archaic and unacceptable Bill. It should be abandoned. Mothers and babies deserve better.

WHAT THE EXPERTS SAID AT THE HEARINGS - AND MORE

ON ABORTION AND SUICIDE

1. All of the medical experts agreed that abortion is never a treatment for suicidality

"There is no evidence either in the 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."

Prof James Lucey, St Patrick's University Hospital

"...we need to become very focused on the fact there are other treatments for suicide. If a male patient pitched up in accident and emergency tonight and said he wanted to kill himself, there would be medical treatments, drugs and therapies, and these would be reviewed in a couple of weeks. That is the first-line treatment, and cases are reviewed after a couple of weeks."

Dr Mary McCaffrey, OB/GYN, Kerry General Hospital

"..there is no evidence that abortion reduces suicide risk in pregnant women, and there is some evidence that it may have a negative effect in some instances."

Professor Patricia Casey, Mater Hospital and UCD

2. None knew of a case where abortion was the only treatment for a woman who was suicidal

"However, 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."

Dr Anthony McCarthy, College of Psychiatry

"Although we have discussed this among the group [of 12 Obstetricians and Gynaecologists] , I personally have no knowledge of ever having cared for a woman who wanted to end her life specifically because of a pregnancy, and in my pursuit of information over the past week or so, I have been unable to identify any other consultant who did know of such a woman, which backs up the information we already have - i.e. that this is an extremely rare situation."

Dr Mary McCaffrey, OB/GYN, Kerry General Hospital

“I was asked if we have ever had to perform a termination of pregnancy because of risk of suicide; not in my experience.”

Dr Sam Coulter Smith, Master of the Rotunda Hospital

“I refer to Deputy Terence Flanagan's question on whether we, as perinatal psychiatrists, have ever seen a situation in which termination of pregnancy has been the treatment for a suicidal woman. To reiterate our statement, with more than 40 years of clinical experience between us, we have not seen one clinical situation in which this is the case.”

Dr John Sheehan, Consultant Perinatal Psychiatrist, Rotunda Hospital

“However, one must remember that it is absolutely individual, and for us, with our 40 years of experience, we have never assessed a woman for whom our management would be to advise a termination and for the legislators, this must be taken into consideration.”

Dr Joanne Fenton, Consultant Perinatal Psychiatrist, The Coombe Women's Hospital

“In my work as a psychiatrist, I run the attempted suicide service in the Mater Hospital in which we see and assess more than 400 attempted suicides in women per year. I have never seen a pregnant woman who was suicidal for whom an abortion was the only answer.”

Prof Patricia Casey, Mater Hospital and UCD

3. None knew of a case where a woman had died by suicide because abortion was not available

“I am not aware of any death from suicide because a termination was declined.”

Dr Mary McCaffrey, OB/GYN, Kerry General Hospital

“All appropriate mental health supports need to be made available for women who are at risk of suicide, have threatened to commit suicide, or have suicidal ideation. The committee can ask the psychiatrists, but most people would agree that termination of pregnancy is not a treatment in this regard.”

Dr Sam Coulter Smith, Master of the Rotunda Hospital

4. Senior psychiatrists testified that abortion would be "completely obsolete" in respect of a person who is extremely suicidal

“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.”

Dr John Sheehan, Consultant Perinatal Psychiatrist, Rotunda Hospital

“If the woman is profoundly depressed and mentally ill, she would be advised not to take any major life decision at that time, and frequently admission to hospital might be advised. Ongoing review and monitoring would typically be required.”

Dr Anthony McCarthy, College of Psychiatry

5. Evidence was given that abortion can actually increase the risk of suicide

“There is also a study which was carried out in Finland, which I did not have an opportunity to refer and which focuses on related suicide in women who had abortions or miscarriages or who gave birth. That study indicates that among those who had abortions, the suicide rate was six times the national average. In those who gave birth, it was half the national average. There is data to support the proposition that there is no evidence that abortion helps women's mental health.”

Prof Patricia Casey of the Mater Hospital on a study which has found that women who undergo abortions were six times more likely to die by suicide.

“Every one of us working in the perinatal service will have seen women who had terminations of pregnancy and who will feel profoundly guilty about that during a subsequent pregnancy, and it will have a negative effect on them.”

Dr Anthony McCarthy, College of Psychiatry

6. Experts confirmed that suicide in pregnancy is very rare. They also warned against ‘normalising suicide’

“The risk of suicide in pregnancy is extraordinarily low.”

Dr Sam Coulter Smith, Master of the Rotunda Hospital

“International studies suggest that the suicide rate in pregnancy is from a third to a sixth of the expected rate in non-pregnant women, indicating that frequently pregnancy confers a protective effect against suicide.”

Dr Anthony McCarthy, College of Psychiatry

One of Ireland leading experts on suicide prevention, *Professor Kevin M. Malone, of St. Vincent’s University Hospital and UCD,* also made a submission to the hearing where he warned of the danger of the law ‘normalising suicide’:

“Legislating for this inexplicably legitimises and normalises “suicidality” under certain conditions - for women only. By foregrounding a theoretical risk of suicide in women, and enshrining “suicidality” in Irish law, the proposed legislation runs the risk of further invisibilising, normalising, and at worst exacerbating the much more real and volatile threat of increased suicide risk in Irish men, and potentially accelerating suicide risk in young women also. ..[I]t would be regrettable and perhaps unethical if legislation on “suicidality” were to potentially compromise the therapeutic alliance between psychiatrist and patient. Extreme caution is advised in terms of uninformed or misinformed legislation generating unintended consequences,” he wrote.

As *Dr Jacqueline Montwill*, consultant psychiatrist, has said, the treatment for suicidality in a pregnant woman "is to make sure that the patient is safe, make sure that patient is on the appropriate medication... and to make sure that the appropriate psychological treatment, support, intervention and nursing support is made available to her.”

OTHER EVIDENCE ON SUICIDE

A. The Chairman of the Irish Association of Suicidology has said that legislation based on the X case would create a ‘logistical nightmare’ for psychiatrists if implemented.

Dr Justin Brophy, a consultant psychiatrist with Wicklow Mental Health Service, made his comments in an interview with an Irish language newspaper, Gaelscéal.

Dr Brophy said that medical judgements can be wrong and that suicidal intent is an 'easily fabricated condition' and that while psychiatrists can show that a woman is suicidal based on her stated symptoms, it is very difficult for them to prove that a woman who says she is not suicidal is not, nor is it their job to do so.”

B. Eleven top-level consultant psychiatrists have also written to Fine Gael advising them that "termination of pregnancy is not a psychiatric treatment for suicidality, nor is it mentioned as such in any of the major textbooks of psychiatry." The letter also expresses the belief that "offering an abortion to a distressed person who is psychiatrically ill would be strongly ill-advised since the person's capacity to make important life decisions is frequently impaired."

C. And former Fine Gael leader, Mr John Bruton, has opposed legalising abortion on suicide grounds. He said that "when you actually look at the words in the constitution which talk of an equal right to life. Well, a possibility is never equal to a certainty. All you can ever say about suicidal ideation is that there is a possibility that it might be fulfilled, whereas in the case of a termination you have the certainty of the ending of that other life ..."

D. A British abortionist has admitted that the mental health clause in the British Abortion Act is routinely abused. In a BBC Panorama programme, Ann Furedi, the chief executive of the British Pregnancy Advisory Service, has admitted that British doctors actively 'pretend' that women's mental health is at risk so that they can sign off abortions without questions being asked.

The programme also heard from Professor Clare Gerada, chairperson of the Royal College of GPs, who confirmed that the mental health risk is not objectively tested. "What we have is what the woman tells us," she says. "It isn't for me to judge her or be moralistic."

ON PROTECTING MOTHERS' LIVES

1. Experts testified that not one woman has died in this country because of our ban on abortion or the provisions of the 1861 Act

"I was asked if there had been any needless maternal deaths because people would not or felt they could not act. I am not aware of any such case."

Dr Sam Coulter Smith, Master of the Rotunda Hospital

"I am not aware of any needless deaths ... I have never withheld treatment because of the law and I am not aware of it occurring in my unit. I have never heard of it from a colleague. Women receive appropriate treatment."

Dr Mary McCaffrey, OB/GYN, Kerry General Hospital

“I am not aware of any situation in which the lack of legal clarity prevented appropriate care. It has certainly not occurred in our hospital and I am unaware of it occurring anywhere else. I have never withheld appropriate treatment from a patient when it was required.”

Dr Sam Coulter Smith, Master of the Rotunda Hospital

2. They confirmed that doctors do not need to directly end the life of the unborn child in order to save a mother's life

“I was asked if there were circumstances in which a foetus had to be killed in utero rather than delivered. In most circumstances it is possible to deliver the baby or foetus without killing the baby inside.”

Dr Sam Coulter Smith, Master of the Rotunda Hospital

“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.”

Dr Rhona O’Mahony, Master of the NMH, Holles Street

3. Doctors reaffirmed that there is a difference between abortion and the interruption of a pregnancy for a life-saving procedure

“There are a number of issues that I would like to highlight. The first, on what might seem a small point but is hugely important, is the terminology we use when we talk about this subject. Some people will use the term ‘abortion’, while some will use ‘termination of pregnancy’. It is of enormous psychological importance to a woman who is having her pregnancy interrupted for a life-saving procedure whether we call that an abortion or a termination of pregnancy.”

Dr Sam Coulter Smith, Master of the Rotunda Hospital

Which echoed the Clinical Practice Guide of the Institute of Obstetricians and Gynaecologist: "Women are sensitive about references to pregnancy loss. As their loss is not out of choice, use of words like 'abortion' can be sometimes offensive at a vulnerable time. Hence, discussion or documentation of management of early pregnancy loss should be worded appropriately."

4. A group of 15 obstetricians wrote to the Committee supporting the view that existing medical guidelines protected mothers and doctors. They had been excluded from giving evidence

"The proposed legislation arises not from any evidence-based medical need but from obligations to the Government arising from the European Court of Human Rights," they wrote. And they pointed out that: "Legislation may influence doctors into taking a legal rather than a clinical perspective when making critical decisions. Well-established clinical practice in seriously ill mothers may become subject to regulations that result in delaying clinical action to transfer or deliver a patient. Existing guidelines cover such situations."

The medical experts also warned that:

"Legalised abortion may affect recruitment of doctors into Obstetrics and Gynaecology in the long term. Compulsion to perform abortions by regulators or employers would exacerbate this.

Section 58 and 59 of the Offences against the Person Act remain the Law in the United Kingdom, and have been used in recent times in the prosecution of illegal abortion providers. The removal of these sections has implications wider than for medical practitioners only."

And they pointed out that "Maternal outcomes in Ireland are acknowledged to be of the highest international standard and better than those of our nearest neighbour, the UK. Psychiatric grounds for abortion on the basis of suicide risk appear non-existent, in the view of experts in this field. An obstetrician, the doctor with a responsibility to two patients, faced with terminating a normal pregnancy on grounds of suicide risk would be placed in an impossibly conflicted situation, where there is no benefit to the mother," they said.

5. One leading obstetrician described as 'histrionic' claims that doctors were in fear of being jailed because of Ireland's pro-life laws

The Irish Independent reported that:

"Claims by Dr Rhona Mahony that obstetricians work under the shadow of going to jail were described as 'histrionic'. Dr Mahony, who is Master of Dublin's National Maternity Hospital, told the Oireachtas hearings on abortion that: "I need to know that I will not go to jail, if in good faith, I believe it is the right thing to save a woman's life, to terminate her pregnancy."

Dr Trevor Hayes, a consultant obstetrician at St Luke's Hospital, said he found her remarks to be 'histrionic'.

"I never heard of any doctor being concerned about the gardai coming in. When you are a doctor, your first law is to above all, do no harm. If you have to bring forward a delivery to save a mother's life, you are clear, as a doctor.”"

www.independent.ie/national-news/maternity-chief-accused-of-histrionics-3350345.html

Liz McDermott <lizmcdermott42@gmail.com>
08/05/2013 02.14 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
proposed abortion legislation

Attention: Paul Kelly

Dear Sirs,

I wish to register my total objection of the proposed Bill introducing abortion (properly defined to mean the intentional targeting of the unborn child in the womb) into Irish law. I would make the foillowing points in relation to it:-

1. The X case is not the Constitution, merely a group of judges' interpretation of it. It is abundently clear on a reading of the plain language of Article 40.3.3 that mother and baby have equal rights to life and that the life of the unborn child may only be risked where there is a real and serious risk to the life of the mother. The majority decision in the X case decided at that time that this would include a risk to the mother's life from suicide. John Bruton has recently outlined the flaws in the X Case decision and the government has never come back at him with any cogent argument against his view. Enda Kenny merely reiterates, parrot fashion, his statement that the government is legislating for X.

2. However even in the flawed X Case judgment the judges also stated that abortion was to be performed only where the medical view was that no other treatment would be possible to save the mother's life. We have the benefit now, 20 odd years later of knowing that abortion is never the only way of treating a suicidal woman and in fact is the very last thing a competent psychiatrist would recommend for her. As with non-pregnant suicidal women, they deserve a proper course of treatment and support, not the alleged quick fix of an abortion.

3. The Irish people voted for this provision and it must be respected. We know the implications of it. Women in Ireland accept that pregnancy carries certain risks and that all sorts of things can go wrong during and after birth. Life is tough for everyone and we have no choice but to accept the challenges it poses at all stages. But we attach enormous importance to the basic right to life which is enshrined in our Constitution.

4. If Enda Kenny says his "book is the Constitution" (rather than the Bible), why is he ignoring its plain wording and respecting the equal right to life of mother and unborn child? A decision of the Supreme Court over 20 years ago which was made on flawed grounds with inadeaquate professional medical evidence - a decision which until quite recently Enda Kenny and all of Fine Gael said they would not legislate on and were voted for by me and many others for that very reason - is not settled law. Government is free to depart from it and has wisely done so until now.

5. It is difficult to avoid the conclusion that such a volte face by the

government has much to do with the unsatisfactory compromises which seem to infect all coalition governments involving 2 such ideologically opposed political parties. Thus Labour supporters are unhappy with their compromises on the economic situation and Fine Gael are unhappy with the compromises on the party's pro-life principles. So everyone loses, but none with thier lives - except the babies, that is.

6. Enda Kenny maintains this legislation will not change the law but merely clarify it. But this is untrue. This legislation is wide ranging and for the first time in Irish history allows for the direct and intentional targeting of the unborn child, in flagrant breach of the Constitution. Once the principle of abortion is introduced, we will follow every other country and the grounds for abortion will widen. At the very least, the suicide ground will become the standard, no questions asked basis for allowing abortion. Every hospital will be obliged to perform abortions in such cases regardless of ethos. Oh I forgot, ethics are so old hat in modern Ireland. A throw back to the old days where we were all belted with croziers and cowed down before our Catholic clergy warlords.

7. I exhort everyone in government to sign up for and read Lifesitenews online. There you will see the brutal reality of the abortion culture and the damage it causes to countless women and their babies. As an ideology, which it is as its advocates would do anything to advance and promote it, it is profoundly and intrinsically evil and every country which allows it is hugely compromised principally. It is big business and has huge political clout , viz Barack Obama and the Democratic party in general are very cosy with Planned Parenthood (one of the biggest abortion providers in the US) cos they donate massively to his election campaigns and in return receive hundreds of millions of dollars in government handouts every year.

8. The argument that abortion is a fact of life and should be regulated and made safe for women is disingenuous. Drugs, prostitution, theft, murder and child abuse are also facts of life but last time I checked we don't have plans to legalise them. Why not? Because they are wrong of course. The truly modern and progressive thing for this government to do is to stick to our pro-life principles as enshrined in our Constitution and resist all pressure from inside and outside our borders to follow the herd. We can and should embark on a programme of real and meaningful support for women in pregnancy, including a peri-natal hospice and an examination of why unwanted pregnancy is such a fact of life these days. Our sex ed programme is seriously flawed and pornography via the internet is the way our young people learn about sex. There is still a huge stigma around unplanned pregnancy; girls and women are mortified to have got caught when there is so much contraception available. The pressure on young girls to perform sexually is putting them under huge stress resulting in all kinds of problems for them, not least pregnancy. Why not put huge resources into these things which will benefit our young people hugely, instead of turning them into sex industry fodder, one deadly aspect of which is abortion.

98. Fine Gael may think Ireland has moved on from our Church devotion and that we therefore need to make our laws more secular, to reflect our pluralist society. Maybe so, up to a point, but that attitude quickly becomes an attack on freedom of religion and the hostility towards the Catholic Church so visible in our media these days reflects a desire to rewrite the whole rule book for modern democracy, which is entirely based on Christian principles and social teaching.

9. Some things transcend politics, and the right to life is one of them.

To paraphrase Lucinda Creighton to Olivia O'Leary, "get a grip" Fine Gael.

Have we not seen enough bloodshed in this country in our troubled history? Do we want to create a new war against babies? It is a bad day's work for Ireland and its principles. This struggle on behalf of unborn babies and their mothers who deserve better support than abortion will not end, even if the government goes ahead with this law. And for the record, the Church has more than "a right to state its opinion", it has a duty to state God's law, which is what it is doing. That Enda Kenny would insult them like this shows just where he has gone in his heart. "What does it profit a man if he gain the whole world but lose his soul". Reading this you may all roll your eyes to heaven (or the sky, if you deny the exisence of heaven), but to ignore its wisdom is a grave mistake.

Please acknowledge receipt of this submission and confirm its contents will be read and shared among the Committeee on Health and Children as part of its deliberations.

Liz McDermott

SUBMISSION TO THE OIREACHTAS ALL PARTY COMMITTEE ON THE PROTECTION OF MATERNAL LIFE IN PREGNANCY BILL 2013

By Loretto Browne RGN ; ICU Cert. (SVUH); DN(.London Univ) ;Dip. N.Tutor

(UCD) ; MEd. (Nat. Univ. Wales)

. **COVERING NOTE**

1. Members of An Dail Eireann and Seanad Eireann representatives of the people of Ireland , I would like you to take note of the following in respect of the proposed Protection of Life in pregnancy Bill (2013.)

I am a Nurse and Nurse Tutor (retired). I make this submission as a member of the noble Profession of Nursing dedicated to the promotion of health, the alleviation of sickness and the provision of scientific evidenced based care of patients of all ages from pre birth to natural death without prejudice and consistent with the individual's right to life, bodily integrity , and freedom from unnecessary pain and suffering whether physical or mental

As a founder member of The Society for The Protection of Unborn Children (Irl.)

I was engaged in The Pro Life Campaign which culminated in the pro Life Amendment (1983). During those years leading up to the Amendment I was actively engaged in public education programmes in the humanity and development of the unborn child and on the bodies engaged in campaigning for abortion, their origins, affiliations and modus operandi, together with gathering of statistics on , and information on the methods of abortion , as well as the adverse effects of abortion on womens' health both mental and physical.

I co- authored " Abortion Now " published by Life Education and Research Network ,

Dublin and " The Facilitators " , Brandsma, Dublin . In these publications I detailed the involvement of International Planned Parenthood and its affiliates of which The Irish Family Planning Association is one such, as key facilitators in preparing the ground for ,and ultimately providing abortion worldwide. I note that the current head of the HSE Mr. Tony O'Brien is former head of The Irish Family Planning Association. I also note that the HSE has a pivotal role in the operation of The Protection of Life in Pregnancy Bill (2013)

Abortion involves the deliberate and direct killing of a defenceless baby not yet born.

In order to facilitate the killing of these babies doctors and nurses have to be trained in specific methods of killing ie:

A) By suctioning the body parts out through the neck of the womb into a suction jar on the operating room floor after the neck of the womb has been artificially stretched to do so. The contents of the suction jar must then be checked by at least two persons

usually nurses, to ensure that all the baby parts are present so as to avoid retention in the womb which retention would be potential for severe infection which could result in septic shock.

B) By administration of intravenous medications to cause the womb to contract prematurely and expel the baby who may be born alive.

C) By injecting toxic substances per vagina directly into the body of the living baby in order to cause death by poisoning , which procedure the child may survive and be expelled alive from the womb.

D) By caesarean section to remove the baby from the womb, which of course means a live delivery, most probably of an immature baby

SUMMARY

1.Concerns in this submission are centred on the right to life of both mother and unborn child as set out in the Pro Life Amendment (1983), the right of medical , nursing and pharmacy personnel to conscientious objection and the fallout for society in general.

The fundamental changes in Statue Law proposed in respect of current best medical practice will impinge on the existing rights of individual medical , nursing and pharmacy practitioners , and on all institutions, medical , surgical, obstetric and gynaecological services provided on behalf of the HSE, and on private facilities also, and on society at large.

2.Termination of pregnancy occurs naturally in the birth of a baby .At present termination of pregnancy may be induced at or around viable gestational age via Caesarean Section or induced vaginal birth with the intention of intervening to save an ill baby or to alleviate a medical condition in an ill mother .It does not intend the death of the baby.

3. The usual layman's connation of the term" Termination of Pregnancy" is understood as the intentional intervention to procure the death of the baby by direct abortion. This Bill proposes that in future, a woman experiencing physical illness eg. cancer or heart disease will be referred to an appropriate facility for direct medical/surgical intervention the intent of which is to procure an abortion .This will precede any specific treatment for her illness and will become the norm. This is a fundamental change to accepted best ethical medical practice.

4.The Bill also proposes that a woman experiencing psychological difficulties during pregnancy which may be deemed to pose a risk of self destruction may also avail of a

similar procedure. This is an entirely novel procedure in Ireland and extends a supposed right to state sponsored abortion for psychological problems in an expectant mother with no scientific reason for such a supposed treatment and significant risk of subsequent morbidity to the mother both psychological and physical . The direct killing of one individual is never, and never can be, a medical treatment for morbidity in another .And abortion per se is not without its risks.

5.This Bill repeals Sections 58/59 of The Offences Against The Person Act (1861)

and as such,constitutes the first breach in the defence of innocent unborn children to their right to life ,by direct intentional abortion. Experience worldwide has shown that abortion laws once enacted are never repealed but rather extended. This Bill provides for abortion at any gestational age up to birth. As such it is a most liberal law.

6.This Bill is repugnant to all reasonable right minded people and, if enacted ,will inevitably lead not just to abortion on demand but to euthanasia as is the case in many countries where abortion is legal.It is an irony that in the same week in which this Bill was published The Chief Justice of Ireland Mrs Justice Susan Denham should have suggested that the Irish Government address itself to legalising euthanasia. Q.E.D.

6.In other jurisdictions proponents of legalising abortion have bitterly regretted the

far reaching consequence of their actions which they intended to provide limited

abortion in controlled circumstances. I refer to Dr Alec Bourne in the UK on whose

aborting a fourteen year old girl who had been raped led to the UK Abortion Act (1967) .Since then over 2 Million abortions have been performed in the UK.

Dr Bernard Nathenson of USA detailed the dirty tricks behind the legalising of abortion there in his book " Aborting America ." He too bitterly regretted his part in the process and became pro life.

7.The provision for conscientious objection in this Bill falls far short of what one would expect to protect the rights of members of the caring professions , are unworkable in practice, and directly contravene the provisions of The Code of Professional Practice For Each Nurse and Midwife (An Bord Altranais 2000) which states :

" The nurse must at all times maintain the principle that every effort should be made to preserve human life ,both born and unborn "

8.Funding of abortion from tax revenue implicates every citizen in abortion whether they agree with it or not.

To enact this Bill on the grounds of an obligation by directive of a court of justice , domestic or EU is to negate the legislator's own personal rights and that of all citizens to freedom of conscience and as such this Bill must be dropped from the legislative programme.

9 Abortion is the ultimate form of child abuse.

RECOMMENDATIONS

Head I The common good.

This Bill proposes a fundamental change to existing Statute law and is not in the interest of the common good .It proposes that abortion ie the direct and intentional killing of the unborn child be available in publically funded institutions. It also disregards the fact that taxpayers who fund these institutions will now be required to fund abortion regardless of their ethical objections. This bill will eventually lead to widespread abortion for social reasons and eventually to euthanasia since all the evidence of other jurisdictions has shown this to be the case. This Bill should be replaced with Regulations by The Medical Council which have the force of law.

The common good is never served by medical personnel bowing to diktats as was seen in Europe in the 1940's

Licensing System for Acute Hospitals.

If the proposed licensing system for acute hospitals were to include the proviso of providing abortion it would be seen as a direct attempt to further widen any existing abortion law and together with the threat to the three existing voluntary maternity hospitals make fig leaf of the supposed conscientious objection clauses in this Bill.

Emergency provisions

It seems that any doctor not just a specialist may act to perform an abortion in an emergency situation. This could mean any NCHD in training. In reality in a busy acute hospital this Bill does not give the doctor any room for ethical objection to the DIRECT killing of an unborn child as first option as opposed to current medical practice This Bill specifically excludes ectopic pregnancy so there can be no argument that what is meant is direct killing of the unborn child .This provision cannot stand.

Reasonable Opinion

The reasonable opinion of a NCHD may fall short of that reasonable opinion of a specialist and may result in unnecessary abortion. If direct abortion is intended then at the very least a consultant ought to be involved in the process.

Head 2 Risk of Life From Physical Illness, Not Being a Risk of Self Destruction.

A)This effects a change to current medical practice since it allows direct abortion in advance of any specific medical treatment for illness in the mother as opposed to current medical practice, in the course of which treatment for the mother, may indirectly cause death to the baby. As such it does not equally respect the right to life of both mother and baby and this is unacceptable. In practice this will result in the intentional killing of the unborn child regardless of gestation. In the UK The Infant Life Preservation Act (1919) which directs that every

effort be made to preserve the life of a child born alive is disregarded when the intention is to abort. Current best practice allows for premature delivery of a viable baby which, thought not without risks to the child , is a recognition of his/her equal right to life with that of the mother. This Bill puts the right to life of the mother ahead of that of the child and, as such , disregards the right to vindicate his/her life .The Current Medical Council Guidelines ought to have the force of law to uphold current best practice.

B)The making of arrangements to transfer a pregnant woman to another ward or hospital for abortion necessarily involves doctors, nurses, porters and ambulance drivers.

How are a limited number of people on a roster to exercise conscientious objection if there is nobody else to replace them? This will mean that only those who are prepared to disregard their conscience will not be able to work.

Potential viability of the foetus

In this situation the propose bill states that " where the unborn may be potentially viable outside the womb , doctors must make every effort to sustain the its (sic) life after delivery. However 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." This proposition since it allows direct abortion while at the same time referring to " delivery" is confusing since it appears to allow for choice as between death and birth of the child .If the intention is to uphold current practice of early delivery of a viable baby this must be spelt out.

Head 4 Risk Of Loss of Life From Self Destruction

This provision allowing for the direct and intentional killing of the unborn child on the risk of self destruction of the mother even should this presumed risk be neither" inevitable nor immediate" and is a mere fig leaf to allow for abortion on any pretext. It replicates the Bourne Case in the UK which has since resulted

in over 2 million abortions. It is simply not acceptable and must be removed.

However, even if it is removed , there is no other medical reason for permitting the direct and intentional killing of an unborn child. The ABC cases are irrelevant since they were pretexts to force the issue of direct

abortion here in this state as opposed to legitimate recognised medical treatment for illness in pregnancy. The judgements in these cases came through the EU Court of Human Rights In an attempt to overrule our Pro Life Status pledged in the Lisbon and European Union Treaties.

There is nothing in international law which obliges another to directly kill

an innocent human being. This was well stated in Nuremberg. Therefore the EU Court is at odds with Nuremberg. And The Irish Supreme Court led by Chief Justice McCarthy overruled the express wishes of the Irish people enshrined in The 1983 Pro Life Amendment. The evidence given by a non medical person with no experience of the medical treatment of a woman in crisis was a pretext to get us to where we are today and ought to be regarded as a rash judgement.

There is the added complication that if the intended abortion results in a live viable baby the obligation to preserve his/her life will further complicate the issue. If the mother does not want the child whose responsibility does he/she become?

The Irish State has shown remarkable inability to care for vulnerable children not to mention callous indifference to their plight and it is stretching credibility to assume that Ireland will have any interest in investing in life support for a survivor of abortion . It is puzzling too as to why The Minister for Children should have had a hand in drafting this Bill since direct induced abortion is the ultimate expression of child abuse. This provision of the Bill must be omitted.

Head 9 General Provisions of The Bill

There are draconian powers given to a committee or an individual on it's behalf to summon doctors to explain their refusal of consent to abortion as part of a review

committee to facilitate the ABC judgement.. This is an outrageous interference with professional autonomy and freedom of conscience.

Head 10 Formal Reports to the Minister

This provision gives the Minister for Health the power to instigate " re education " of doctors in the form of "further guidance from the professional bodies " if the annual reviews show that "all terminations that had taken place had gone through the formal review process" . This effectively gives a politician the power to direct professional bodies to disregard conscientious objection and to toe the political line. It has connotations of totalitarianism.

Head 11 Notification

The Bill expressly prohibits public knowledge via The Freedom of Information Act

(1997) of the number and reasons for abortions, and the locations , grounds for termination of pregnancy ,and gestation , which information will be available only to the Minister and, presumably to the head of the HSE (who as we have seen has more than a passing interest), as it is supposed to " inform policy ."

This provision effectively allows the Minister for Health and the head of the HSE to conceal, alter, or otherwise manipulate the facts to suit their own agenda. There is no mention of parliamentary privilege. One assumes that such policy will be constructed to ensure that only doctors, nurses and pharmacists with no objection to direct abortion will be employed .This head is outrageous and suggests a nefarious intent .This is a dangerous precedent and may herald further such situations in other departments if the Minister for Health is allowed to behave like this .All such statistics should be available in a democracy.

Head 12 Conscientious Objection

It is noteworthy that this Bill negates the rights of institutions to object to abortion provision .This is outrageous .This provision does not apply in the USA so to assert that institutions and by implication their boards/directors/managers cannot be exempt

from abortion provision is tantamount to totalitarianism and has no basis in fact.

With respect to nurses and midwives The Code of Professional Practice for Each Nurse and Midwife is quite clear. It states:

" The nurse must at all times maintain the principle that every effort should be made to preserve life , both born and unborn.."

It further states:

" The nurse shares the responsibility of care with colleagues and must have regard to the workload of and pressures on, professional colleagues and subordinates and take appropriate action if these are seen to be such as to constitute abuse of the individual practitioner and /or to jeopardise safe standards of practice."

This Bill also places unethical obligations on those nurses who are teachers and clinical supervisors of students and one assumes that students will have to participate

as learners in the care and management of women undergoing such procedures..

This Bill will be unworkable in practice by nurses licensed in this jurisdiction and it is a presumption to assume that nurses will disregard the Code of Practice simply because abortion is legal. Making something legal does not make it ethical.

There may also be fallout in respect of the attrition of those foreign nurses currently employed here to whose ethos and culture abortion is repugnant .

It should be noted also that in the experience in the UK it became impossible for nurses to exercise the right of conscientious objection when the methods of abortion changed from surgical to chemical, the latter administered intravenously at ward level by and supervised by nurses. Despite the clause admitting of objection it became unworkable in practice and The Royal College of Nurses caved in leaving nurses to fend for themselves.

If that were to happen here the current staffing problems in our hospitals would become much worse .Any attempt to hire only those who were willing to assist in abortion would then become discriminatory and therefore illegal under The Equality Act .

Head 18 Repeals And Consequential Amendments of other Acts.

This Bill repeals sections 58/59 of The Offences Against The Person Act (1861) which prohibits the use of drugs or instruments for the express purpose of procuring an abortion and replaces them with the provisions of Head 2 of the Bill which proposes to permit direct abortion heretofore considered a heinous crime.

It defies reason why such heinous acts should now be considered appropriate

" treatment " in a civilised society. The repeal of the 1861 Act is the first legislative step on the road to legal abortion and as such will give comfort to those who hope to see complete freedom of choice procuring abortion for social convenience.

There is no obligation on any human being to vote for the legalised killing of another defenceless human being. Nuremberg was the definitive answer to that. No court in any jurisdiction can oblige any member of Dail Or Seanad Eireann to legislate for abortion .To acquiesce in this matter is to negate your own individual right to freedom of conscience and that of all other citizens.

Please do not vote for this Bill.

Signed

Loretto Browne . RGN; ICU Cert ; (SVUH) DN (Lond Univ) RNT;

DIP N Tutor (UCD) Med (N Univ.,Wales)

Note .If in the event this submission is published it would be appreciated if you would kindly omit my tel. number and the specific details of my address because in the past my house was defaced. Thank you.

Lynda Finneran

For the Attention of Paul Kelly, Clerk to the Committee

The draft legislation (the outrageously mis-named Protection of Human Life in Pregnancy Bill 2013) which provides for the intentional killing of a child in utero, at any age, where there is a threat of suicide on the part of the mother should the child not be killed (given under a procedural, pseudo-medical framework) is IRRATIONAL, egregiously UNJUST and flagrantly UNCONSTITUTIONAL.

Following is a non-exhaustive list of the reasons grounding the above assertion:

1. The whole scheme provided for in the draft Bill is patently unjust and based on many false premises, as will be shown, infra. It is a scheme designed to enable the direct, intentional killing of an innocent, defenceless child in utero to be carried out with impunity on the mere following of a set of procedures disguised as medical practice, designed just for that purpose.

2. However, what this draft Bill purports to do, it cannot do under the Constitution, not just under the recognition of the right to life of all human beings (persons) under Article 40, but under the Fundamental Rights provisions as a coherent whole, and indeed under the whole Constitution, which has a unified Natural Law philosophy, given under God, by the People, to the People. The direct, intentional killing of an innocent person, such as a child in utero, can never be permitted under our Constitution which recognises the inherent sacredness/dignity and inviolability of all human life from its natural beginning (conception) to its natural end.

3. The prohibition of killing a child in utero which has always existed under the common law and is currently provided for in the Offences Against the Person Act 1861, by the crimes relating to the procuring of a miscarriage, purports to be repealed, and replaced with a wholly inadequate residual-type prohibition which is subject to a whole procedural scheme providing for the carrying out of an intentional killing of a child in utero. Thus, the ever-existing ban on, and crime of, the intentional killing of a child in utero, is clearly (and cynically) subverted by the draft Bill. The protection of our most innocent and defenceless, the child in utero, from the most extreme attack, that of being intentionally killed - is effectively removed; babies up to the time of their birth will be without the protection which is their right (and our duty).

4. The draft Bill is designed in such a way as to be a charter for abuse by those who want abortions carried out in this country by any means, in that it would enable a woman (even one who became pregnant for just that purpose) to just maliciously follow the procedure regarding threatening suicide if she weren't granted an abortion, to procure such abortion, with the assent of psychiatrists. Firstly, it is always bad law, and could never be constitutional, to provide for a situation (as the draft Bill does) where a woman may threaten to kill herself (something which is seriously bad and against the natural law in its own right) unless her child in utero is killed. Secondly, the intentional killing of a child in his mother's womb has nothing to do with psychiatry or medicine in toto, (in fact its the opposite of medicine) and a competent, diligent and

honest psychiatrist would never cooperate so as to allow him or herself to be used to enable the carrying out of an abortion. Conversely, a psychiatrist who is not acting competently, diligently or honestly, and who wishes abortions to be carried out in this country, will use the proposed law as cover for his/her enabling of the killing of a particular child. The Bill abuses psychiatry and psychiatrists.
5. A person who really intends to kill him or herself tends not to tell anyone before the fact in case he/she would be thwarted in carrying it out. People who commit suicide generally do not tell anyone, and afterwards those who knew the person who killed him/herself say that they did not suspect it and if they had, they would have taken some action to stop it. It is simply not possible to tell when a person is seriously intent on killing him/herself before the fact. Apparent "attempts" are usually not a real attempt at suicide but a desperate plea for help by a person who is suffering mentally and when well are glad for the help they received. No one knows if another person will kill him/herself in a given set of circumstances. If they truly intend to do it, they will not tell anyone else who might prevent them doing so.

6. As for the threat of suicide by a pregnant woman, where she is genuinely depressed and suffering from suicidal ideation, this woman is suffering from mental illness (probably situational and temporary) and should be given the treatment, care and supervision a person with such an illness requires. The killing of her child in utero, because she maintains she will kill herself if this is not carried out, is the last thing that ought to be done to a woman who is depressed, and not thinking rationally, and incapable of seeing beyond her immediate situation. Depression, suicidal ideation, etc., is a contra-indication for abortion, and this has been recognised by the medical profession in Britain. An abortion ought never be carried out on a depressed woman, for obvious reasons. The depression can be treated, and will pass, as will pregnancy, with birth. However, killing her child is permanent and likely to cause long-term depression particularly in a woman who has already suffered from depression.

7. Although, one can never say definitively that an individual will kill him/herself before the fact, making the draft Bill irrational on this basis alone, there are well-known statistical facts (supported by general experience) which show the Bill as grounding itself contrary to the facts: a pregnant woman is much less likely to kill herself than women of child-bearing age generally; and furthermore, a woman who has lost a child through abortion is much more likely to commit suicide than women of child-bearing age generally. Thus, carrying out an abortion, killing a woman's child in utero, increases the risk of suicide by that woman, as well as depression and suicidal ideation. On the other hand, pregnancy lowers the risk of death by all causes, including suicide. Introducing abortion will increase deaths of women, including by suicide. Keeping abortion illegal, as is necessary under the Constitution will keep deaths of women in Ireland lower than otherwise. (The Supreme Court judgment in the X case, 1992, was clearly erroneous.)

8. The various methods of killing a child in utero by "procured abortion" are all not only fatal for the child but inherently dangerous for the mother, who risks death, serious, often permanent physical injury, as well as serious, and often long-term mental injury. All methods of abortion necessarily entail some physical injury by virtue of the physical or chemical forcing open of the uterus, and the scraping of the lining of the womb. Infection is common. Death of the mother due to abortion occurs in every country, including first-world countries, but the cause of death is notoriously under-reported to protect the abortionists and the abortion

industry.

9. Due to the very nature of abortion methods, which are invasive, introduce high risk of infection, damage the cervix and lining of the womb, etc. (not to mention many other frequent injuries), the woman will have an increased risk of miscarriage occurring in subsequent pregnancies, and an increased risk of subsequent children born to her being born prematurely, with all of the attendant risk of illness, disorders or disabilities for the child.

10. Not only is the purported legalisation of the systematic killing of an innocent child in utero, irrational, unjust and necessarily unconstitutional, but the draft Bill purports to compel hospitals (free organisations set up by free persons to provide medicine and care to individuals according to their objectively-valid ethos (e.g. that of the Catholic Church, in accordance with morality knowable by reason)) to carry out the intentional, and brutal killing of a child of any age in utero in accordance with the Bill's terms (shown to be irrational, unjust and unconstitutional). This constitutes yet further attacks on natural and constitutional rights, the right to not act in contravention of a rational conscience, the right not to carry out or cooperate in any way with, an objective evil, the right to form associations and organisations such as hospitals to conduct objectively-moral medicine.

11. Should this draft Bill ever purport to be passed by the Oireachtas, it must be referred to the Supreme Court, which must find it unconstitutional on many grounds.

Lynda Finneran

Notes:

1. The time given for people to make submissions on this radical, unconstitutional draft Bill, was derisory.

2. Please do not publish either my postal or email address.

Máire Lowry <mclmir@gmail.com>
08/05/2013 04.58 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Protection of Life during Pregnancy Bill 2013-re-submission slight amendment

Dear Mr Kelly

I wish to register my total opposition to the proposed legislation PROTECTION OF LIFE DURING PREGNANCY BILL 2013. Despite this Bill's title, which is preoccupied with the protection of the mother's life over that of her
child, is at variance with the Constitutional provision of equality of the right to life of both mother and child. Indeed, the Supreme Court's verdict in the 'X' case on the basis of suicide merely served to confuse and compound the issue, leaving a veritable mess for the Government to resolve, without discriminating against the right to life of either mother or child.

This is the first time in our history that any legislation ever permitted the deliberate destruction of human life in instances where pregnant women claim to be suicidal.

No evidence has yet been produced to indicate that abortion is an appropriate treatment for pregnant women with suicidal tendencies.

This legislation also proposes to deny medical personnel the right of conscientious objection in refusing to perform, accomodate, 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 or embryo for any reason, in direct contravention of resolution 1763 of the Parliamentary Assembly of the Council of Europe which reaffirms the right of medical personnel to refuse such procedures on conscience grounds.

As the mother of a son with quite a severe disability I'm deeply concerned about the right to life and personhood for all pre-born children and it is my firm view that aborting the most vulnerable, namely the preborn, constitutes the most horrendous human rights abuse of all.

Yours sincerely,

Máire Ní Thighearnáin

"Mairtin.O'Droma" <Mairtin.ODroma@ul.ie>
08/05/2013 04.28 p.m. To
<healthandchildren@oireachtas.ie>
cc

bcc

Subject
Proposed Abortion Law

Dear Committee Members,

We as a people, in the referenda to date where the matter came up, have opposed abortion. So to legislate for abortion in the face of that is anti-democratic.

In the X case the Supreme Court found room in the letter of the law for abortion in cases of suicidal ideation; but this is completely against the spirit and intention of the 1983 referendum.
This has also been reinforced by every independent poll taken since has shown very sizeable majorities opposing legalisation of abortion where full and appropriate medical care is always available and accorded to both mother and child, including where sometimes this might even lead to the un-intended, even if foreseen, death of the child. The intent of the two-patient medical practice is well known and understood by all; and supported by the majority.

Astoundingly, the government, and those advocating abortion, have not advanced any evidence to show that abortion is a treatment for suicidal ideation. In fact, as is now clear, –and especially so from the recent Oireachtais hearings, as recorded in the evidence of experts, and also in the evidence of relevant solid scientific psychiatric research– that all evidence and expert opinion in regard to suicide ideation points in the opposite direction. This makes the X-case judgement –effectively a judgement about prescribing a particular 'medical treatment,' as a whole and sole treatment for suicide ideation, at best a medically unsound judgement, completely unsound and without an evidence-based scientific or medical foundation. At worst, it is obsolete but with a deadly outcome – the death of a child every time it is prescribed.

Rather than further buttressing and embedding this judgement, by legislating for abortion in accordance with it, the major duty of legislators is to recognise the error in the X-case judgement and seek ways to counteract and reverse that judgement.

I am, and I'm sure you the legislators are, in favour of the provision of the best possible medical care to expectant mothers and their babies which has given this country its world-class top-drawer reputation for maternal care. Legislation for abortion, as proposed, immediately detracts and undermines that. Ireland without abortion is a world leader in this very real and practical area of medicine and in defence of all human life.

The direct targeting and intentional taking of innocent human life is always a grave chilling evil. For our government now to legislate for this even in one instance does not bear thinking about.

Is mise,

Máirtín Ó Droma
==========
Dr. Máirtín O'Droma, BE, PhD, CEng, FIET, SMIEEE, MIEI
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==========

Majella Meade <majellameade@ymail.com>
07/05/2013 23:22
Please respond to
Majella Meade <majellameade@ymail.com> To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Paul Kelly re abortion bill

Dear Mr. Kelly,

Thank you for asking to hear the views of the public regarding this most important issue.
it is my firm belief as a young Irish woman, that abortion should never come in to Ireland, in
any form. no matter how this issue is dressed up, in reality that will not be the case.
abortion is the killing of our children. the case of Savita, was used as a pro choice attack on life.

I can confirm wholeheartedly, I will never ever again vote fine gael or labour, and will also
ensure no member of my family will either, should this bill be passed.

I am shocked at the fact, that people are not listened too. it is like a few people make decisions,
many of them bad, and we pay the price.

yours sincerely,

Majella Meade

Mandy Curtis <curtis.mandy@gmail.com>
08/05/2013 04.40 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Protection of life during pregnancy Bill concerns

Dear Mr Kelly,

I am writing to you regarding my serious concerns about the heads of the "Protection of Life during Pregnancy Bill" and in particular, the 'suicide intent' matter.

It is very clear to me, from what I have seen, heard and read over the last number of weeks and months (including the Oireachtas Committee on Health and Children hearings) that both medical and psychiatric evidence is unanimous in stating that abortion is not a treatment for women who are suicidal . How can the proposed legislation be justified on this basis? All evidence shows that abortion is not a treatment for suicidal ideation.

Women who are actually suicidal in pregnancy need to be given all the appropriate non judgemental supports, love and care that would be given to any other person considering suicide. The HSE itself acknowledges this in its "Aftercare" booklet which publishes the services available (both medical and counselling) post abortion.

I would also like to raise the general issue of consent. In every area of medicine a freely given, fully informed consent is needed to proceed with an intervention. If a psychiatrist diagnoses a woman to be suicidal this would raise very serious concerns regarding her ability to give informed consent to such a drastic and non- reversible procedure. It thus also raises many concerns for medical ethics.

Thank you for taking the time to read my concerns.

Regards,
Mandy Curtis.

Marcia Mooney <marciamny@gmail.com>
08/05/2013 12.59 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Human Life in Pregnancy Bill

Dear Mr. Kelly,
We wish to state our opposition to this Human Life in Pregnancy Bill. In light of all the evidence shown that Ireland continues to be one of the safest places in the world for pregnant mothers and their unborn babies and in view that many psychiatrists have pointed out abortion is not a treatment for suicidal ideation, why then is the government persisting with this bill against the vast majority of views by the very people they are supposed to represent!
Thanking you,
Marcia & Nicholas Mooney

margaret barry <mbarry34@gmail.com>
08/05/2013 02.58 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
maternity bill

dear mr kelly, i am writing to let you know that i am completely opposed to the current proposed maternity bill. it is a violation to the right to life of the unborn which is just as important as the mothers life. also the psychiatric profession does not see abortion as a solution to a suicidal mother. regards margaret barry

Submission by Margaret Hickey

Dr. Kermit Gosnell is hardly a household name in Ireland. Not in the way that Amanda Knox, Josef Fritzl and Fred West are household names. Both print and broadcasting media in this country did not think the story of his trial of interest or relevance. Or perhaps they believed it to be of particular interest and relevance and for that very reason kept it under wraps. Dr. Kermit Gosnell is on trial for brutally ending the lives of viable aborted babies in his clinic in Philadelphia. The details of the case are chilling and sobering, as instructive to us of the dark places that human nature can descend to as any of the other cases mentioned. No blanket coverage however for Gosnell or even a modicum of coverage unlike the wall to wall reporting on the Knox, Fritzl and West proceedings. Instead a veil of secrecy and denial.

The case raises huge questions as it touches on the delicate line that for a secular, largely pro-choice society like the US marks the point at which abortion becomes infanticide. Leaving a potentially viable foetus to gasp its way to extinction on a hospital slab is legal in many American states. President Obama while Senator for Illinois not once but twice supported the law that permits this barbarity. Many would say the difference between Obama's position and the practice of Gosnell was very little in ethical terms.

Ireland is now at a signal crossroads. As a country we have a choice to make between what is genuinely about the 'protection of life in pregnancy' as the new legislation is headlined and a culture that denies the inalienable right to life of the unborn which the Constitution upholds. Quite simply legislating for the X case is choosing the latter.

There is a fundamental difference in terminating a pregnancy to save a woman's life when the risks to her arise from a physical condition which her medical team cannot otherwise treat and allowing abortion in a healthy pregnancy because the woman involved, for whatever reason, fundamentally does not want to be pregnant. This is what the ' threat of suicide' means. No psychiatrist on either side of the debate has stated that abortion is appropriate treatment for suicide ideation. Not one. There are many who argue that abortion gives rise to mental health problems including suicide ideation. Even pro-choice authored studies and research (such as Fergusson's) have come to this conclusion. Therefore, the suicide ideation we are dealing with here does not have the context of any pre-existing psychiatric disorder but simply arises from the unwanted situation in which the pregnant woman finds herself. This is not to say that suicide ideation may nevertheless be genuine but it will be impossible for any psychiatrist or number of psychiatrists to either confirm or deny. For a doctor the professional risks and potential consequences of a denial are clear to be seen. A group of a hundred and three Irish psychiatrists have written to the government about the corrupting effect of the pending legislation. It is hard to see how any psychiatrist who undertakes the assessment of a suicide threatening pregnant woman who makes a consistent statement will not sign off on whatever paperwork is required. By the same reasoning it is very hard to see how any psychiatrist who is not pro-choice would sign up to make such assessments in the first place.

Anyway you look at legislation for X it is opening a Pandora's box of complications and questions that go on to further compound themselves. The government state they will monitor the number of abortions in different hospitals to discern any significant anomalies. Given that some psychiatrists and hospitals associated with them will have a high frequency of abortion referrals and other psychiatrists who decide to opt out on the grounds of conscience and professional integrity will have zero referrals, anomaly is built into the process from the time the ink is dry on the legislation. As has been the experience of other countries from the UK to California this is one area of legislation where checks and balances are impossible to apply.

The X case set no time limits for abortion. A woman who may initially be happily pregnant may seek an abortion under suicide ideation for reasons of changed personal circumstances or because a scan discloses some abnormality in the fetus. The very things that the proposed legislation is meant to exclude can actually be covered by the all inclusive grounds of suicide ideation. For the government and pro-choice groups to harp about the "

very limited" basis for abortion in the legislation, to insist that it will not " open the floodgates" flies in the face of the facts that one in four pregnancies end in abortion in the UK and that the vast majority of those are grounded in mental health issues. It is hard to see any difference between mental health issues as grounds for abortion and threatened suicide. The reality of both may be very different but as means to procuring an abortion they are both equally unchallengeable.

Why then given what we now know, given the testimony of a large cohort of Irish psychiatrists, the findings of up to date research, the expert opinion given last January to the Oireachtas and an open letter from a significant group of Irish obstetricians published in the Irish press at the end of April is the government still closed to all argument ? The X case was wrong. It was based on evidence of very poor quality by today's standards. Either a judicial review or a referendum is the only way forward. It is true that in two referenda the people failed to remove the risk of suicide as grounds for abortion. However, those who so voted were on both sides of the argument. Pro-life voters objected to exclude suicide as they believed it was a tacit inclusion of other grounds and they believed there were no grounds at all to justify the direct intentional killing of the unborn. Given the slight majority for the 'no' side it is certain that the vote would have gone the other way if Dana Rosemary Scanlan and similar campaigners had urged pro-life supporters to vote to exclude suicide. The government however are blinkered because they are already spoken for by way of a pact between the coalition parties, despite the clear undertaking of the larger partner in government Fine Gael not to legislate for abortion during the general election campaign.

This betrayal which unlike other failures to honour election promises cannot be attributed to intractable economics is a clear sign of corrupted political conscience. What hope then for the rights of conscience of individual deputies or of medical professionals who under the terms of the legislation published will be obliged to refer abortion seeking patients to colleagues? There are implications for freedom of conscience which may well be played out in our courts.

There are other forces at play too in this debate. Like a lot of contentious debates, the issues themselves are not the entire narrative. There is a sense that this is a battle for the soul of Ireland on both sides. While it is on one side about the protection of all life however frail, about the horror and barbarity of abortion, the hurt is brings women and the undermining of our Constitution it is also part of a counter-movement against post-modern moral relativity, the primacy of individual and group rights over the good of society as a whole and our duty to future generations. On the other hand behind the campaign for a woman's autonomy over what is viewed as her body alone and the right to individual self-determination there is a wider aim of finally seeing off the obscurantist influence of a church with a flawed moral authority and a misogynist state that was for too long beholden to them. All these dimensions make the stakes very high for both sides. It is vital that the politicians fully inform themselves and understand the issues and make their decisions accordingly. To act on political or ideological imperatives and pacts will do neither the state nor society any service. This momentous piece of legislation will not sink quietly away with the summer recess. In other countries it has marked a sea change in politics as well as in society. It has changed and determined voting patterns. Where politicians stand on this legislation will shape their political futures. It is for them to decide how.

Insert Margaret Meagher here

REPRODUCTIVE HEALTH matters

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8 May 2013

TO: Principal Clerk
Joint Commission on Health and Children
Written Submission
Re: Protection of Life in Pregnancy Bill

Dear Madam/Sir,

Please accept the attached submission regarding the current content of the **Protection of Life in Pregnancy Bill.**

Yours sincerely,

Marge Berer

Marge Berer, Editor
and pp. Lisa Hallgarten, Online Editor

Re: Protection of Life in Pregnancy Bill: Key Concerns

Submission from:
Marge Berer, Editor and Lisa Hallgarten, Online Editor
Reproductive Health Matters
444 Highgate Studios
53-79 Highgate Road
London NW5 1TL, UK

We are writing this submission based on our expertise as researchers, authors and editors on the subjects of maternal mortality and morbidity, emergency obstetric care, and termination of pregnancy as a political, legal, ethical and human rights issue. Our international journal, *Reproductive Health Matters*, has been publishing evidence-based research and analysis on all these issues since 1993.

Given the short time we have to prepare this submission, we will make brief points here. We would be more than willing to provide further, more in-depth information upon request.

Summary of recommendations:

Head 2: Risk of loss of life from physical illness

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

The scope for uncertainty for doctors, and for mischief-making by those whose ideological stance is to prevent any abortion, even in life-saving situations, should be minimised as far as possible.
R.1 It should be made clear that the appeals process is not intended to be used by those who seek to block an abortion procedure.
R.2 Sufficient safeguards should be put in place to insulate public prosecutors from political pressure to prosecute doctors.
R.3 Doctors need to know that their clinical judgment is trusted rather than open to scrutiny and challenge and that they are operating with clarity and are not under the constant fear of criminal prosecution
R.4 *"There is only one way to be sure a woman's life is at risk, that is, after she dies."* (Statement by Austrian obstetrician-gynaecologist, Christian Fiala). The bill you send for debate and vote **must make this dilemma clear** if it is actually intended to allow terminations in Ireland to save women's lives to be done – in Ireland.

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

R.7 The judgment of a clinician with prior knowledge of the woman should be sufficient to assess the risk that refusal of abortion will lead to suicide. A woman should retain the right to an alternative medical opinion if initially refused, and/or referral for information on obtaining a legal abortion in a country where it is legal.

R.8 A pregnant woman should not be threatened with incarceration if she requests an abortion because of suicidal ideation. Her rights and dignity should be respected and appropriate treatment provided if she wishes it, whether or not she is permitted to have an abortion.

Head 12: Conscientious Objection

R.5 The part of the bill emphasising the right to individual, as opposed to institutional, conscientious objection should be strengthened to protect employees in Catholic institutions in the situation where they provide or participate in provision of a life-saving abortion.

R.6 The legal and ethical obligation to save a woman's life must be protected and supported, and Catholic institutions which refuse to provide life-saving abortion must be stripped of their right to provide maternity services.

Full Submission

1. Overall comment

1.1. This bill appears to seek to comply with the requirements of the European Court of Human Rights and at the same time apply the Irish Constitutional amendment on the equal right to life of a pregnant woman and the embryo/fetus she is carrying. Moreover, this bill covers termination of both wanted and unwanted pregnancies where the woman's life is at risk. These all make your task particularly complicated, but what is most unclear is what you intend to achieve with this bill. It does change the current law on abortion in Ireland, even if that was not the intention, and does not necessarily make the situation easier for pregnant women or medical professionals.

Head 2: Risk of loss of life from physical illness

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

Obstetric emergencies – need for greater clarity as to when a termination is justified

2.1. The bill does not sufficiently clarify the situation for doctors, because it does not define or differentiate sufficiently the different categories of obstetric/medical emergencies that would allow one or two doctors to decide to carry out a termination. As you may know, obstetric emergencies include conditions such as:

i. Hydatidiform mole (molar pregnancy) – there is not a viable embryo and the pregnancy will kill the woman if it is not terminated very early.
ii. Ectopic pregnancy – pregnancy outside the uterus that is not viable and will kill the woman if it is not removed medically or surgically as soon as possible within the first trimester.
iii. Severe complications of pregnancy that may occur without warning and are fatal unless treated in a very timely way – such as haemorrhage (which can kill within 24 hours), eclampsia or sepsis

(which can kill within 1-3 days). Sepsis, for example, may be caused by bacteria entering the womb and upper reproductive tract, e.g. via an open cervical os due to an inevitable miscarriage.

2.2. Experienced obstetrician/gynaecologists do not need a clinical definition of what constitutes an obstetric or medical emergency. But they do need to know how this bill distinguishes the two, in order to feel confident in their own decision to terminate or not, and whether one or two doctors are needed to make that decision. Clinicians who deal with obstetric emergencies where termination of pregnancy is legal do not need the same kind of detailed information that clinicians do when a termination may or may not be considered legal. Rather, because of your bill they will want answers to the following questions:

- At what point in the deterioration of a pregnant woman's health can one or two doctors agree that it would be legal to end the pregnancy?
- What are the criteria for deciding that there is a "medical emergency" that would justify one doctor proceeding with an abortion rather than two doctors needing to agree?
- Will the doctor/doctors involved need to report specific clinical indicators to justify their decision? If so, who would define those indicators and who would judge whether or not the criteria were met?
- Who will be allowed to challenge a clinical decision that a termination is required to save the woman's life, if anyone? Where would such a challenge need to be heard?
- What protection will you guarantee to a doctor (and other clinical staff) in this situation if his/her decision to carry out a termination is challenged later (including via the media or in a public space such as a church) despite any safeguards?

2.3. With a potential 14-year prison sentence facing them, doctors will need a clearer sense of the protection they have from allegations of wrongdoing and criminal prosecution – if, that is, you actually intend any abortions to be performed. Without protection, it will appear to doctors (and to the world) that rather than legislating *for* life-saving abortion, this legislation will actually make it harder to provide one. This is surely not the intention of the European Court directives, the Supreme Court decision in X, nor reflective of the will of the people, nor of doctors following the Halappanavar inquest.

2.4. What assurances will there be that the Director of Public Prosecutions can be insulated from political/religious pressure to investigate and prosecute anyone who is accused, given the existence of well-funded and highly vocal anti-abortion activists and church.

- What will be the threshold of evidence, the criteria that would trigger an investigation, and the process of investigation that would allow a prosecution to go ahead?

3. Putting together the concept of "real and substantial" risk with the concept of "inevitable or immediate" risk

3.1. In several places in the bill, it says that termination is justified if there is a "real and substantial risk to the woman's life". In another part of the bill, it says once and once only that death need not be "inevitable or immediate". These are the two most important defining phrases in the entire text, as regards what clinicians must act on. By putting them into different parts of the bill, rather than together, clarity is lost and there is a danger that these two phrases may be interpreted to contradict each other, which must not be allowed to happen. The second one clarifies the first in a crucial manner and this should be made far more clear.

3.2. The appeals process timeframe is far too long. It is also not clear whether the appeals process can be used to block a request for abortion, as well as to challenge a refusal to provide an abortion. It should be made absolutely clear that this is not the case.
The scope for uncertainty for doctors, and for mischief-making by those whose ideological stance is to prevent any abortion, even in life-saving situations, should be minimised as far as possible.

Recommendations under Heads 2 and 3
R.1 It should be made clear that the appeals process is not intended to be used by those who seek to block an abortion procedure.
R.2 Sufficient safeguards should be put in place to insulate public prosecutors from political pressure to prosecute doctors.
R.3 Doctors need to know that their clinical judgment is trusted rather than open to scrutiny and challenge and that they are operating with clarity about what grounds and criteria need to be met for them to proceed with abortion so that they are not under the constant fear of criminal prosecution
R.4 *"There is only one way to be sure a woman's life is at risk, that is, after she dies."* (Statement by Austrian obstetrician-gynaecologist, Christian Fiala). The bill you send for debate and vote **must make this dilemma clear** if it is actually intended to allow terminations in Ireland to save women's lives to be done – in Ireland. Otherwise, the only really operative part of the bill is the clause which says: "You can still go abroad."

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

4. Suicide risk

4.1. Anyone with expertise and/or an interest in mental health and human rights will be disturbed by the process set out to assess a woman presenting a risk of suicide, starting with the term "self-destruction". The law provides a 21st century ducking stool, in which a woman may be found insufficiently suicidal to have the abortion she requests, but sufficiently suicidal to be held in a mental health institution against her will for the remainder of her pregnancy. This presents a danger to the woman and should be seen as cruel and degrading treatment, a huge breach of her human rights, and an unethical approach to mental health from every possible point of view. It appears designed to appease anti-abortion criticism rather than support the health and well-being of women. It is not supported by medical evidence. The only thing it will do is to frighten women with mental health issues away from seeking help, including with suicidal ideation, rather than supporting good medical practice.
Recommendations under Head 4
R.7 The judgment of a clinician with prior knowledge of the woman should be sufficient to assess the risk that refusal of abortion will lead to suicide. A woman should retain the right to an alternative medical opinion if initially refused, and/or referral for information on obtaining a legal abortion in a country where it is legal.

R.8 A pregnant woman should not be threatened with incarceration if she requests an abortion because of suicidal ideation. Her rights and dignity should be respected and appropriate treatment provided if she wishes it, whether or not she is permitted to have an abortion.

Head 12: Conscientious Objection

5. Institutional vs. individual conscientious objection

5.1. There is likely to be serious pressure from the church to allow an institution as well as individuals to exercise "conscientious objection". An Irish bishop has already been quoted in a newspaper report that under this bill, Catholic institutions with maternity services will be expected to comply with the law and good practice, which will mean sometimes performing an abortion. They have shown (and not only in Ireland but also the USA, Costa Rica and El Salvador) that this is something they will not do.[81]

No national or international professional obstetrics & gynaecology association accepts institutional conscientious objection as ethical, and no country that allows abortion at the least to save the life of the woman allows conscientious objection on the part of individuals in cases of a threat to the woman's life, i.e. in emergencies. This is a fundamental ethical principle, ensuring that a woman's right to life is not trumped by non-clinical beliefs. This part of the bill must not be watered down. In fact, it should be strengthened to protect employees in Catholic institutions in the situation where they provide or participate in provision of a life-saving abortion. The legal and ethical obligation to save a woman's life must be protected and supported.

Recommendations under Head 12

R.5 The part of the bill emphasising the right to individual, as opposed to institutional, conscientious objection should be strengthened to protect employees in Catholic institutions in the situation where they provide or participate in provision of a life-saving abortion.

R.6 The legal and ethical obligation to save a woman's life must be protected and supported, and Catholic institutions which refuse to provide life-saving abortion must be stripped of their right to provide maternity services.

Head 18: Repeals and consequential amendments of other Acts

While there is justification for getting rid of Section 58 and 59 of the 1861 Offences against the Person Act, it seems completely over the top to include a clause in a bill about saving women's lives that make it an offence to have or to provide an abortion not covered by the bill with 14 years in prison. The anti-abortion movement will never be assuaged no matter how restrictive the law is. They do not want women to control their fertility for any reason. The law should not try to accommodate that view, but should support doctors in making evidence-based, clinical decisions that will save and protect women's health and lives, including their mental health.

[81] See Berer, Marge. Termination of pregnancy as emergency obstetric care: the interpretation of Catholic health policy and the consequences for pregnant women. An analysis of the death of Savita Halappanavar in Ireland and similar cases. *Reproductive Health Matters* 2013;21(41):9-17. In press. Pre-print copy attached.

To- Mr Paul Kelly,

I'm sending this submission on a personal basis, in my capacity as a woman and a mother.

I have strong objections to the PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 201

I recommend that the bill is re-examined and that termination of pregnancy because of suicidal ideation and intent is removed from the bill. There is no evidence that abortion is of any benefit to a woman who is suicidal in pregnancy and to legalise abortion on this basis would not be in line with good practice.

I'm particularly concerned with Head 4 of the Bill- Risk of loss of life from self-destruction.

Psychiatrists only have to form a "reasonable" opinion that the threat of suicide can only be averted by aborting an unborn baby.

1 This is very objective and could be highly influenced by a psychiatrists pro-choice ideology.

2 This head does not respect the equal right to life of the unborn as the unborn will face certain death while the woman has the opportunity to avail of psychiatric support, medication and care.

3 There is no time limit.

4 There is no obligation in the head to provide care for the viable unborn child.

5 What are the rights of a baby who is disabled because of early delivery in the event of survival. Who represents this child's rights?

I believe this bill is being rushed through with a haste that is not required,

I recommend much more contact with the public to discuss the implications and the change in focus of care. For the first time, an unborn baby canbe targetted directly.

This is unacceptable and is a breach of the right to life.

Yours sincerely.

Maria Conroy Byrne,

48 Hermitage Park,

Kilcullen,

Co Kildare

Ph- 085 1519901

8th May 2013

Maria Colfer <colfermaria@gmail.com>
08/05/2013 03.42 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Abortion

Mr Kelly I cannot express how horrified I am at plans to introduce abortion to this country. Since when did innocent unborn children become legitimate targets and an inconvenience for those whose own rights are paramount to the exclusion of all other considerations of morality or common humanity. I do not recall us voting in favour of legalised abortion. The reason is we NEVER did. In 1983 the substantive issue was defeated 2 to 1. To some that might seem like the ideal platform to have mock hearings and attempt to bully the people into accepting this vile proposition. Whoever heard of consultations AFTER decisions are made. That is an insult to us and to the very concept of democracy.As someone who has been a lifetime supporter of FG I can assure you that this is a bridge too far and that the slaughter of at least 10,000 babies a year (like the Uk experience) will not be tolerated. I will be looking forward to working night and day against any party which stoops to this level.

Yours

Maria Colfer

mar rubio <marimardeasy@gmail.com>	To	healthandchildren@oireachtas.ie
07/05/2013 23:35	cc	
	Subject	For the attention of Paul Kelly

Abortion Four Times Deadlier Than Childbirth

Dear Mr Kelly,

My name is Maria del Mar. I am Spanish, married to a Cork man, mother of three small children and I have been living in Cork for the last 6 years. I am writing to you with regard to the Abortion Bill. I have been following the debate very closely and I am very disappointed with the introduction of the suicidality element. I know what the "risk for the mental health of a woman" has meant for Spain for the last ten years: the rise of abortions by 75%, 98% of them being for this reason. Obviously, women had to be assessed by doctors and psychologists. But these doctors happened to work in the abortion clinics and in many, many cases they did not even talk to the women (the most recent case being Dr Morin's clinics in Barcelona, where women in their 8th month of pregnancy went for illegal abortions because of their mental health). In other words, the door was open to abortion in all its forms and stages. The very same will happen here. It is a matter of time. People are debating about rights for the mother and rights for the unborn baby. I go further. This thing of the suicide seems just like a little step that does not change things too much but we cannot deceive ourselves into believing that that will be it. I know there is a push for abortion every where in the world because abortion is part of an ideology that involves many other things that I will not go into now. We have to remember what ideologies have meant for man along history. It is not so long ago that Nazism killed millions of innocent humans in the name of ethnic cleansing and the supremacy of the Arian race. It horrifies us and we wonder how man was able to do evils acts like those committed in the concentration camps. And somehow we are doing the very same thing now. China alone is responsible for the death of more than 300 million unborn babies thanks to their one child policy/population control ideology. How long is it going to take us to open our eyes and defend the lives of our future generations? Why not look at other countries and see what abortion is doing to them? Only recently I read what Vladimir Putin said: if we want a strong and prosperous nation we have to defend life and the family. This is coming from a man considered to be a gangster but who can still recognize what abortion will do to Russia. Many pro-abortion people claim abortion is a question of women's rights and in many countries it is actually girls who are being aborted for the simple reason of being girls. We cannot deceive ourselves. Abortion is a question of money. It is a great business. And once the abortion clinics push their tentacles into this country they will push for more and more and more.
Defend the unborn. They are our sons, daughters, cousins, brothers, sisters... future teachers, doctors, politicians, nurses, lawyers.... Courage! Defend all life!

I attach a very interesting study carried out in Finland. It is amazing the amount of women who actually kill themselves after going through an abortion!

Thank you very much for your time,

Maria del Mar

Rape and Incest Victims Reject Abortion, Survey of 192 Victims
Abortion Nearly Four Times Deadlier Than Childbirth: New Government Study In Finland Ignored by Abortion Providers
After Abortion

Abortion Four Times Deadlier Than Childbirth

New Studies Unmask High Maternal Death Rates From Abortion

Abortion advocates, relying on inaccurate maternal death data in the United States, routinely claim that a woman's risk of dying from childbirth is six, ten, or even twelve times higher than the risk of death from abortion.

In contrast, abortion critics have long contended that the statistics relied upon for maternal mortality calculations have been distorted and that the broader claim that "abortion is many times safer than childbirth" completely ignores high rates of other physical and psychological complications associated with abortion. Now a recent, unimpeachable study of pregnancy-associated deaths in Finland has shown that the risk of dying within a year after an abortion is several times higher than the risk of dying after miscarriage or childbirth.(1)

This well-designed record-based study is from STAKES, the statistical analysis unit of Finland's National Research and Development Center for Welfare and Health. In an effort to evaluate the accuracy of maternal death reports, STAKES researchers pulled the death certificate records for all the women of reproductive age (15-49) who died between 1987 and 1994–a total of 9,192 women. They then culled through the national health care data base to identify any pregnancy-related events for each of these women in the 12 months prior to their deaths.

Since Finland has socialized medical care, these records are very accurate and complete. In this fashion, the STAKES researchers identified 281 women who had died within a year of their last pregnancy. The unadjusted mortality rate per 100,000 cases was 27 for women who had given birth, 48 for women who had miscarriages or ectopic pregnancies, and 101 for women who had abortions.

The researchers then calculated the age-adjusted odds ratioof death, using the death rate of women who had not been pregnant as the standard equal to one. Table 1 shows that the age-adjusted odds ratio of women dying in the year they give birth as being half that of women who are not pregnant, whereas women who have abortions are 76 percent more likely to die in the year following abortion compared to nonpregnant women. Compared to women who carry to term, women who abort are 3.5 times more likely to die within ayear. Such figures are always subject to statistical variation from year to year, country to country, study to study. For this reason, the researchers also reported what is known as "95 percent confidence intervals." This means that the available data indicates that 95 percent of all similar studies would report a finding within a specified range around the actual reported figure. For example, the .50 odds ratio for childbirth has a confidence interval of .32 to .78. In other words, it is probable that 95 percent of the time, the odds ratio of death following childbirth will be found to be between 32 percent and 78 percent of the non-pregnant woman rate. The 95 percent confidence interval for the odds ratio of death following abortion was reported to be 1.27 to 2.42 of the annual rate for non-pregnant women.

Deaths from Suicide

Using a subset of the same data, STAKES researchers had previously reported that the risk of death from suicide within the year of an abortion was more than seven times higher than the risk of suicide within a year of childbirth.(2) Two of these suicides were also

connected with infanticide. Examples of post-abortion suicide/infanticide attempts have also been documented in the United States.(3)

The same finding was reported in STAKES' more recent study. Among the 281 women who died within a year of their last pregnancy, 77 (27 percent) had committed suicide. Figure 2 shows the age-adjusted odds ratio for suicide for the three pregnancy groups compared to the "no pregnancy" control group.

Notably, the risk of suicide following a birth was about half that of the general population of women. This finding is consistent with previous studies that have shown that an undisturbed pregnancy actually reduces the risk of suicide.(4)

Abortion, on the other hand, is clearly linked to a dramatic increase in suicide risk. This statistical finding is corroborated by interview-based studies which have consistently shown extraordinarily high levels of suicidal ideation (30-55 percent) and reports of suicide attempts (7-30 percent) among women who have had an abortion.(5) In many of these studies, the women interviewed have explicitly described the abortion as the cause of their suicidal impulses.

The original publication of the STAKES suicide data prompted researchers at the South Glamorgan (population 408,000) Health

Authority in Great Britain to examine their own data on admissions for suicide attempts both before and after pregnancy events. They found that among those who aborted, there was a shift from a roughly "normal" suicide attempt rate before the abortion to a significantly higher suicide attempt rate after the abortion. After their pregnancies, there were 8.1 suicide attempts per thousand women among those who had abortions, compared to only 1.9 suicide attempts among those who gave birth. The higher rate of suicide attempts subsequent to abortion was particularly evident among women under 30 years of age.

As in the STAKES sample, birth was associated with a significantly lower risk of suicide attempts. The South Glamorgan researchers concluded that their data did not support the view that suicide after an abortion was predicated on prior poor mental health, at least as measured by prior suicide attempts. Instead, "the increased risk of suicide after an induced abortion may therefore be a consequence of the procedure itself."(6)

Interpretation of these statistical studies is aided by numerous publications describing individual cases of completed suicide following abortion.(7) In many cases, the attempted or completed suicides have been intentionally or subconsciously timed to coincide with the anniversary date of the abortion or the expected due date of the aborted child.(8) Suicide attempts among male partners following abortion have also been reported.(9)

Teens are generally at higher risk for both suicide and abortion. In a survey of teenaged girls, researchers at the University of Minnesota found that the rate of attempted suicide in the six months prior to the study increased ten fold–from 0.4 percent for girls who had not aborted during that time period to 4 percent for teens who had aborted in the previous six months.(10) Other studies also suggest that the risk of suicide after an abortion may be higher for women with a prior history of psychological disturbances or suicidal tendencies.(11)

It is also worth noting the suicide rate among women in China is the highest in the world. Indeed, 56 percent of all female suicides occur in China, mostly among young rural women.(12) It is also the only country where more women die from suicide than men. For women under 45, the suicide rate is twice as high as that of Chinese men. Government officials are reported to be at a loss for an explanation.

Traditionally, Chinese families placed a high value on large families, especially in rural communities. But after the death of Mao Tse-Tung, who also valued large families, China instituted its brutal one child policy. This population control effort, encouraged by governments and family planning organizations from the West, has required the widespread use of abortion–including forced abortion–and infanticide, especially of female babies. Given the known link between abortion and suicide, can there be any doubt that maternally-oriented Chinese women who are coerced by their families and communities to participate in these atrocities are more likely to commit suicide?

Deaths from Accidents

In this most recent study from Finland, the STAKES researchers also reported that the risk of death from accidents was over four times higher for women who had aborted in the year prior to their deaths than for women who had carried to term. Of the 281 women who died within a year of their last pregnancy, 57 (20 percent) died from injuries attributed to accidents.

Once again, giving birth had a protective effect. Women who had borne children had half the risk of suffering a fatal accident compared to the general population. On the other hand, as shown in Figure 3, women who aborted were *more than twice as likely* to die from a fatal accident than women in the general population.

This finding suggests that women with newborn children are probably more careful to avoid risks which could endanger them or their children. Conversely, women who have had an abortion are apparently more prone to taking risks that could endanger their lives.

This data is consistent with at least two other studies that have found that women who abort are more likely to be treated for accident-related injuries in the year following their abortions.

In a study of government-funded medical programs in Canada, researchers found that women who had undergone an abortion in the previous year were treated for mental disorders 41 percent more often than postpartum women, and 25 percent more often for injuries or conditions resulting from violence.(13)

Similarly, a study of Medicaid payments in Virginia found that women who had state-funded abortions had 62 percent more subsequent mental health claims (resulting in 43 percent higher costs) and 12 percent more claims for treatments related to accidents (resulting in 52 percent higher costs) compared to a case matched sample of women covered by Medicaid who had not had a state-funded abortion.(14)

It is quite likely that some of these deaths which were classified as accidental may have in fact been suicides. Reports of postabortive women deliberately crashing their automobiles, often in a drunken state, in an attempt to kill themselves have been reported by both post-abortion counselors and in the published literature.(15)

It is also likely that many of these deaths are simply related to heightened risk-taking behavior among post-abortive women. This may occur simply because some women care less whether they live or die after an abortion. Other women may seek to "selfmedicate" a sense of depression with the adrenalin rush that often comes with taking risks. In addition, heavier drinking and substance abuse are well-documented aftereffects of abortion, both of which increase a person's risk of fatal accidents.(16)

Deaths from Homicide

The STAKES study also found that 14 (5 percent) of the 281 women were killed by another person. Most of these deaths occurred among women who had undergone an abortion. As shown in Figure 4, the risk of dying from homicide for post-abortive women was more than four times greater than the risk of homicide among the general population. This finding, especially when

combined with the suicide and accident figures, once again reinforces the conclusion that women who abort are more likely to engage in risk-taking behavior.

An Elliot Institute survey of 256 post-abortive women found that nearly 60 percent stated that they began to lose their temper more easily after their abortions, with 48 percent saying they also became more violent when angered. Increased tendencies toward anger and violence after abortion were also significantly associated with substance abuse and higher suicidal tendencies.(17)

In other words, women who were more prone to anger were also more prone to "giving up" on life. This is a dangerous combination which can more easily lead to fatal confrontations with others.

In the STAKES study, an additional 6 deaths that were due to traumatic physical injuries were listed as "unclear violent deaths." In these cases, the researchers could not make a determination of whether the cause of death was due to accident, suicide, or homicide.

Deaths from Natural Causes

Of the 281 deaths, 127 (45 percent) were attributed to natural causes. As seen in Figure 5, the age adjusted odds ratio of dying from natural causes within a year following any outcome of pregnancy is less than the odds ratio of dying for non-pregnant women.

The obvious implication of this finding is that women who are capable of becoming pregnant are simply healthier and less likely to die of natural causes than women who cannot or do not become pregnant. In other words, women who are most likely to die from a natural physical ailment are less likely to have been pregnant in the last year of their lives.

Comparing abortion to birth, however, we once again see that the risk of death from natural causes was significantly higher (60 percent higher in this sample) for women who had an induced abortion in the prior year compared to those who carried to term or had a natural pregnancy loss.

One possible explanation would be that the women who died after an abortion were already in ill health before the abortions and sought the abortion to protect their health. But this hypothesis was rejected by the STAKES researchers when an examination of abortion registry records showed that only a single woman in this group had her abortion for reasons of maternal health.(18) The STAKES data would appear to support the view that induced abortion produces an unnatural physical and psychological stress on women that can result in a negative impact on their general health.

This theory is also supported by a 1984 study that examined the amount of health care sought by women during a year before and a year after their induced abortions. The researchers found that on average, there was an 80 percent increase in the number of doctor visits and a 180 percent increase in doctor visits for psychosocial reasons after abortion.(19)

Ten years later, another study of 1,428 patients chosen at random from their office visits to 69 general practitioners found that pregnancy loss, especially abortion, was significantly associated with a lower assessment of general health.(20) The more pregnancy losses a woman had suffered, the more negative her general health score. In addition, loss of a woman's most recent pregnancy was more strongly associated with lower health than were losses followed by successful deliveries.

While the researchers found that miscarriage was also associated with a lower health score, induced abortion was more strongly associated with a lower health assessment and more frequently identified by women as the cause of their reduced level of health. More than 20 percent of the women participating in the study expressed a moderate to strong need for professional help to resolve their loss.

From this data, Dr. Philip Ney, who led the research team, concluded that acute or pathological grief after the loss of an unborn child, whether by miscarriage or abortion, has a detrimental effect on the psychological and physical health of some women.

Ney proposed several possible reasons for this: (1) depression has been linked to suppressed immune responses, (2) psychological conflict consumes energy that would otherwise be spent in more healthy ways, and (3) prolonged or unresolved mourning may distract the woman from taking care of other health needs or confuse her interpretation of situations and events. In addition to these factors, abortion has been linked to sleeping disorders, eating disorders, and substance abuse, all of which can have a direct negative impact on a woman's health.

Conclusions

The STAKES study of pregnancy-associated deaths is beyond reproach. It is a record-based study in a country with centralized medical records. While a small number of women who died during the period investigated may have had births or abortions outside of Finland which would not have been identified in the records, there is no reason to believe these few cases would have altered these dramatic findings.

Clearly, the odds of a woman dying within a year of having an abortion are significantly higher than for women who carry to term

or have a natural miscarriage. This holds true both for deaths from natural causes and deaths from suicide, accidents, or homicide. In addition, the study underscores the difficulty in reliably defining and identifying maternal deaths. Only 22 percent of the death certificates examined had any mention of the woman's recent pregnancy.

Unfortunately, there is often no clear way of determining when there is any causal connection between a death and a previous pregnancy, birth, miscarriage, or abortion. According to the lead author of the STAKES study, Mika Gissler, in maternal health reports throughout the world, "[t]here is no consensus concerning which cases should be included as maternal deaths. Problematic are, for example, some cancers, stroke, asthma, liver cirrhosis, pneumonia with influenza, anorexia nervosa, and many violent deaths, such as suicide, homicide, and accidents."(21)

By stepping back from a predefined notion of what constitutes a pregnancy-related death, the STAKES team has shown that deaths among women following a pregnancy cannot easily be tracked when a study is based purely on short-term post-operative recovery. This is particularly true following an abortion. Maternal deaths after an abortion are seldom identified as such unless the death occurs on the operating table, if even then (see accompanying article on page 5). By examining all death certificates and all pregnancy events in the prior year, the STAKES team avoided the basic problem of pre-defining what deaths will be included or excluded in maternal mortality reports.

Even this study, however, has shortcomings. The most obvious limitation is that the researchers examined only a single year of the reproductive history of women who had died during the study period. Since suicide attempts are often associated with the anniversary date of the abortion, some portion of deaths from suicide or accidents that occurred slightly over one year after a prior abortion were probably missed.

As seen in Figure 6, the distribution of suicides by month following the pregnancy event indicate an increased level of suicides at seven to ten months following an abortion. This may correspond to a negative anniversary reaction related to the expected due date of the aborted child. A similar spike is seen among women who had miscarriages, though it peaks a couple of months earlier, perhaps because the miscarriages generally occurred further along in gestation than the abortions.

Figure 6: Suicide Rate by Month After Pregnancy Event

Another disadvantage of the one-year limit on the STAKES data set is that it does not reveal how long the protective effect of birth extends, or conversely, how long the odds ratio of death for those who abort remains elevated. A study spanning a longer period of time would be needed to identify these longer term effects.

Finally, the STAKES study does not shed any light on whether or not women who died from suicide or risk-taking behavior after an abortion were already self-destructive before their abortions. It is probable that many were. Women with a propensity for risktaking
would be more likely to become pregnant and perhaps more likely to choose abortion. In such cases, while abortion may not be the underlying cause of their problems, it probably contributed to their psychological deterioration and was a contributing cause of their death.

On the other hand, it is also clear from other studies that many women who were not previously self-destructive become so as a direct result of their traumatic abortion experience. Whether this latter group represents a major or minor portion of those who died in the STAKES sample is unknown.

Additional insights could be gained by looking back over several more years of the women's medical records. It is likely that prior suicide attempts, a high incidence of treatment for accidents, prior psychological treatments, and other prior pregnancy losses would all be associated with an increased risk of subsequent death by suicide, homicide, or accident.

Abortion advocates will naturally argue that abortion did not "cause" any of these deaths, but rather that these women were simply self-destructive or ill beforehand and would have died anyway. This is a flimsy argument, since clearly this same data shows that giving birth has a protective effect. Even women who committed suicide after giving birth waited until after their children were born to take their own lives.

It is quite probable that the best way to help a self-destructive woman to change her life, and value her own life, is to encourage her to cherish the life of her unborn child. Conversely, it is clear that aiding and encouraging a self-destructive woman to undergo an abortion is likely to aggravate her self-destructive tendencies.

These findings underscore the importance of holding abortion clinics liable for screening women who are seeking an abortion for a history of suicide, self-destructive behavior, and psychological instability. The failure to screen for these risk factors is clearly gross negligence. In addition, when abortion clinic counselors falsely reassure women that abortion is safer than childbirth, they should be held accountable for false and deceptive business practices.

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Learn More:

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Higher Death Rates After Abortion Found in U.S., Finland, and Denmark
Multiple Abortions Increase Risk of Maternal Death: New Study

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Posted by EI on June 3, 2000.
Categories: ALL, Mortality, Research, Volume 8

9 Responses
1. for me personally i think it is completely sad that girls would do that. i
by *cassie* on Apr 7, 2011 at 3:52 pm
2. [...] [12]^ http://www.ncbi.nlm.nih.gov/pubmed/9292639 [13]^ http://afterabortion.org/2000/abortion-four-times-deadlierthan-childbirth/ [14]^ http://www.afterabortion.org/pdf/DeathsAssociatedWithAbortion.pdf e [...]
by *L'aborto aumenta la mortalità della donna | UCCR* on Jul 18, 2011 at 8:30 pm
3. I agree these abortion clinics should be held accountable for misinforming women that it is a safe procedure. I am post abortive did it when I was younger and now and for the last 5 years have had mental health problems that I never had before but then there's also the emotional and physical pain. If I only knew now what they did not tell me. T hose places are awful.
by *shannon crozier* on Nov 9, 2011 at 7:28 am
4. "T he ST AKES study of pregnancy-associated deaths is beyond reproach. It is a record-based study in a country with centralized medical records. While a small number of women who died during the period investigated may have had births or abortions outside of Finland which would not have been identified in the records, there is no reason to believe these few cases would have altered these dramatic findings."
As a Psychology student, this paragraph tells me something about this study does not ring true. (Correlation is not causation). Just because these statistics seem to fit the study, it does not mean that it is.
T he last sentence "there is no reason to believe these few cases would have altered these dramatic findings" tells me that if the facts of the cases don't add up to the study, they will ignore them.
by *Neva* on Jan 14, 2012 at 1:24 am
5. We are not claiming that correlation proves causation.
But correlation, especially strong correlation such as in this case is strong evidence that the hypothesis that abortion

reduces death rates among women is false. Similarly, it strongly contradicts the claim that mortality rates associated with abortion are lower than those for childbirth. It even provides evidence that mortality rates after an abortion are higher than for non-pregnant women.
Moreover, the Finland study published in BMJ showing a 6.5 higher rate of suicide in the year following an abortion, compared to women who deliver, supports self-reports, case study reports, and the evidence of suicide notes identifying abortion as one of the causes of suicide. So while the suicide studies do not prove causation in and of themselves (and almost no study can prove causation in the social sciences), the fact that they are consistent with self-reports indicates that these self-reports should not be dismissed as merely anecdotal. T his is statistical evidence that "anecdotal" claims of suicidal behavior due to an abortion *may be* statistically relevant.
Also, we are claiming that the ST AKES study has no self-reporting or self-selection bias. It is 100% record based. Any few cases that may have occurred outside of Finland would have had a negligible effect on the findings.
Bottom line: the Finland and California record based studies are far more reliable than past efforts, especially by the CDC, to rely solely on death certificates and newspaper reports.
For a more complete review of the literature on mortality rates associated with abortion, we strongly recommend reading "Deaths associated with abortion compared to childbirth–a review of new and old data and the medical and legal implications."
by *EI* on Jan 14, 2012 at 5:14 pm
6. Simple question. T he references given are all from around 1998. Surely there are more recent studies and studies from other countries. Why not update the research?
by *Frank Mlinar* on Sep 18, 2012 at 1:59 pm
7. T here is newer research on maternal death rates, discussed in an article posted here.
You can usually find information on the latest research on our news page or at our sister site, http://www.abortionrisks.org.

Recent Posts Pages
We have a *lot* of information here, stretching back years, so its a constant challenge to keep it all up to date. But these links should help you find some of the latest information.
by *Amy at Elliot Institute* on Sep 18, 2012 at 7:41 pm
8. T his is an archived article, and just as a newspaper or journal does not generally update archived articles, we don't try to update our archived articles. It would be very difficult to find and update every article touching on every issue raised by new research. Our more recent news releases will reference the more recent studies. We do also try to update our fact sheets.
T he most comprehensive list of research articles and findings will be found at http://www.abortionrisks.org . . . but even that resource needs improvement.
by *EI* on Sep 18, 2012 at 7:43 pm
9. Oops, the link to the news page above was meant to point here: http://afterabortion.org/2010/elliot-institute-news-releases-2/
by *Amy at Elliot Institute* on Sep 18, 2012 at 7:43 pm
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Repeat Abortions: What the Research Says
An Open Letter to Congress, RNC, DNC and the Media
"Invisible" Abortion Deaths

marieb morgan <mariebmorgan@hotmail.com>
08/05/2013 05.00 p.m. To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>

Subject
Submission to Oireachtas Committee

To the Oireachtas Committee on Health and Children.

I contend that the judgement made by the Supreme Court in 1992 in the X case was a flawed judgement. No medical evidence was sought from professional psychiatrists or any other medical person.
In 2013 there is much evidence which shows that abortion has a detrimental effect on a woman's health.
There is evidence that it increases the risk of mental health problems, it may cause breast-cancer especially if the first pregnancy is aborted and there is a six times higher risk of committing suicide than a woman who has not had an abortion.
To pass a law which allows a suicidal woman who is pregnant to have an abortion goes against all the medical evidence which is available to us today. If the Supreme Court had all this evidence available to them they may have come to a very different conclusion.

All the psychiatrists who appeared before the Oireachtas hearings in January were unanimous that a pregnant woman who had suicidal ideation would never be offered an abortion and yet this scenario which would never happen is to be put into a law!

Legislation ought to be based on firm moral premise. It is an immoral act to take the life of another. You are forming a law which is about to permit the immoral act of taking the life of an innocent victim.

Legislation ought to have a solid foundation. Is the threat of suicide a solid foundation in which to build law? Are the suicidal feelings of a pregnant woman or the suicidal feelings of any person going to be the basis of laws in the future. Should people who are suicidal because they cannot pay their mortgage to have a law passed for them?
What if a woman commits suicide having been given an abortion by the State, will the State be liable to compensate her family for having made the wrong decision?

Labour has followed an ideological stance on the question of abortion but it seems to blind them and our present Government to the real facts.

What has been illegal is about to be legal, the killing of an unborn child. Kermit Gosnell is now before the courts in America having committed infanticide in his abortion clinic. The legalisation of abortion in other states effects the way all maternal care in offered. It can lead to maternity care staff callously offering or suggesting that mothers abort their unborn babies. Women miscarrying are often in the company of women going to have an abortion procedure.

The sensitivity and compassion for women who are pregnant and in a crisis is not to administer death to their unborn baby but to say there is room for all of us on this planet. Which no Government, man or woman has made but we have all received this gift of life and that is one gift we can share and not rob from our unborn brothers and sisters.

Marie Duffy, Curators House, Waterworks, Lee Road, Cork Tel.0214541207

Sent from my iPhone

Begin forwarded message:

From: marie lynch <marielynch14@hotmail.com>
Date: 7 May 2013 19:13:57 IST
To: "healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
Subject: ABORTION IS MURDER

Dear Paul Kelly, I submitted this email previously but didnt address it to Mr P Kelly. I object to this bill completely. UN statistics prove that Ireland is in the top 5 countries in the world for our maternal care, Ireland is one of the safest countries in the world to have a baby, for both mother and child.
The majority of psychiatrist agree that abortion is never a treatment for suicide, making life decisions when in a distressed state is never advisable, and I believe abortion could be very detrimental to a woman's mental health. I have heard anecdotal evidence of woman who are left with a lifetime of pain, anguish and loss.
Science has also proved that at the moment of conception there exists a complete new person, just think that between 18 and 21 days the baby's heart starts beating, this happens even before a woman may know she is pregnant.
What if the baby is born alive, if they survive abortion, will the medical team care for the child..... allow it to die for hours on a tray.... throw it in a bucket of water..... strangle the baby.... cover their mouths to stop them breathing..... this sounds outrageous, but no worse than poisoning a baby in their mother's womb or pulling their little limbs off and then look for their head, this is the reality, I do not want this in Ireland, the majority of the public don't either.
Abortion is a disgusting cruel murder of the most vulnerable group in our society, using words like therapeutic does not make it any less ugly.
I hear the pro abortionists, the media and government officials using false statements such as abortion is needed in cases where there is a real and substantial risk to a woman's life, this treatment already is in place in Ireland, a woman is never denied treatment while pregnant even if this results in the unfortunate loss of the baby.
The European court decision on the X case does not require Ireland to legislate, that is a lie. What is needed in Ireland is clearer guidelines to legally cover medical staff.

Yours Sincerely

Marie Lynch
Bunkilla
Donoughmore
Co Cork

Submission to the Oireachtas Joint Committee on Health and Children regarding the Outline Heads of the Protection of Life During Pregnancy Bill 2013

1. **Introduction**
   I am making this submission as a woman and Irish citizen because the proposed Bill will provide for the first time in this State for abortion.

2. **Executive Summary**
   The Bill provides for the introduction of abortion i.e. the direct and intentional taking of human life in cases of threatened suicide. This is contrary to the intention of the people who voted for the original pro-life Constitutional amendment. Rather than the current Bill, the matter should be referred back to the people by way of another referendum. The legalisation of abortion will result in lasting harm to Irish society as well as to the death of many innocent lives.

3. The Bill does not recognise the equal right to life of the unborn child nor ensure that all steps are taken to protect its life. The definition of "reasonable opinion" in Head 1 should be amended accordingly.

4. Unlike Heads 2 and 3 which provide for situations covered by the Medical Council Guidelines, Head 3 provides for the termination of pregnancy on grounds of threatened suicide. This is abortion. The proposal flies in the face of all evidence that abortion is not a treatment for suicidal ideation but in fact, can be a cause of it. An abortion in such circumstances gives no certainty that the woman will not attempt suicide. The only certainty is that the unborn baby is killed.

5. A subsection 5 should be added to Head 11 Notifications providing that the Minister will be required to publish statistical information on the number of procedures undertaken, the grounds for same and the locations where carried out, on an annual basis. This will allow the impact of the Bill to be monitored and provide for public accountability.

6. Conscientious objection is inadequately protected in draft Head 12. It does not recognise this human right for all medical professionals who may be required to participate in or facilitate an abortion. Hospitals are obliged to provide facilities for abortions under the Bill even if doing so is contrary to their ethos. Medical personal are obliged to ensure another doctor takes over the woman's care – this is more coercive than the current Medical Council Ethical Guidelines and is an infringement of the right to conscientious objection.

7. **Recommendations to be considered by the Committee**
   a. Head 1 Interpretation – definition of "reasonable opinion" should be amended to make explicit reference to the equal right to life of the unborn baby and to provide that every effort should be made to protect both human lives involved i.e. the mother and her child.
   b. Head 4 Risk of loss of life from self-destruction should be deleted in its entirety
   c. Head 11 Notifications – a subsection 5 should be added providing that the Minister will be required to publish statistical information on the number of procedures undertaken, the grounds for same and the locations where carried out, on an annual basis.
   d. Head 12 (1) - Conscientious Objection.
      i. Subsection 1 should be amended to include all medical professionals who could be obliged to participate in, or facilitate, an abortion under the Bill.

ii. Subsection 2 is unclear as regards its purpose and effect. The Committee should ensure that it does not overrule the right to conscientious objection where suicide is concerned.
iii. Subsection 3 should be amended to provide that a hospital or other "appropriate location" will not be required to provide facilities for abortions if it is contrary to its ethos.
iv. The Committee should investigate if subsection 3, as currently drafted, undermines the constitutional protection afforded to such establishments?
v. Subsection 4 should be amended to provide that in the event of a doctor or other health professional having a difficulty in undertaking a required medical procedure, he or she will ensure that appropriate medical care is available as per current medical ethics.

8. Submission

a. The Bill provides for the introduction of abortion i.e. the direct and intentional taking of human life in certain circumstances. I believe that this is contrary to the intention of the people who voted for the original pro-life Constitutional amendment and that the matter should be referred back to the people by way of another referendum.
b. The legalisation of abortion will result in lasting harm to Irish society as well as to the death of many innocent lives.
c. Head 1 – definition of "reasonable opinion". This should be amended to make explicit reference to the equal right to life of the unborn baby and to provide that every effort should be made to protect both human lives involved i.e. the mother and her child.
d. Head 4. - Risk of loss of life from self-destruction**.** This head should be deleted in its entirety for the following reasons:
i. There is no evidence whatsoever that abortion will have an ameliorating impact on a woman with suicidal idiation.
ii. In fact, there is ample evidence – both from academic research and from the experience of women who have had an abortion – that abortion can result in lasting mental health problems for the woman involved including attempted suicide.
iii. There is no doubt that women with crises pregancies can feel under immense psychological pressure but other supports are available than abortion. The State should invest and develop these services rather than provide for abortion.
iv. It will be abused. Evidence of this was given by a woman on the Joe Duffy show last Thursday who clearly stated that when she was pregant 18 years ago she would have said and done anything to have resolved her delima. She had an abortion in the UK and has suffered mentally since including attempting suicide. She stated clearly that, though not suicidal at the time, she would not have hesitated to say she was if it would have procured her an abortion in this country.
v. It puts psychiatrists and obstetrician/gynaecologists in an invidious position – they must make a decision in a highly subjective environment.
e. Head 11 Notifications – a subsection 5 should be added providing that the Minister will be required to publish statistical information on the number of procedures undertaken, the grounds for same and the locations where carried out, on an annual basis. This will allow the impact of the Bill to be monitored and provide for accountability in a matter of grave public concern.
f. Head 12 (1) - Conscientious Objection. The Head as drafted confines the right to conscientious objection to a medical practitioner, nurse or midwife. The subsection should

be amended to include all medical professionals who could be obliged to participate in, or facilitate, an abortion under the Bill e.g. radiologists, pharmacists etc.

g. Head 12 (2) - Conscientious Objection. The Committee should seek clarification of the purpose and effect of Subsection 2? The notes to the head do not address this Subsection. It appears to overrule the right to conscientious objection where suicide is concerned. If that is the case it should be deleted.

h. Head 12 (3) - Conscientious Objection. The ethos of medical establishments should be respected even if, as is claimed, they are not the subject of human rights. The subsection should be amended to provide that a hospital or other "appropriate location" will not be required to provide facilities for abortions if this is contrary to their ethos. The Committee should investigate if the subsection, as currently drafted, undermines the constitutional protection afforded to such establishments?

i. Head 12 (4) - Conscientious Objection. The Subsection imposes a duty on doctors who have conscientious objections "to ensure that another colleague takes over the care of the patient as per current medical ethics". This in fact goes further than the current Medical Council Ethical Guidelines which state "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". **In effect, the subsection as currently drafted obliges the doctor <u>to ensure</u> that another doctor will take over care of the patient. This is could result in them making a referral to abortion. This is clearly an infringement of their right to freedom of thought, conscience and religion.** The subsection should be amended as follows: *In the event of a doctor or other health professional having a difficulty in undertaking a required medical procedure, he or <u>she will ensure that appropriate medical care is available as per current medical ethics.</u>*

Dear Committee members,

1.I am a general practitioner working in a mixed urban / rural practice in Co. Donegal. I have 14 years experience in General Practice and post graduate training in psychiatry. In my work, I have had a lot of experience in dealing with women in pregnancy and more specifically with women in a crisis pregnancy. I have treated pregnant women with psychiatric illness. I have also seen first hand the after effects of abortion.

2.I strongly oppose the governments plan to introduce legalised abortion in this country. The current laws allow for a woman to recieve all necessary treatments to save her life whether she is pregnant or not. The proposal to legislate for suicide risk as grounds for termination of pregnancy will almost certainly lead over the next decade to freely available abortion as it has in other countries.

3 (a)I recommend the current law be upheld to ensure the safety of the mother and her unborn baby and that the direct intervention to end the life of a baby in the womb remains illegal.

(b)I also ask the committee to recommend the exclusion of suicide as a reason for termination.

4(a). I am very concerned about the government's plan to introduce abortion legislation. As it stands the law provides for the treatment of all and any conditions which place a mothers life at risk during pregnancy. To legislate further will shift the focus from treating the mother, with the possible unfortunate and unavoidable consequence of causing harm to the baby, towards directly intervening to end the babies' life. This can never be justified and is not in the best interest of either mother or baby. In the first instance, treating the mother is an attempt to avoid loss of human life. The intention is to save life. Failure to do so will result in the likely death of the mother and of course this will inevitably mean the loss of the babies' life also. In the second instance, the intention is to cause harm to the baby and, no matter what the circumstances, the intentional and deliberate ending of a human beings life is, and must be, against all laws, civil and moral.

(b)The plans to include suicide as a reason for abortion is very inadvisable. Experience from other countries has shown that as soon as this is introduced the number of abortions increases exponentially. The majority of experts in this country concur that abortion is not a treatment for suicidal ideation in pregnancy. Abortion increases the risk of suicide and mental health problems later. Depression can be treated safely and effectively in pregnancy. Caring for the mother should take into account her immediate and her long term welfare. A vulnerable and depressed mother should be protected from interventions which may cause her greater harm and suffering in the long term.

(c)Medical practitioners are taught from the outset to "first do no harm". Our aim must be to promote health and well being and to work to restore people both mentally and physically."Special circumstances" such as rape, sexual assualt etc have long been used as an argument for abortion. In these

circumstances how can the further violation of both the mother's and unborn child's bodies be considered restorative or therapeutic?

(d)We as doctors have a responsibility as "gate keepers" to act in the best interest of our patients. This does not always mean giving the patient the treatment they want . Patients may request treatment that is inappropriate, unhelpful or harmful to the themselves or wider society. I believe that the introduction of abortion in Ireland would be harmful both to the individual women, to their babies and to wider society.

(e)The unfortunate and tragic case of Mrs Halappanavar has been used to fuel the debate on abortion and unfortunately has been used to apply pressure for the introduction of abortion here. Unfortunately, there were gaps in the care of Mrs Halappanavar that led to her death. Proper management would have involved expediting the miscarriage which had already started and was inevitable. This is completely different from initiating direct intervention to end the life of a baby.

Thank you for taking time to consider my submission. In summary, I hope the committee will agree that no mother should ever be denied any treatment necessary to save her life even if this indirectly results in the loss of life of her unborn child. However, the direct intervention to end the life of a baby is a separate issue and is a violation of that baby's basic human right to life.

Yours Sincerely,

Dr. Marie Therese McKenna, MB, BCh, BAO, BMed Sci, DCH, MICGP.

Martha Casey <marthakkc@yahoo.com>
08/05/2013 03.26 p.m.
Please respond to
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"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
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bcc

Subject
Abortion Legislation

Mr. Paul Kelly
I wish to convey my absolute opposition to the proposed maternal health bill, for a variety of reasons, but in particular the fact that it proposes to legislate for abortion in the case of threatened suicide.
There is no evidence to show that abortion is ever beneficial in the treatment of women with mental health problems. On the contrary, it is associated with increased risk of mental health problems. Thus we have over 100 psychiatrists stating their opposition to the proposal that they be involved in certifying a womans need for abortion as this would be asking them to abandon best practice, ie evidence -based medicine.
This is an obvious means of introducing abortion on a wide scale, and it is pointless to deny that this will be the outcome .
International experience shows that provision for abortion on the grounds of mental health will be abused.
This is a horrific abuse of the inviolable right to life which the unborn share with the rest of humanity.
This proposed legislation is not necessary for the protection of maternal health and wellbeing in pregnancy and childbirth. The clarity, as requested by the European Court judgement, could be provided by providing guidlines to re-affirm that women would receive all necessary life saving treatments in pregnancy, whilst also requiring that we exercise a duty of care to the unborn.

There is NO appeal process on behalf of the unborn child.
The legislators have no mandate to abolish sections 58 and 59 of the Offences Against The Person Act.
ABORTION IS AND SHOULD REMAIN A CRIMINAL OFFENCE.
I am intensely disappointed that the Taoiseach has led us to this point.
He has betrayed the voters on a life and death issue.
He will NOT BE FORGIVEN, nor ever forgotten for having stood in leadership whilst this travesty is being introduced.
I can only hope that their plans founder.
Thank you ,
Martha Casey

Martin Colfer <marcol@eircom.net>
08/05/2013 03.18 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Abortion

Attention: Mr Paul Kelly

I have been following with interest and dismay this government's attempts to introduce abortion in direct contravention of Fine Gael promises made prior to the election. Why?

* I do not believe that there is a mandate from the people or that 5 Supreme Court judges can trump the constitution. We have ignored this perverse judgment for 21 years and can continue to do so.

* The ECHR has no right to compel us to introduce abortion in Ireland and it is a downright LIE to say otherwise. This issue is being manipulated by Labour and their pro-abortion allies in the media in a manner which is extremely undemocratic. The minority trying to foist their opinions on the majority.

* Aborting babies on spurious mental health grounds is horrific. 98% of Uk abortions on this ground - does that tell you anything? An abortion holocaust globally every 2 months (40m a year)- all on compassionate grounds in hardship cases! Does that tell you anything?

* Previous Oireachtas hearings were informed that lack of abortion was never an issue in Irish medical practice and neither was suicide which in any case only arose in one in 500,000 (half a million!)cases.

* If FG introduces the direct and intentional killing of the unborn they can forget about my vote and those of the hundreds of people whose signatures we have and who feel the same way.

Yours very sincerely

Martin Colfer

To the Committee for Health and Children and all members of the Oireachtas and Seanad,

I am writing to urge you to reject the proposed Maternal Health Bill which has been introduced by the Government. This Bill is flawed in its language and in the possible implementation of the measures proposed. While this Bill claims to act in the best interest of the mother during pregnancy, it ignores the best interest of the baby which is present in the mother's womb. I welcome the parts of the Bill which clarify for doctors, the medical treatment and interventions which they can take in the event of a life threatening emergency, during the term of a woman's pregnancy. These proposals clarify for doctors the existing medical guidelines which are already in existence and will help in the saving of women's lives in the event of a medical emergency during pregnancy. These interventions taken by doctors are medical interventions during a pregnancy and are not intended to take the life of the baby in the womb, although in some cases the baby does not survive. These actions are medically necessary treatments and are acceptable under current Irish law as the intention is not to harm the baby. It is a mistaken belief that these interventions are the same as abortion, which is instead the intentional killing of a baby in the womb in order to end a pregnancy. These interventions are not abortions. The treatment given by doctors to pregnant women in this country is among the best in the world under current Irish law and it is not necessary to introduce any further laws to aid doctors as the medical guidelines currently in place give them the guidance and legal permission to act in the best interest of the health of the woman and child. From the Oireachtas hearings on this issue late last year, the evidence given by doctors urged the Government to provide clarification on these guidelines. They did not seek a change in the law which would allow abortions to take place.

While the sections of the Bill which provide this clarification for doctors is to be welcomed, the proposal in the Bill to allow the abortion of a baby in the case of a mother who is threatening suicide is deeply flawed. This proposal ignores the evidence of countless psychiatrists, including the Irish Association of Psychiatrists, which provided evidence at the Oireachtas hearings, that abortion is not a successful treatment for a pregnant woman who is suicidal. Medical and psychiatric evidence has shown that in cases such as these, women are more likely to commit suicide after they have availed of an abortion for suicidal tendencies. It is vital that the government help these women not by trying to provide a seemingly quick solution to their problem but to assure these women that they are valued and cared for by providing them with all the help they need to overcome these suicidal feelings. A pregnant woman is only going to feel suicidal because of the circumstances in which she finds herself while pregnant i.e. in financial difficulties, relationship difficulties or as a result of a traumatic experience such as rape or abuse. In these circumstances, it is vital that we help the woman in whatever way she needs help, by providing the financial and therapeutic services she needs to feel secure and reassured in her pregnancy. In the case of rape, this is made more difficult due to the nature of the pregnancy but abortion is not the answer to her emotional turmoil in this case. Women who have had abortions following rape have testified that they have felt regret for taking the life of an innocent baby. Evidence from psychiatrists who have helped women in these circumstances has shown that women who have an abortion following a rape are at a greater risk of suicide as they are not only trying to overcome the trauma and violation of the rape but are also suffering grief at the loss of a baby. Women who have been raped and carried the pregnancy to full term and have given birth to their baby, have overcome the trauma of the rape with less difficulty than those who have chosen to have an abortion.

The proposed Bill before the Oireachtas Committee introduces for the first time into Irish law the intentional killing of a healthy baby. This cannot be allowed to be introduced as the Irish constitution seeks to protect the lives of all Irish citizens. The child within their mother's womb is the most vulnerable of all Irish citizens and should be protected by the Government. One of the main worries which I have regarding this Bill is that there is no mention of restrictions on abortions for women over a certain term in their pregnancy. In other countries in which abortion is legal, there is a restriction in place which prevents

abortions from taking place after 24 weeks of pregnancy. There is no such restriction in the proposed Bill before the Oireachtas. This means that a woman can seek an abortion to end her pregnancy due to a danger to her life by suicide at any stage of her pregnancy. This would make the proposed Bill unworkable as no doctor would willingly perform an abortion on a woman who is so far advanced in her pregnancy that she would be able to give birth to a healthy baby within a few weeks. If the medical evidence on the formation of a baby within the womb is taken into consideration, it is plain to see that the baby is a fully formed human being deserving of the protection of Irish law from well before the 24 week restriction which is present in other countries. These babies need our protection and should not be allowed to die on the decision of their emotionally distressed mother. If a woman is not in a position to be able to provide for a baby, the adoption services in this country are able to provide a loving and safe home for each baby among the countless numbers of couples who are spending thousands of Euros on IVF treatment for children which they cannot normally conceive.

The Government argue that this proposed Bill provides abortion on very restricted circumstances and can be governed and reviewed when necessary. However past experience of other countries which have introduced such laws shows that this is not possible. The 1967 Abortion act in England provided for abortion under similar restrictions and within a few years had abortion available on demand with hundreds of thousands of babies being killed across the countries every year (in 2011 the figure for abortions carried out under mental health grounds was 97% of the total 190,000 abortions) for mental health and medical reasons which are horrific to comprehend. Among the reasons given for some of the abortions carried out in the U.K. are simply treated medical problems such as cleft palate, which can easily be treated within the first couple of years of a child's life and does not affect their quality of life at all. A similar circumstance occurred in the state of California when abortion was introduced there on very restrictive grounds. These restrictions included a provision that the woman would have to a danger to herself and others and in need of institutionalisation for an abortion to be carried out. Within a year of this law being enacted, over 98% of the 61,000 women who claimed abortions did so under this provision. It seems incomprehensible that so many women were in need of institutionalisation in order to qualify for an abortion. This situation will occur in Ireland if we allow abortion into our country even in very restricted circumstances. Once the door to abortion is opened, once the lack of respect for human life takes hold, there is no reversal.

The government also claims that they are required under European Law to introduce abortion in order to legislate for the X-Case. This is not the case. The European Court did not require that Ireland legalise abortion or legislate for the X-Case. It asked that the government clarify for women and doctors the circumstances in which medical treatment may be required during pregnancy. These guidelines as I have already stated are already in place and just need clarification under Irish law. With regard to the X-Case, a review of this case needs to take place before legislation is introduced based on the ruling of this case. The X-Case judgment followed from a flawed trial in which no medical evidence from doctors or psychiatrists were heard in relation to the case. The only 'medical' evidence given was from a sex therapist which should not have been allowed by the judge as the sole medical testimony. Legalising abortion based on this flawed judgment, allowing abortion to be carried out on the grounds of suicide throughout the nine months of pregnancy will lead to abuse and chaos within psychiatric medicine. The Irish Psychiatric Association has refused to co-operate with this Bill as they can see that it is unworkable and as one expert put it, it could 'potentially compromise the therapeutic alliance between psychiatrist and patient'. Senior psychiatrists have testified that abortion would be pointless and obsolete for a woman who is extremely suicidal as it is not a treatment for suicidal feelings and if a woman is at that much risk of suicide, she needs medical and psychiatric treatment rather than an abortion. By legalising abortion under the threat of suicide, we will only normalise suicide rather than try to prevent it. There are countless campaigns going on in this country to try and end suicide and let people know that they should seek help for their problems rather than destroy their lives and the lives of their families, friends and communities, through the taking of their own life. This should be extended to pregnant women who are feeling suicidal rather than worsening the situation by placing more trauma and emotional turmoil through the grief for a

lost child on their shoulders. There has never been a case in which abortion has been the only treatment for a woman who is suicidal and countless experts agree that it is not a treatment at all for suicide.

It is time that the Government listened to the voices not only of the people of Ireland but also the medical experts in this field. The proposed Bill brought before the Committee should be dismissed and the Government should take definitive action in providing the help and support which women in these circumstances actually need. The guidelines which are in place for medical treatment during pregnancy need clarification instead. There is a clear distinction between abortion which is the intentional killing of a child in the womb and life-saving medical treatment which safeguards both the mother and the baby but which may unintentionally lead to the end of a baby's life. Ireland has never legalised the intentional killing of any of its citizens and it should not do so now especially for those citizens who rely on the Government for protection and help, the unborn children of Ireland.

Martina Caffrey M.A.

Constituency of Meath East

Martina Kealy <martinakealy@hotmail.com>
04/05/2013 10:09 To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Submission on Bill on Protection of Life

From: Martina Kealy <martinakealy@hotmail.com>
Date: 2 May 2013 20:31:55 IST
To: John Deasy <john.deasy@oireachtas.ie>
Subject: Submission on Bill on Protection of Life

Dear Deputy Deasy and the Oireachtas Committee Members

On behalf of myself I would like to say that the approach in the Bill toward suicidal women who are pregnant is regrettable.

I am a 'well' bipolar for many years. I have been suicidal many times, mainly postnatally. I was not in my right mind when I was suicidal and when I was treated with psychiatric drugs I saw things very differently. I was glad that I did not take my own life, for my own sake and for the sake on my children, my husband and my family. I was in a black hole and now spend a lot of time pulling people out of black holes.
The point that psychiatrists realise and all agree on is that a suicidal pregnant woman, is not in her right mind. Killing her baby, will make her feel worse, and what about the poor father of the child. He is NEVER mentioned. A woman, post abortion, may never recover fully from the guilt of killing her own child. In fact, she may become even more suicidal as a result. The State has an obligation to acknowledge her true mental state when she is suicidal. The State needs to offer her counselling and/or mediction. The State needs to pull her out of her black hole, but not by killing her baby.
I believe life begins at conception and ends in natural death. Human life is sacred and has the same status from conception to natural death.
I am now a mother to 4 grown up children, one a trainee pilot. On his and two other pregnancies, I was prescribed an antidepressant which was researched by my psychiatrist to be safe for pregnancy. The two girls which I was on medication for during their pregnancy are at third level and doing exceedingly well, one attaining first class honours, all the time. One girl is studying science the other girl is studying Arts.

No one, who is suicidal is in their right mind. This is how we lose such fine people, even Ministers, as happened recently.
Even women who are told are carrying babies with abnormalities that cannot sustain life, gain solace to give birth to their babies and to hold them in their arms until their natural death.
Pam Stenzel, an American, is a living result of a rape and is speaking in Dublin next weekend to packed audiences. I know that is a difficult one but her testimony is incredible. I have heard her speaking before. I brought all my children to hear her. They were amazed at the courage of her mother not to abort her. After all, its NEVER the baby's fault. They just can't speak for themselves and because they are vulnerable in this

way, they have no voice and can be killed.
Killing any baby from conception onwards is not the answer. This Bill does not properly protect life.
The real problem in the Salvita case was Medical Negligence which needs to be addressed and all that needs to take place is a tightening up on the Medical Council Guidelines on Intervention to save the life of the mother.

Thankyou for your time in reading this.

Martina Kealy (BA) Mod Natural Sciences TCD. School Librarian. Consultant Cataloguer.
MA TCD
Diploma Library and Information Sciences UCD
New Student Diploma in Theological Studies Maynooth 2013/2014
Volunteer with Aware
Volunteer Information Centre St Patrick's University Hospital (7 years 1 evening a week)
Previous Volunteer Simon Community Shelter (7 years 1 evening a week)

Certificates in the ASSIST and SafeTalk programmes on Suicide Intervention.

To: healthandchildren@oireachtas.ie

RE: Proposed Abortion Legislation

I am devastated that the Government is pressing ahead with abortion legislation, even initially naming it "Protection of Maternal Life Bill", when medical evidence shows that abortion, far from helping women in pregnancy, may actually expose them to greater risks, mental and physical. The proposed legislation would be based on the flawed judgment of the X Case; which heard no medical evidence. Recent, unanimous, Psychiatric evidence to the Oireachtas stated that abortion is not a treatment for suicidal feelings. The Irish Medical Organisation strongly rejected motions calling for abortion under X Case ruling.

Claims that the legislation will be "extremely restrictive" do not stand up, as seen in UK with nearly 200,000 abortions pa, 97% giving mental health reasons and +60,000 in California within a year of legislation, 98% also giving mental health grounds. Abortions in US are now 1,500,000 pa. This adds to a lot of defenceless, murdered babies denied their natural right to life. This 'Right to Life" of the unborn is enshrined in the Irish Constitution and cannot be removed by Fine Gael/Labour outside of a Referendum.

Like everyone else I am in agreement that women in pregnancy must receive whatever treatments are necessary to safeguard their lives, even where this unavoidably results in the death of the baby. But legalised abortion is something entirely different. It is the deliberate and intentional killing of an unborn child through abortion. This is against the Natural Law and also violates the 5th Commandment which states: "Thou shalt not kill".

Our present Government needs to reflect also on the horror of what an abortion culture entails and the negative consequences of abortion for so many women.

I urgently appeal that Legalized Abortion must not become a reality in Ireland. Once the right to life of the unborn is conceded, there is no going back. We must listen to individuals involved in introducing abortion in UK and US who stated with regret afterwards that they had no idea at the time that they were opening the flood gates to abortion on demand.

Women in pregnancy must receive whatever treatments are necessary to safeguard their lives. The lives of the unborn must also be protected. The medical profession must get clear medical guidelines, as sought by the European Court, to clarify the present position. Medical experts must be heard when they say: "Abortion is not a treatment for suicide".

I desperately want you to preserve Ireland's pro-life ethos of caring for both mother and baby during pregnancy. I am a Secondary Teacher and mother of 7 adult children with 5 grandchildren. Many colleagues, friends, neighbors and family members are aware of and support my concerns.

Sincerely, Mary B Killeen, Bawnmore, Eyrecourt, Ballinasloe, Co Galway

Mary Daly <mjrdaly@yahoo.ie>
07/05/2013 23:37
Please respond to
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"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
abortion legislation

I support the Catholic Bishops stance on the forthcoming proposed legislation on abortion

Rita Daly

Mary Doherty

Submission
Protection of Life During Pregnancy Bill 2013

Summary

Head 2
Head 3
Head 4
Head 18

Head 2: Risk of loss of life from physical illness...

We object to the wording ‘it is not an offence to carry out a medical procedure’ abortion is not a medical procedure and it is never needed to save a mother’s life. Head 2 will gives medical practitioners more scope and flexibility to decide when human life should be ended this will lead the way to abuse of the legislation and a more liberal regime of abortion. This has already happened in other jurisdictions.

Head 3: Risk of loss of life from physical illness in a medical Emergency.

Again the wording is objectionable it states ‘it is not an offence... for a medical practitioner to end the life of the unborn in an emergency, thus giving the medical practitioner a lot of scope to end the life of the unborn child.

The present Medical Ethical Guidelines make it very clear that a medical practitioner can intervene to save the life of the mother if her life is in danger, therefore there is no need to make a law to give doctors the green light to pave the way for relaxing the laws on abortion which is what this legislation would do.

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

It has been made very clear by the evidence at the Oireachtas Committee hearings that suicide in pregnancy was extremely rare this evidence was made clear by the Obstetricians and Gynaecologists and the Psychiatrists made it extremely clear that abortion was not a treatment for suicide. So the grounds for abortion for suicide ideation has been widely discredited by the evidence.

Head 18: Repeal and Consequential Amendments

The Offences Against the Person Act 1861 protects the unborn child from abortion now the government with this Bill wants to repeal sections 58 and 59 these are the sections that protects the life of the unborn child so again we can see that the government want the medical practitioners to have more scope in carrying out the ending of the unborn child's life if they feel it's necessary.

This will inevitably lead to abortion on demand.

They government, politicians, some doctors and some sections of the media have been and are still misleading and being dishonest when they trot out the mantra that abortion is needed to save a woman's life. Abortion is never needed to save life all the necessary medical care can be given to the women and the pregnancy can be terminated if the woman's life is in danger without resorting to this legislation.

Recommendations

 We recommend that the government do not repeal the sections 58 and 59 of the Offences Against the Persons Act

1861

 We recommend the government listen to the Psychiatrists when they say abortion is not a treatment for suicide.

 We believe the government must listen to the majority of the Irish people who do not want the killing of unborn children.

 We recommend they get all the Medical and appropriate experts to strengthen the existing guidelines as to make no mistake that the unborn child life is of equal importance as the mother's therefore protecting both of their lives.

Mary Kelly <redzer1951@hotmail.com>
08/05/2013 16:41 To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
The Government's proposed legislation on abortion

Dear Mr Kelly,

The governments proposed legislation on abortion is of grave concern to us. The protection of the unborn is enshrined in our constitution. It has been clearly established at the Oireachtas hearings in January that abortion It is not a treatment for suicide.

That means the supreme court decision of many years ago is flawd and out of date and should not form the basis of any legistation. It would lead in time to the direct intentional killing of unborn babies which is always wrong and it would be a serios breach of our constitioun in which the protection of the unborn child is enshrined.

Therfore we submit to the Oireachtas members that the proposed legislation in regard to abortion a treatment for suicide does not merit our support.

Yours Sincerely,

Mary Kelly

Mary Mc Conalogue

In relation to risk of loss of life in physical illness- Heads 2&3

1. I agree wholeheartedly with the provisions in these Heads which will provide clarity to doctors on which actions to take in those circumstances when a mother's life is physically at risk. The legislation re-affirms that it is lawful to carry out life-saving interventions if the foetus poses a physical risk to the mother's life, even if this results in the death of the foetus. This is vastly different to the direct targeting of a child's life in abortion. Abortion is the deliberate, intentional destruction of the unborn child in utero. It is important to make the distinction between abortion and a pregnancy termination which may result from a medical intervention necessary to save the life of the mother.

2. I believe it's also crucial to make the point that this is nothing to do with one life having more value than the other, it just makes more sense to save one life rather than none. The Constitution currently upholds the rights of both the mother and the unborn child but this situation is not about rights really- it's about treating two patients and doing one's best to preserve life. As the foetus is dependent on the mother's life, it is imperative to treat the mother as priority. In this way, the life of the foetus is not directly targeted, yet its death may be an unavoidable consequence of saving the mother's life. Both are valuable human beings.

In relation to risk of loss of life from self-destruction- Head 5

3. I firmly believe that suicide should NOT be included as a grounds for abortion under the legislation for the following reasons:

4. There is absolutely no evidence that abortion is an effective treatment for suicidality in pregnant women. Conversely, all of the available studies in medical literature point to the protective effect of pregnancy on mental health. If anything, as will be shown in the following studies, suicide risk is lowest in pregnant women and highest post abortion. Of all unplanned pregnancies- both those carried to term and aborted-we will see that the suicide rate is six times higher in those who had abortions. Moreover, in the group of women with pre-existing mental health issues, abortion was shown to exacerbate these mental health issues and increase the risk of suicide over time.

    4.1.1. The most recent Meta analysis of all the relevant medical literature concludes an "*81% increase in mental health problems in women post abortion, 10% of which is directly attributable to abortion*." Coleman et al. 2011

    4.1.2. A previous study conducted in 2008 concludes as follows " *the findings of this study have some important implications for the legal status of abortion in societies such as New Zealand and the UK, where over 90% of abortions are authorised on the grounds that proceeding with the pregnancy would pose a serious threat to the woman's mental health. In general, there is no evidence in the literature on abortion and mental health that suggests that abortion reduces the mental health risks of unwanted or mistimed pregnancy. .....These trends are evident in the present study, which shows that although abortion was associated with increased risks of mental health problems, no increase was evident for those having unwanted pregnancies that came to term. Although these conclusions are limited by the relatively small number of unwanted pregnancies that came to term, there is nothing in this study that would suggest that the termination of pregnancy was associated with lower risks of mental health problems than birth following an unwanted pregnancy. "* Fergusson et al. 2008

4.1.3. Finally a literature review conducted by Gissler et al. 1996 *clearly showed ' that women who have experienced an abortion have an increased risk of suicide"* and *"The suicide rate after an abortion was three times the general suicide rate and six times that associated with birth."*

4.1.4. In light of our proposed legislation on the grounds of the X case, I think it is worth pointing out that abortion did not put an end to the suicidal ideation of Miss C, the first girl to whom the conclusions reached in X were applied. She made repeated suicide attempts after the State took her to England for an abortion.

4.1.5. Is it not therefore both unsafe and unjust to legislate for abortion on the grounds of suicide, not only because it destroys an innocent life, but because, for certain categories of women, abortion itself can INCREASE the risk of taking one's own life?

4.1.6. Not surprisingly, a recent letter signed by 11 top Irish consultant psychiatrists states that "termination of pregnancy is not a psychiatric treatment for suicidality, nor is it mentioned as such in any of the major textbooks of psychiatry", and further states that "offering an abortion to a distressed person who is psychiatrically ill would be strongly ill-advised since the person's capacity to make important life decisions is frequently impaired".

5. **Suicidality itself is complex and multifactorial.** It is not a concrete, diagnosable condition, it is very rarely due to a single cause and we cannot predict who will or will not carry it out. Suicidal ideation is frequently characterized by extreme despair or a distorted thought process- in either case, the solution is not usually to take away the trigger factor-desirable as that might be. In fact, 'Just removing the cause' is quite simplistic when you think of the various causes there can be for the despair that characterizes suicidal ideation- unemployment, bereavement, loss or break-up of a relationship, financial hardships, abuse, low self-esteem The majority of these causes cannot be just 'taken away'What the mother needs is a system of psychiatric care which challenges her suicidal thoughts and in doing so directly addresses the underlying issues with the objective of helping her to cope better with whatever stressful circumstances life has thrown at her. To say that taking away one stressor is the sole treatment option for such a serious condition is at best archaic in this era of evidence based medicine and totally defies the holistic approach which characterizes modern medicine.

5.1.1. In spite of all this, Psychiatrist Prof Veronica O'Keane testified recently that in some cases, an unwanted pregnancy could be the sole cause of suicidal ideation. She then proceeded to say that abortion is not a treatment for suicide-rather it's a treatment for unwanted pregnancy- and to take away the pregnancy would in fact take away the suicidal ideation. Simple as that. In that case, dare I ask, if a woman with a newborn baby is suicidal due to postnatal depression or a perceived inability to cope as a parent-is it justifiable to take the life of that newborn in an effort to remove the stressor in this case? Is this baby any more worthy of life just because it's outside the womb? Does passage through the birth canal suddenly confer a value on an otherwise invisible and therefore unviable human being?? An obstetrician recently gave the following treatment plans for two scenarios- the first was a woman presenting at 24 weeks pregnant with suicidal ideation-the second a woman at 20 weeks with the same symptoms. At 24 weeks the treatment plan was to commit her to psychiatric care and induce delivery….at 20 weeks - abortion was the answer. Between 20 and 24 weeks gestational age this baby had somehow acquired the status of a human being with a right to life despite the fact that an increase in size would have been the only anatomical development at this stage. This is tantamount to saying that in developmental terms a 3 month old baby is more worthy of saving than a 2 month old.

6. How ethical is it to place a decision of such magnitude in the hands of a woman, in such a precarious position with regard to her mental health? To ask her to make a decision which could have lifelong repercussions in terms of regrets/guilt etc.? At the end of the day, regardless of how many doctors/psychiatrists etc. sign off on her ‘eligibility‘ for an abortion- it is her own decision. Is a distressed woman on the cusp of taking her own life really capable of giving ‘informed consent’ on this most irreversible of procedures? Will she have the emotional resources to deal with the inevitable grief associated with the loss of a child? Abortion never reverses a pregnancy. Can she seriously look back in a few years time and say that she was given the best care?

7. Not one of us has the right to deliberately end the life of another human being, UNLESS this is the only way of physically saving the life of the mother, in which case you are not deliberately targeting the life of the child.

    7.1.1. The first principle in medicine is 'First, do no harm'. In the case of suicide, where it's believed that the pregnancy is the sole cause of the suicide and by extension that termination will remove this 'cause', the problem is that you are already doing the utmost harm, by taking the life of a helpless human being.
    7.1.2. In suicide, the baby itself is not in any way endangering the mother. How can we justify taking its life 'just in case' she decides to take her own life?

8. Pregnant suicidal women deserve the same care, support and medical treatment as non-pregnant suicidal women, to do otherwise is discriminatory and bad medical practice. In the same way that you do not treat a stomach illness with a cardiac procedure, you do not treat a psychiatric illness (however temporary it may be) with an obstetric procedure.

9. In conclusion, if there is no evidence to suggest that abortion is an effective treatment for suicidal ideation in pregnancy, why are we legislating to have it enshrined in Irish law?

    9.1.1. If Ireland is currently one of the safest counties in which to have a baby with one of the lowest maternal death rates, why are we legislating to change the existing law?

    9.1.2. Does the government have the resources to deal with the inevitable increased burden on mental health services down the line if you do introduce abortion onto these shores?

    9.1.3. Lastly, is it ever right to deliberately take the life of an innocent child as an end in itself?

10. My recommendation is to remove the suicide clause from the legislation on the grounds that there is no medical evidence to suggest a beneficial effect on the mental health of the mother. In contradiction to its name, the ‘Protecting Life in Pregnancy’ legislation may in fact **endanger** the life of the mother during pregnancy, if we are to look at the evidence.

On foot of this, the government should focus its efforts on challenging the Supreme Court decision in 1992 on the grounds that it was a flawed judgment based on the lack of any psychiatric input whatsoever. 21 years on, there continues to be no evidence to support the introduction of abortion as a treatment option in suicidal ideation in pregnant women.

In relation to Head 5: medical opinion in the form and manner described by the minister

11. The number of doctors on the case is irrelevant when you are asking them to prescribe a treatment plan for which there is no medical evidence and which is likely to cause further harm to the patient. The presence of 3 or 6 or 12 doctors on an assessment panel will not change the fact that abortion is not indicated as a treatment for suicide in any of the medical literature. The danger is that in these cases, the doctor's judgment may depend on the social acceptability of abortion to that doctor as an option for the mother as opposed to using it as a necessary medical treatment for suicide.

12. No matter how stringent the regulations or how narrow the terms under which abortion can be carried out, we cannot ignore what has happened in other jurisdictions with equally restrictive grounds for the granting of an abortion.

13. In California's Therapeutic Abortion **Act** of 1967 abortion was only permitted if the threat to the mental health of the mother was acute. The woman needed a committee of two licensed doctors (or 3 if after the 13th week of pregnancy) to be in unanimous agreement to allow an abortion. Prior to approving an application for an abortion the committee must have certified that there was "a substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother". The term "mental health," was defined as "mental illness to the extent that the woman is dangerous to herself or to the person or property of others or is in need of supervision or restraint." These were the same grounds as for committal to a mental health institution, leading legislators to believe that it was a very rigorous standard. **So, what happened?**

14. In 1970, just one year, there were 63,872 abortions approved and 61,572 performed. Virtually all of them, 98.2%, were approved and performed under the mental health exception. (The Act also allowed for abortion where the pregnancy resulted from rape or incest.)

15. The California Supreme Court, **reflecting** on the flood of abortions coming from the mental heath exception said in 1972 that: "Serious doubt must exist that such a considerable number of pregnant women could have been committed to a mental institution. Either pregnancy carries risks to mental health beyond those ever imagined, or legal writers and members of the therapeutic abortion committees, two groups we must assume to be of at least common intelligence, have been forced to guess at the meaning of this provision and have reached radically different interpretations."

16. So, are California doctors more prone to collusion than Irish doctors? Are they less trust worthy? That is not the issue. The issue is that **the experience of other jurisdictions shows that even rigorous standards have been widely abused.** And according to the expert evidence given at the recent Oireachtas Committee hearings, abortion is never a treatment for suicidality.

17. Similarly, Lord David Steele, the architect of the 1967 law that brought wide-ranging abortion into Britain recently said it would be a 'mistake' for Ireland to introduce abortion on the grounds of threatened suicide, adding he 'never envisaged there would be so many abortions' in Britain resulting from the law he introduced. (Irish Independent 21st December 2012). In 2011, no less than 97% of the 189,931 abortions in England and Wales were performed on mental health grounds. (Abortion Statistics, England and Wales: 2011, National Statistics, Department of Health, May 2012, pp8-9.

https://www.wp.dh.gov.uk/transparency/files/2012/05/Commentary1.pdf)

18. Not only did the number of abortions in the UK increase exponentially, but there was a significant widening of the grounds for legal abortion. The abortion legislation in the UK has now evolved to allow for legal abortion up to birth where a baby has a disability (Human Fertilisation and Embryology Act, 1990).

19. The British Pregnancy Advisory Service (Britain's biggest abortion provider) openly admits ' it is not the case that the majority of women seeking abortion are necessarily at risk of damaging their mental health if they continue their pregnancy. But it is significant that, because of the law, women and their doctors have to indicate that this is the case'. (Abortion Review, 2nd May 2012, http://www.abortionreview.org/index.php/site/article/963).

20. It would be extremely naïve of legislators to believe that the case will be any different in Ireland, following on from the same so called *"restrictive"* legislation.

Mary Mcmenamin <mary.mcmenamin99@gmail.com>
08/05/2013 01.54 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
F.A.O. Paul Kelly

Dear Mr Kelly,

I am emailing you today to submit my strong opposition to the Legislating of Abortion on the grounds of suicidal women in pregnancy.

There is treatment for suicide, Abortion is not a treatment. I have met with and spoken to many women over the last 20 years who have had an abortion and have had deep regrets which many have lead to suicidal thoughts. Women have committed suicide as a result of having an abortion.

Ireland has always been known as one of the safest countries in the world to have a baby, please do not let these high standards change.

Yours sincerely
Mary McMenamin

"murray16" <murray16@gofree.indigo.ie>
08/05/2013 05.02 p.m. To
<healthandchildren@oireachtas.ie>
cc

bcc

Subject
FAO Paul Kelly

Submission on Protection of Life during Pregnancy Bill

I would like to make 2 points under Head 4:

(i)The Bill is designed here I feel to protect the life of women who are suicidal - it should be borne in mind that approximately 50% of the babies who may be aborted as a result of this bill coming into law would also be women - if allowed to live (i.e. female babies).

(ii)I think the biggest flaw is that the Supreme Court judgement was flawed - the people who voted on the referendum never intended what the Supreme Court interpreted - I feel the Supreme Court made a judgement in my name so to speak that was never what I voted for.

Regards

Mary Murray

Maura Molumby <mauramolumby@gmail.com>
08/05/2013 04.26 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Submissions.

Dear Paul Kelly, Is it not logical to presume that the proposed abortion legislation should be based on real facts, I think so, so lets look at the actual facts. First, the UN, having surveyed more than 100 countries, declared that Ireland, without legalised abortion, is the safest country in the world for a woman to be pregnant and give birth. Second, when an Oireachtas Committee earlier this year took submissions on this subject, all the medical experts, both Obstetricians and Psychiatrists, said that abortion could NEVER be a suitable option for suicidality in a pregnant woman. Third, the IMO, representing all the doctors in the country reached the same conclusion. Fourth, numerous surveys have shown that a majority of Irish people do not want abortion legalised. So on what grounds are our Government basing their decision, the statistics are readily available from other countries, eg, in the UK in the last 20 to 30 years, a far greater number of women have died as a result of abortions than have women in Ireland giving birth, we have the lowest maternal mortality rate in the world. In one year, 66 babies who survived abortions in the UK were just left to die, to me that is infantacide, so will we be legalising that here as well? This practice is also common in the USA, and as the Gosnell trial has shown, some abortionists there actually kill the babies who survive abortions. It has also been proven that doctors in the UK tell their patients to say they are suicidal if any questions are asked at the hospital. One of my biggest worries is, since so many of our doctors have disagreed with these proposals, will they be forced to carry out abortions against their will, where has our Freedom of Conscience gone, I believed that was enshrined in our Constitution. If Ireland is still a Democracy, then our Government have no mandate to introduce this legislation, and they are obviously lying when they say they have a duty to go ahead with this because the people want it, the people have not been asked and are being given no say in this decision. I also believe the Supreme Court decision on the X case was very flawed, no medical evidence was called, and no time limit was put on the procedure, so legislation based on that case will allow abortion for all 9 months of pregnancy. In view of this how can our Government talk about "limited" or "restricted" abortion. I hope our Legislators finally accept the real facts, and legislate accordingly, otherwise they will be turning into complete Dictators. Yours faithfully. Maura Molumby.

Maureen Blackwell <mblackwell5@hotmail.co.uk>
08/05/2013 03.12 p.m. To
"." <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Abortion legislation

Dear Mr. Kelly, The legislation you and your colleagues are introducing is not life saving and I totally disagree with what ye are doing. Legalising Abortion on suicide ground is not required by the European Court judgement. This legislation is harmful to both the mother and her unborn baby. Abortion can never be beneficial as a treatment for anything. I would hope ye would listen to the voice of the people ye are supposed to represent. Yours sincerely, Maureen Blackwell.

FAO: Mr. Paul Kelly, Principal Clerk Joint Commitee on Health and Children.

I, Maurice Fitzgerald, Shanbally, County Cork, hereby make the following submission in respect of the "Protection of Life During pregnancy Bill 2013".

To the Committee as follows:

Executive summary

The public consultation on this controversial abortion legislation ***Protection of Life During Pregnancy Bill 2013*** might be regarding by some as a closed shop.
The requirements for submission mandate that people give: "***A brief introduction outlining any experience you or your group have or any work that you or your group have engaged in that is relevant to this issue***", before you are allowed to make a submission. This is not fair and leads one to believe that the consultation is designed for the medical profession only and special interest groups. To call it a public consultation per se is ridiculous and it is clear to my mind that special interests are in play. I make my submission in any case.

Notwithstanding the public consultation. The invocative-named "***Protection of Life During Pregnancy Bill 2013.***
" is littered with a ultra anti-choice agenda and does more to sure up the already ridged position on abortion in this country, than anything else. The Bill makes it extremely difficult to render an abortion without the highest degree of medical profession say so. The woman's choice only applies where a termination is granted and she changes her mind, but not the other way around.

Heads of the Bill deviate somewhat from the "X" case Supreme ruling and state: "there is a real and substantial risk of loss of the pregnant woman's life, other than by way of self-destruction." Suicide was indeed a factor in the "X" case.However, the Bill merits this as a cause in selected sections, in contrary.

The Bill invokes an extremely bureaucratic mechanism for general determinations under any condition that will be impracticable and unworkable. The purposed legislation even mandates a particular location for any procedure to be carried out, again in certain circumstances. Head 3, subsection 3 of ***Protection of Life During Pregnancy Bill 2013.*** has an absolute position on the life of the mother stating "her physical illness can only be averted by a termination." A lot of politics could played with this and again we could end up in a situation such as the Halappanavar tragedy.

Head 3 also recognises "both patients" denoting the woman and the unborn and gives a very clear indication that this legislation is being drafted by those of a Catholic persuasion. There is heavy demarcation in the draft Bill between the "life" of the woman as opposed to the "health". It could be argued that they are exactly the same thing.

There are further grey areas throughout the Bill which stipulate and "immediate" situation where the woman's life is in danger. This could be open to wide interpretation and speculation. The Bill is contradictory in many parts and any provision could be invoked depending subjective interpretations and situations on the ground—which could be endless.

There is also prolix and exhaustive requirements on practitioner registration and spurious references to case law, which in themselves are subject of many contentious debates. These include notifications to the Minister, special registration and committees.

Head 12 of the Bill speaks of "conscientious objection" and allows nurses and mid-wives a opt out. However, insists under section (3) that conscientious objections will not be "grounds" for institutions that are obliged to carry out terminations? This may be unworkable and goes on to cite European rulings on the matter regarding people's conscience.

Head 14 of the Bill gives Carte Blanche power to the Minister to bring the Act into effect and to issue "ancillary provisions" which could mean anything. The Human Life in Pregnancy Bill formally criminalises abortion and the Offences Against the Person Act 1861 is repealed so far as it deals with this issue. It essentially re-criminalises abortion and brings in fresh legislation to make it a serious offence under a specialist piece of legislation. Provision is also made for criminalising not alone the person carrying out the abortion, but also the woman involved, such is the anti-abortion agenda and input.

The Bill is a mess from top to bottom and is arguably one of the worse drafted Bills in history of the state, and far from providing legal certainty, it will serve to confuse and complicate matters more. There are 9832 words in the draft Bill so far, with further heads planned. And it should be remembered that the consultation process has not finalised yet, so any legislation could be far in excess of what is already a lengthy piece of purposed legislation. It may also be successfully constitutionally challenged under Article 40.3.3. by anti-choice activists or others, if not referred to the Supreme Court under article 26 by the President and found constitutional, which could complicate matters to an extreme level?

It has a very real potential to backfire disastrously and will ensure that the abortion debate becomes more complex and dangerous for women.

List of Recommendations

1) **All Heads**) That the entire Bill be scrapped because of its biased language. That is partisan towards the anti-abortion agenda. It is badly laid out and a mess from layout point of view throughout.
2) **Head 2**: (explanatory notes) That its wording under the Constitution 40.3.3 regarding the word "practical" is undefined. More definition is needed regarding the so-called rights of the unborn as it is "practicable" to save it in the legislation.
3) **Head 2** (explanatory notes) The distinction of the health of the mother as opposed to the life is a dangerous demarcation and should be scrapped. They should mean exactly the same thing. There must also be an "immediate threat to the life of the mother". This could be open to wide speculation. What indeed does immediate mean, where are the parameters?
4) **Head 2,3,6**,: Registration requirements regarding doctors are prolix, bureaucratic in the extreme and unnecessary. All licensed MD's should be automatically authorised.
5) **Head 12**: Mid-wives and nurses should be required to make their objections known to the place of employment where they work if this legislation passed, so it does not cause problems (when) terminations are sanctioned. Their views must be known well in advance.
6) **Head 6**: (explanatory notes) The Bill repeatedly refers to case law. These cases are subject to wide legal interpretation and will cause incredible confusion when taken in context to this purposed legislation.
7) **Head 3, subsection 3** of the ***Protection of Life During Pregnancy Bill 2013*** has an absolute position on the life of the mother stating "her physical illness can only be averted by a termination." A lot of politics could played with this and again we could end up in a situation such as the Halappanavar tragedy.
8) **Head 2 page 7** explanatory notes also recognises "both patients" denoting the woman and the unborn and gives a very clear indication that this legislation is being drafted by those of a Catholic persuasion or a anti-choice persuasion. The public at large have not recognised the unborn as a patient.

Main Body of Submission (ALL HEADS)

The Review committee should recognise from the word go that this consultation has come about as a result of the Halappanavar incident in Galway and for not for other reasons it would seem. This must be accepted by all present. This woman clearly wanted a termination and was refused. It was stated to her that "it was a Catholic Country" Mrs. Halappanavar was not Catholic and her view ignored. It is not known whether the decision not to proceed with a termination was (truly) as a result of feared legal consequences or religiously motivated by the staff. The latter would seem to be more potent.

The abortion position in this country has been ruled by fanatical people who are engaged in religious fundamentalism, totalitarianism and repression of the individual. The person who is pregnant has no rights in this country whatsoever once pregnant regarding abortion. A liberal position on abortion can only protect women from uncertainty.

The ***Protection of Life During Pregnancy Bill 2013.*** seeks to make it very difficult to get a sanction termination and it is calculated to do so in line with an undemocratic view contrary to the personal rights of the individual, which the unborn is not. It seeks to interfere with the personal wishes and choice of the person, as does Article 40.3.3

The Bill far from providing clarity for medical practitioners, does exactly the opposite. It is unworkable for practitioners and will fail in real life scenarios because of the mechanisms it employs and the time needed to comply with procedures.

It is accepted that 5000 or more woman are getting abortions in the UK and other countries and it must be accepted that the anti-abortion view is just one view, not held by everybody. And to the contrary in the case of Irish woman that travel abroad.

The committee must surely recognise in the light of the Halappanavar case that woman face very serious situations in a miscarriage situation and why indeed should an ultra-strict position on abortion legislation be adopted to suit those who are against abortion because it disagrees with their moral standards.

The Committee must have regard for EHRC rulings regarding the woman's right to privacy in such matters, which has legally established at the highest EU level. This privacy to decide may be seriously infringed by this legislation. The legislation is designed to make it almost impossible to have an abortion, where all decision making power is expunged from the woman and where she has not rights at all.

The submitter believes that unborn rights under this legislation are purely artificial and contrived. Rights must be capable of been exercised. Individuals can only exercise rights. Unborn rights are artificially exercised by other individuals by force of legislation only and interfere with the individual's rights and choices.

You many publish this submission in full. Please do NOT publish my Email address as i have given my full postal address.

Maurice Fitzgerald,
(Shanbally),
Ringaskiddy,
County Cork.

_____

mauricefitzgeraldshanbally@gmail.com

Submission to the Oireachtas Hearings on the Protection of Life During Pregnancy Bill 2013 from Mayo For Life: 4-5-2013

We in Mayo for Life believe that the Protection of Life during pregnancy Bill should be rejected by the Oireachtas for the following reasons:

1.The law as it stands in Ireland does protect women and give them every treatment they need in pregnancy even if, as a consequence of that treatment, that means the unborn baby may die.

2.The law as it stands says the doctors should always save the woman's life even if the baby dies as a result.

3.The law as it stands gives certainty to women and doctors. No woman in Ireland has ever died because of the lack of abortion. A countrywide study of maternal mortality in Ireland between 1989 and 1991 was published in the Irish Medical Journal in 1996. Its authors found that Ireland, without recourse to abortion had only half the maternal mortality rate of England and Wales. **(** *Jenkins DM; Carr C; Stanley J; O'Dwyer T. Maternal Mortality in the Irish Republic, 1989-1991 Irish Medical Journal 89(4): 140-1.)*

The Medical Council governs practise for doctors in Ireland - and they insist that doctors treat pregnant women even if that leads to the unintentional death of her child.
The Ethical Guidelines of the Medical Council state that 'should a child in utero suffer or lose its life as a side effect of standard medical treatment of the mother, then this is not unethical.'

Therefore pregnant women in Ireland do not die because they do not have access to abortion and Ireland has one of the lowest maternal mortality records in the world. ***(****The 2005 Report on Maternal Health written under the auspices of WHO, UNICEF and the World Bank confirmed Ireland as Number 1 and a leading example to the world for its low maternal mortality records.)*

4. Doctors said at the Oireachtas Hearings on abortion in January 2013 that they would never hesitate but always saved the life of the mother.

See Youtube: http://www.youtube.com/watch?v=4dTmvgNBq_Q.
Therefore what is contained in the bill is not needed.

5. The Government say that they must legislate for the X Case following the Supreme Court Judgement on X in 1992. This is not true. No government is obliged to do so. That judgement was deeply flawed as it did not hear any evidence from any psychiatrist at the

time. It also has been overtaken by best medical practice in the field of psychiatry as psychiatrists now agree that abortion is not an appropriate treatment for suicidal ideation.

There is no evidence that abortion is an intervention that reduces suicide. No textbooks of psychiatry or research papers suggest this. Almost the totality of psychiatrists in this country were asked about abortion as a treatment for suicidality. There was a 42pc response rate and of those 90pc said that abortion is not a treatment for suicidality and had serious concerns about the proposed legislation.

Professor Patricia Casey reviewed the data available :

"I reviewed the reports of the Masters of the three Dublin maternity hospitals covering the periods 1950 to 2011. These show that in total there were 394 maternal deaths. Of these, five died by suicide – one during pregnancy (at 30 weeks' gestation) and four shortly after giving birth.

Vitally and crucially, the data obtained from these reports shows that the five women who died by suicide did not do so because of their pregnancy but because of problems external to it such as mental illness." Therefore the women who died by suicide did not do so because they were refused an abortion.

6. The Government say they are obliged because of the ECHR ruling of Dec 2012 to legalize abortion in line with the X case. This is not true. The ECHR has no mandate in Ireland to force our Government to enact or change any law. The ECHR asked the government to clarify the position in Ireland for pregnant women. This did not mean that the Government were being asked to legalize abortion.

Conclusion:

We in Mayo for Life appeal to the Government to halt their plans to legalize abortion in Ireland under this bill and instead to :

(a)The Government, if they wish to satisfy the ECHR, which they under no obligation to do, should issue new and clear guidelines for doctors on when they can intervene to save a mother's life in situations where a woman is pregnant and her life is at risk. This does not necessitate legislation.

(b) Ensure that women that are suicidal in pregnancy are given every support, treatment and protection that protects the woman's life and that of her baby. To ensure this, we ask

the Government to ensure that the HSE is sufficiently funded in the area of psychiatry to enable this to happen.

(c) That resources be made available to develop comprehensive supports for women in crisis pregnancy including financial and emotional support i.e the provision of accommodation for women in crisis pregnancy and proper counselling for the duration of the pregnancy and beyond.

(d) That the Government, for the protection of women in crisis pregnancy in the future, ensure that the HSE investigation into the Crisis Pregnancy Agencies be concluded. . A recent sting operation revealed that these agencies were giving out lethal advice to pregnant women. If necessary the investigation should be followed up by the DPP to ensure that these agencies are working within the law.

Yours sincerely,

Nuala Uí Laimhín

Chairperson.

Meave Hughes

Secretary,

Pádraig O Laimhín

Treasurer,

Mayo For Life.

Summary of Submission to the Oireachtas Hearings on The Protection of Life During Pregnancy Bill 2013 from Mayo For Life

1. Present law does protect pregnant women.
2. Present law tells doctors to save the mother even if the baby dies as a result.
3. Present law gives certainty to doctors.
4. Doctors in Ireland have always intervened to save the life of the mother.
5. The Government says they must legislate for the X case. This is not true.
6. The Government says they are obliged because of the ECHR ruling of Dec 2012 to legalize abortion in line with the X case. This is not true.
7. Conclusion and recommendations.

Conclusion: We appeal to the Government to halt their plans to legalize abortion in Ireland under this bill.

Recommendations:

(a) Ensure that women that are suicidal in pregnancy are given every support, treatment and protection.

(b) That resources be made available to develop comprehensive supports for women in crisis pregnancy.

(c) That the Government, for the protection of women in crisis pregnancy in the future, ensure that the HSE investigation into the Crisis Pregnancy Agencies be concluded.

"dillon" <dillonmargaret@eircom.net>
08/05/2013 04.40 p.m. To
<healthandchildren@oireachtas.ie>
cc

bcc

Subject
Bill

In regard to the new Bill, I wish to make the following brief submission:

(i) Overwhelming medical evidence proves that abortion can never be a cure for suicide.
(ii) The Supreme Court judgement is critically flawed as no expert medical evidence was examined.
(iii) The Bill if passed will be amended in the years ahead to allow for abortions in other scenarios not yet envisaged or encountered, leading to a real danger that abortion on demand will be introduced.

Michael Dillon

Submission to Joint Oireachtas Committee – Protection of Life During Pregnancy Bill

Dear Members,

Introduction

I am submitting the following as a concerned citizen and individual only - who, while being "pro-life" minded, is not a member of any organisation or pro-life group. I have followed the discourse closely over the last few months and have contributed to a number of debates on the issue, most notably on a number of online forums attached to papers of record.

Brief Summary

While my underlying objection to the Bill is the issue of directly targeting human life for the non-evidence based gain of an individual experiencing suicidality, this is not considered in the submission here. I am sure other submissions will aptly outline the principle objections on that substantive issue. The main thrust of my submission is to highlight the problems of competing legislation/medical guidelines, and that of conscientious objection. In this, I would urge members to be cognisant of the following:

1. Head 4 - Consideration of the competing (and arguably trumping) Medical Council Guidelines in proposed legislation.

2. Head 12 – Consideration of broadened conscientious objection rights for institutions and individuals in line with the Council of Europe's *The right to conscientious objection in lawful medical care* resolution.

Finally, I would urge the members of the committee to be pragmatic in finding that the current Heads of Bill cannot reasonably be enacted in their current form.

Yours sincerely

- Michael Foley (Micheál O'Foghludha)

Signed

Michael Foley, 5/5/2013

Issues around Medical Council Guidelines competing with Protection of Life During Pregnancy Bill

Head 4

4.1.b of the Heads allows for an abortion where *(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.* We know that updated guidelines, which presumably must now informed by both science and any enacted legislation, will inform the clinical decision process, particularly in relation to (ii) above. It was very apparent from the earlier Oireachtas hearings that clinicians wanted a strong provision for the place of scientific developments informing legislation.

Now, it is clear that a place for developments in the area of psychiatry are not catered for in the proposed Bill, so it is reasonable to suggest that there will be something in future Medical Council Guidelines which will have some bearing on the praxis of the proposed legislation. One concern is, as there is very clear evidence* emerging which contraindicates the option for 'self-destruction terminations' (for want of a better term) as an appropriate course of action, then presumably Medical Council Guidelines must be faithful to the science and reflect this in measures - which may go as far as censuring clinicians who follow through on contraindicating terminations. Such Guidelines would be seen to trump the opposing legislation and no suicidality-abortions would thereby be possible. I believe the Medical Council, being an evidence based organisation, will withstand pressures to ignore the science from lobbyists and powerful cultural, and eventually put in place such measures.

In my view, such a scenario is likely and will mean inserting redundant appendices in the law, already obsolete at the time of enactment, and the very antithesis of what has been argued is a solution to the supposed lacuna in the legislation. I would urge the Committee to consider this issue in the questioning and deliberations of the evidence provided by, in particular, those with a clinical background making submissions to the Oireachtas hearings.

Proposition (ii) in Head 4 makes abortion lawful, where in the reasonable opinion of the clinical team this risk can be averted only by that medical procedure. It has been reasonably argued that it is **never a reasonable opinion** to hold that the risk of "self-destruction" can only be averted by a termination, as alluded to in recent research by Professors David Fergusson, John Horwood, and Joseph Boden* and to which one hundred and thirteen Irish psychiatrists have recently added their weight to those findings. It is a fact that nowhere has it been argued, by any psychiatrist or research body that I am aware, that abortion is an appropriate therapeutic procedure for a woman experiencing suicidality.

** - Fergusson (who is considered reputable by the British Academy of Medical Colleges) in an April 2013 paper indicates, "the growing evidence suggesting that abortion does not have therapeutic benefits cannot be ignored indefinitely, and it is unacceptable for clinicians to authorize large numbers of abortions on grounds for which*

there is, currently, no scientific evidence".
http://anp.sagepub.com/content/early/2013/04/02/0004867413484597.abstract

Issues around Conscientious Objection

Head 12

Notwithstanding the primary unjust function of in Head 4 targeting the life of the baby, Head 12 of the Bill is problematic in its limits of conscientious rights for individuals, and which also purposely omits the extension of *any* conscientious objection rights to institutions.

As it is argued above, the science will likely impose on clinicians the contraindicating problem of abortion-as-therapy that is already clear from currently accepted medical research. However an arguably greater problem, as Simon Mills alludes to in a recent article in the Irish Times**, is the inclusion for the first time in Irish law that impels institutions and individuals to perform non-emergency and arguably non-life saving abortions against their will. The Iona Institute also sets out a similar argument***. Heads 12 of the Bill goes much further than other countries (even those with much more liberal abortion regimes) in limiting conscientious objection rights. I would argue that it is reasonable to foresee that the Bill will be challenged should it be passed, as it will contravene the principles set out in the 'The right to conscientious objection in lawful medical care' resolution passed by the Council of Europe back in 2010. The resolution 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 or embryo, for any reason." The proposed legislation looks set to fail in properly balancing rights, not just that of mother and child but between the rights of the state and conscientious rights of citizens.

**http://www.irishtimes.com/news/social-affairs/bill-s-omissions-guarantee-that-abortion-issue-will-return-as-divisively-as-ever-1.1382152

*** http://ionainstitute.ie/index.php?id=2920

I would urge the members of the committee to be pragmatic in finding that the current Heads of Bill cannot reasonably be enacted in their current form.

I would also like to thank members for their time and efforts in considering these concerns.

"Michael Howard" <mjhoward@eircom.net>
08/05/2013 04.41 p.m. To
<healthandchildren@oireachtas.ie>
cc

bcc

Subject
Abortion Bill 2013

To Mr. Jerry Buttimer TD,
Chairman,
Oircheachtas Committee.

Dear Sir,

1. We are a married couple with adult children and in this respect are well aware of the development of the baby in its mother's womb.

2. Summary of our submission
Abortion is not an answer to suicidal inclinations in a pregnant woman.
There is no published research to say that this is so.
This has been confirmed by Dr. David Fergusson from new Zealand on Morning Ireland as late as yesterday the 7th May.
Prof. Fergusson also confirmed, based on his research, that there is a great risk of suicide after a woman has had an abortion than if she had carried the baby to full term.
Why go against all professional advice.

3. Recommendation
i) Improve on the medical guidelines where a woman's life is in danger in the course of her pregnancy.
ii) No need for any reference to the X case judgement
iii) Give the people a chance to reverse the supreme Court Judgement with another referendum. This was already done in the case of the divorce referendum.

Yours sincerely,

Michael & Jacueline Howard

"Michael Lavin" <lavinm37@gmail.com>
08/05/2013 03.31 p.m. To
<healthandchildren@oireachtas.ie>
cc

bcc

Subject
Submission on Protection of Life During Pregnancy Bill 2013

Attention Paul Kelly

Dear Mr. Paul Kelly

We wish to express our opposition to the Protection of Life During Pregnancy Bill 2013, particularly to the issue surrounding suicide.

We feel that there is no foolproof method of saying without doubt that a person is suicidal no matter how imminent the psychiatrist is. How can anyone say for certain that a person is suicidal? It is subjective and not an exact science.

We feel that the upshot of this will see abortion on demand.

Michael & Theresa Lavin.

Michelle Pykett <michelle.pykett2@gmail.com>
08/05/2013 02.04 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Re. New maternity and Pregnancy bill

Dear Mr Kelly,
I am a secondary school teacher and I am extremely concerned about this new bill being proposed.
I have had girls come to me seeking an abortion and claiming they were suicidal. Many go on to have their children and either keep them or give them up for adoption but I have had a few cases where they proceeded to travel to England and follow through with the abortion. Now unfortunately these girls suffer so much afterwards. I have witnessed the grief and trauma they suffered post abortion despite their absolute wish to proceed in the first place. It is terribly heart breaking to witness.
The other girls who had their children generally go on to further their studies and have a healthier mind set.
The other side people seem to forget is the father of the child involved. A lot of my pregnant students would be in the same class or school. I have seen the effect of an abortion on father of the child. I cannot describe the utter heartbreak and suffering they go through, and also after having agreed to travel with their girlfriend.
I used to be pro choice especially in certain circumstances but having witnessed the tragic effects on my students and grief and loss they suffer after an abortion there is no right in allowing this to be legal in cases of suicide. It does not make the situation better it worsens it drastically! Instead we need to focus putting our resources into helping these women and couples. Abortion is never a cure for suicide. Even our psychiatric professionals agree it is not a solution. Please consider all the advice and stories to prevent this bill from being passed. We have fabulous doctors and nurses, don't put them into moral or difficult dilemma situations. Please please do not let this bill be passed.
Thank you,
yours sincerely,
Michelle Pykett

Moira Liddane <moiraliddane@gmail.com>
08/05/2013 03.18 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
FAO Paul Kelly rehuman life/pregnancy bill

Dear Paul,
I write in response to the request for written submissions re the protection of human life during pregnancy Bill,
 I disagree with the introduction of abortion into Ireland on any grounds. I particularly fins the suggested allowing of abortion on grounds of potential sucide of the mother offensive to all Irish people. Abortion is not a recommended nor effective treatment for suicidal feelings. Indeed, eliminating the perceived cause of suicidal feelings is never a cure for suicidal feelings. The person feeling vunerable deserves attention, assistance and any medical help which can help eliminate the suicidal feelings, and thus help the person make more reasoned choices re the issue of concern, whatever the matter of concern happens to be.
The proposed Bill also allows abortion right up to the end of the pregnancy, which is more liberal than even most pro abortion supports see as reasonable.
PLEASE DO NOT PASS THIS bILL.
MOIRA lIDDANE,
DUKES lODGE,
ATHY
CO KILDARE

Monica O' Reilly <monicalumurphy@hotmail.com>
08/05/2013 12.29 p.m.

To "healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>

cc

bcc

Subject
Protection of life during pregnancy bill

I object to the passing of the "Protection of Life during pregnancy Bill"

(1) It is based on the X case which is flawed.

(2) Abortion is never a treatment for suicide.

(3)The Government is not compelled to introduce legislation, clarity to existing legislation is all that is needed.

Monica O'Reilly

To Paul Kelly,

healthandchildren@oireachtas.ie

The mantra is that we must legislate for abortion because the Supreme Court decision was given **21 years ago**.

But is this not the **very reason for not legislating? I. E. because it is so old.** Science is always updating itself. New conclusions are coming out every day.

In this regard, Eilis O'Regan reported in the Irish Independent of 25.4.2013 that **113 psychiatrists** had signed a statement that "legislation allowing abortion as a treatment for a threat of suicide, has no basis in medical evidence". **So they are saying that there is no evidence that killing the baby would cure the pregnant girl of her idea of suicide**.

So why are we going illogically for legislation? If there were a Supreme Court case right now, and that conclusion was submitted, would the Judges not **give a ruling contrary to the 1992 decision?**

Mrs K Cronin

14 Glandore Park

Dun Laoghaire

Insert Myra O'Regan here

Submission to the Oireachtas Committee on Health and Children on Protection of Life During Pregnancy (Heads of) Bill 2013

Wednesday 8th of May 2013

Introduction

Founded in 1973, the National Women's Council of Ireland is the leading national women's membership organisation. We seek full equality between men and women. We represent and derive our mandate from our membership, which includes 165 member groups from a diversity of backgrounds, sectors and locations. Our mission is to lead, and to be a catalyst for change in the achievement of equality between women and men. Our mandate is to articulate the views and experiences of our members and make sure their voices are heard wherever decisions are made which affect the lives of women in all their diversity. Our vision is of an Ireland, and of a world, where there is full equality between women and men.

The NWCI has worked on the issue of abortion for over thirty years and our position on abortion has developed over time in recognition of the diversity of views and perspectives which women have on the issue. We have been mandated by our membership to adopt a pro-choice position on abortion. This position is rooted in an analysis of gender equality, women's human rights and social inclusion. The NWCI is well placed to make a considered contribution to the draft legislation.

In 2013, the NWCI produced a position paper on abortion. Most recently the NWCI has led an online campaign to legislate for the X case where over 76,000 emails were sent from more than 17,000 women and men, representing every constituency in the country, calling on TDs and Senators to bring forward legislation as a matter of urgency to give effect to the X case. This demand is reflected in recent opinion polls which reveal that 84% of the population support abortion where the mother's life is threatened, including by suicide.[82] Our role is to give voice to the experiences of women in Ireland who remain largely voiceless in this debate due to the stigma that surrounds abortion in Ireland and to support women's access to reproductive health.

[82] See Irish Times / Ipsos MRBI opinion poll February 2013

NWCI Concerns and Recommendations
NWCI welcome the fact that after 21 years of government inaction the General Scheme of the Protection of Life during Pregnancy Bill 2013 has been published to give effect to the X Case judgement. This is an important step towards ensuring that women's lives during pregnancy will be protected.

We welcome its clarity that it is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is immediate or inevitable as this approach insufficiently vindicates the pregnant woman's right to life. We further welcome that in the case of emergency, one doctor is sufficient to assess the danger to a woman's life.

However we have grave concerns in relation to other aspects of the Heads of Bill. In our analysis of the Bill we have focused on the Bill's capacity to ensure that there are accessible and practicable procedures in place to allow a woman to realise her constitutional right to an abortion in life-threatening circumstances, including the risk of suicide. We will discuss this on a 'Head by Head' basis as requested:

Head 1: Interpretation
The NWCI would share the concerns of one of our member organisations, the Irish Family Planning Association, in relation to the definition of the unborn as contained in Head 1.This new definition gives equal protection to a non-viable foetus and to a woman and limits the government's ability to introduce measures in the future to allow terminations in cases of fatal foetal abnormalities where there is incompatible with life. In D v Ireland (2006) ECHR the State argued that where there is no prospect of life outside the womb a foetus may not be considered 'unborn' for the purposes of Article 40.3.3.

The Irish Council for Civil Liberties in January 2012 also expressed concern that that while the ECHR has not yet made a finding that Ireland is in violation of Article 3 in relation to our stance on fatal foetal abnormality, it is strongly arguable that we are in breach. The NWCI would support the ICCL in their view that the government should include provision for termination in the case of fatal foetal abnormalities.

The NWCI recommends revision of the definition of the unborn to include a provision regarding incompatibility with life which is consistent with our Constitution and Ireland does not run the risk of falling foul of Article 3 of the European Convention on Human Rights in the future.

Head 2: Risk of Loss of life from physical illness, not being a risk of self-destruction
The NWCI has three concerns in relation to this Head of Bill. Firstly, in the case of a woman at risk of loss of life from physical illness, not being at risk of self-destruction, the Heads of Bill makes no provision for referral protocols, timeframes for assessment, determination or time limits in which a woman can expect her pregnancy to be terminated. Pregnant women need to be confident that they will have timely access to termination services in the case of life threatening pregnancies and that there are clear protocols and procedures in place about how to invoke the assessment process once she has made a request for termination. Women need to have comprehensive information set out in legislation and regulations so that they can be clear about their rights in accessing abortion services at all stages of the procedure. The legislation and/or subsequent regulations must also provide the possibility of advocacy support to a woman to help her with the initial and review stages of the assessment and determination procedures.

Secondly, the requirement of a General Practitioner (GP) to be consulted to certify that a risk to life exists is another unduly onerous layer on an already complex procedure. This amounts to a third doctor

in the decision making in relation to physical risk to life and four doctors in the case of a risk to life by suicide. The NWCI share the concern of our member organisation, the Irish Family Planning Association (IFPA) in relation to the fact that there is no requirement to ascertain the consent of the woman to her GP being consulted on this matter and the fact that there is no precedent for such a consultation in medical practice.

Thirdly, the NWCI recommend that the legislation should clearly assign a duty of care on the Health Service Executive and the treating institution to ensure that women receive appropriate information and care, including post abortion care. In the draft legislation we are concerned that there is a strong emphasis on the duties of women and their doctors and does not specify the duty of care of the Health Service Executive and the healthcare providing institution in ensuring that women have access to appropriate care in accessing abortion in life threatening situations. This anomaly needs to be addressed.

The NWCI would recommend that clear protocols and procedures are set out in the legislation of how a woman can set in motion the assessment procedures once her request for termination has been made and the supports available for her to do so; to remove from the legislation the requirement to consult with GPs and for the legislation to clearly assign a duty of care on health service providers to ensure that women receive appropriate information and care including post abortion care.

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

In the case of risk of loss of life from self-destruction, the draft legislation requires the unanimous decision of three doctors to determine real and substantial risk to a woman's life and for one of these doctors to consult with the woman's GP where practicable. In the case of appeal three further psychiatrists are required to make an assessment with the requirement for unanimity. The European Court of Human Rights in their judgement in the A, B & C case require that measures and systems to give effect to their judgement must be accessible and effective. The NWCI is of the opinion that the procedures provided for in the Heads of Bill to determine suicidal ideation would not satisfy this requirement. The provision for unanimity does not satisfy the accessibility test of the European Court of Human Rights. Further it is totally unworkable and unduly onerous for women in these vulnerable situations.

Appropriate procedures, such as those suggested by the expert group report[83], must be put in place whereby competent and qualified mental health specialists can assess the risk of suicide. These procedures should not be stigmatised with additional barriers but be subjected to standard clinical practice whereby the opinion of two doctors are sufficient to determine risk. NWCI agree with Doctors for Choice that a psychiatric emergency is not considered to be any different to any other medical emergency in the practice of medicine. The requirement of four doctors has no basis in clinical practice and two doctors are sufficient. The requirement in the Heads of Bill to consult with the woman's GP is not standard practice in psychiatric cases and should be removed. The requirement to involve an obstetrician in making a decision about mental health which is outside his or her area of competence is also not justified or relevant.

The NWCI questions the practical application of the procedures in the context of the current health system where it is considerably difficult for people with psychiatric difficulties to see a psychiatrist in the first place. Any procedures that are likely to be unworkable do not pass the accessibility test and should be removed.

[83] Report of the Expert Group on the Judgement in A, B and C v Ireland (November 2012) p.35.

Pregnant women must be trusted. Women's lives must not be endangered by unduly onerous procedural requirements. The legislation must follow normal clinical practice to ensure that women at risk of self-destruction are not further stigmatised by overly restrictive guidelines. It is important to remember that the test in the X case does not require immediacy or inevitability. It requires on the balance of probabilities that there is a real and substantial risk to the life of the mother. A requirement of two doctors is sufficient to meet this test.

The NWCI recommends that this section be amended to provide for the unanimous opinion of two psychiatrists to determine that there is a real and substantial risk to the life of the woman in cases of risk of loss of life from self-destruction.

Heads 6-9: Formal Medical Review Procedures

The NWCI believes that the review framework is not sufficiently accessible to women with life threatening pregnancies. The review process must not be of such procedural complexity as to be rendered ineffective in practice. In our opinion the review process of up to 14 days may lead to excessive delay and should be a maximum of three days to be timely and effective and to meet the accessibility requirement of the A, B and C judgement.

There should be a provision for assistance to the woman to support her with the review process taking into account that these are life threatening cases and it is highly likely that a woman will be in need of advocacy support. This would ensure that the review mechanism would adequately examine and resolve differences of opinion between a woman and her doctor or doctors.

The NWCI also has concern regarding the composition of the independent review panel. The appeal procedure can only be independent and impartial if persons with a conscientious objection to abortion are prohibited from participating in such an appeal and this needs to be expressly stated in the legislation.

The NWCI recommends that it is provided in legislation that women will receive advocacy support in taking a case to the review stage and that the review process be a maximum of three days to ensure a timely and effective remedy. The legislation must stipulate that no person who consciously objects to performing an abortion can be a part of the review panel.

Head 12: Conscientious Objection

The NWCI welcome the limits that have been placed on the refusal of care in Head 12. However, the NWCI would share the concerns of our member organisation, IFPA, regarding lack of adequate safeguards for women the case that they are refused care on the basis of conscientious objection. The NWCI is concerned that conscientious objection will be used to delay or refuse access to lawful abortion. We feel that there is insufficient duty placed on a doctor who refuses to perform a lawful termination to save a woman's life to ensure that the termination is carried out by another doctor in a timely manner.

Doctors invoking conscientious objection must have a duty to refer a patient to another doctor and to give all relevant information in a timely manner. Conscientious objection cannot be invoked where there is no other doctor available to carry out the lifesaving procedure. Ultimately the obligation must be jointly placed on the HSE and the treating institution to ensure that a woman is treated appropriately.

Head 19: Offence

The NWCI welcome Head 18 that repeals the relevant sections of the Offences Against the Person Act 1861 but is extremely concerned at Head 19 that creates an offence of a 14 year prison sentence for any

woman obtaining an abortion in Ireland due to the 'gravity of the crime'. The Bill does not fully decriminalise abortion and still provides for the potential imprisonment of a woman who has an abortion or self-aborts outside of the very restrictive boundaries of the Bill. This Head does not take into account the reality for many women every day in Ireland who have a crisis pregnancy and make the difficult decision to have an abortion outside of these guidelines, having to travel abroad if they can afford it and have the ability to travel or to self-abort if not.

It is our considered opinion that the continued criminalisation of abortion with the severe penalties provided for in the Heads of Bill will deepen the significant chilling effect on both women and doctors. Criminal laws can impede access to lawful sexual and reproductive health services and information, including family planning due to the chilling effect such laws have on women and medical practitioners who are worried about possible prosecution. This was highlighted in the A, B and C case. Because criminal laws are based on and perpetuate stigma women face discrimination and prejudice when accessing lawful healthcare. Our members have reported that women coming in to get counselling on their options in a crisis pregnancy situation are terrified of the possibility of going to jail and feel like a criminal in accessing lawful information services. It is absolutely unacceptable that women are made feel like this and the Head 19 offence does nothing to change this perception and situation.

As the UN Special Rapporteur on the Right to Health stated on his visit to Ireland in December 2012 "criminal laws and other legal restrictions disempower women who may be deterred from taking steps to protect their health, in order to avoid liability and out of fear of stigmatization."[84] The criminalization of abortion increases this stigma and discourages women from taking steps to protect their health due to fear of prosecution and stigmatization. Doctors and women need to be absolutely certain that they will not be incarcerated for providing for or accessing a lifesaving procedure. The continued criminalisation of abortion takes away that ability.

Abortion must be taken out of the criminal law. Canada decriminalized abortion in 1988 and is the first country to manage abortion as part of standard health care rather than within the civil or criminal law. After 25 years with no legal restrictions on abortion, abortion rates are low and have declined since 1997. Prohibition of abortion should be placed within medical ethics, not criminal law. The effect that criminalization has women is detrimental to their physical and mental health and the real danger that they will not access reproductive services that is an integral part of the right to health. These criminal provisions are bad for women and must be removed. There is no requirement by our constitution that we enact criminal provisions to complement Article 40.3.3.

The NWCI recommends that the legislation provide for the full decriminalisation of abortion and to remove Head 19 from the draft legislation.

Concluding Remarks

While the NWCI welcome the publication of the Heads of Bill as an important first step we consider that many of the procedures being proposed are too complex and laden with obstacles which may have the effect of discouraging women and their doctors from availing of them. We feel that the chilling effect of criminal liability will continue to persist resulting in women not accessing lifesaving healthcare services for fear of prosecution. The legislation needs to have timely and clear systems and procedures in place that responds to the needs of all women living in Ireland. It is important that all services provided for under this legislation are physically and financially accessible to all women in Ireland without any

[84] UN Special Rapporteur on the Right to Health Mr. Anand Grover speaking at the Women's Human Rights Alliance conference "Realising a Women's Right to Health" December 2012. See also his report to the UN Human Rights Council (2011)

discrimination. The Irish government has an obligation to ensure that this legislation is accessible, practical and effective to protect the rights and dignity of women.

This legislation will only deal with a very small number of cases and will not change anything for the majority of women in this country. Ireland will still have one of the most restrictive abortion regimes in the world. It will provide no solution to women who are pregnant as a result of rape or incest, in the case of fatal foetal abnormalities or where there is a risk to the health of the woman. Women in crisis pregnancies will still be forced to travel abroad for abortions due to the lack of access to full reproductive rights in Ireland.

Further information

Orla O Connor, Director, National Women's Council of Ireland. Email: orlaoc@nwci.ie Tel. 087-6483516

Dear Mr. Kelly,

I am writing as a concerned constituent and mother. The legislation the government is planning to introduce is not based on facts but political parties ideology.
I want this country to protect the mothers and child's life. There is no research that shows abortion is a treatment for suicide so I am perplexed to why our country feels the need to legislate for this. Countries like the UK have seen their rates sky rocket since introducing legislation based on this idea.
Are we really to believe that 20% of UK pregnant women are suicidal? This legislation is flawed and we should be learning from other countries mistakes.
This legislation is unacceptable, to think that we will be able to kill babies up to 9 months is unbearable. No mother goes around telling people she's carrying a foetus, so why is our country planning on demeaning human life. It is clear that there are huge objections to this legislation which included a rally with 35,000 people in attendance. Even during this horrific recession where have you seen this amount of people join forces against the government?It is a clear sign it is unwanted and unjustified. The government needs to wake up and realise this isn't the right thing to do. Ireland is a safe country for children and there needs to be guidelines set up for doctors not this.
The Irish medical organisation has voted against this, why are we ignoring them? The evidence at the oireachtas committee also shows this is the wrong way to proceed. We need to stand strong and show the people of Ireland we know what's best for our country and we don't change laws without good reason, evidence and the people's support. This is a huge step backwards for Ireland. I hope you take my concerns on board and the government realises this is not the way to progress.

Kind regards

Neil Johnston

Noel McKervey <noelmckervey@gmail.com>
08/05/2013 02.07 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
NEW ABORTION BILL

DEAR PAUL
WE NOEL AND MY WIFE ANNE MCKERVEY TOTALLY OBJECT TO ANY LEGISLATION THAT WOULD PERMIT ABORTION INTO THIS COUNTRY. WE PARTICULARLY OBJECT TO THE USE OF POTENTIAL RISK OF SUICIDE AS A GROUNDS FOR ABORTION.
PLEASE BE ESPECIALLY MINDFUL THAT ALL PSYCHIATRISTS AT THE JANUARY COMMITTEE HEARINGS WERE OF THE ONE OPINION THAT ABORTION IS NOT A REMEDY FOR SUICIDEALITY.

--
Regards,
Noel and Anne mckervey

nollaigml@eircom.net
08/05/2013 12.48 p.m. To
paulkellyonhealthandchildren@oireachtas.ie
cc
healthandchildren@oireachtas.ie
bcc

Subject
FAO Paul Kelly

FAO Paul Kelly - Chief Clerk
From Nollaig M. NÃ- Mhaoileoin
7.5.2013

My principal request is and has been all along for 'Medical guidelines only.' To legislate for the killing of even one baby is the wrong decision. This government is using the flawed X Case law as the main reason for not listening to the decent Irish people who value life and even down to breaking a solemn promise that Fine Gael made to the people of Ireland. During that Supreme Court hearing on the X Case there, it appears, to have been deficiencies in the case brought before the Supreme Court Judges. No proper expert with an experienced knowledge of suicide appears to have been present. Whoever represented the baby on that day failed to show the equality between mother and baby as desired by the Irish people who voted in 1983. Now we are stuck with a flawed Supreme Court judgement that is being used as a tool to bring into our society the killing of babies in the mother's womb. Each one of you, is subject to a Higher Law. You will answer for even one baby killed by bad law. This contravenes the Commandment 'Thou shalt not kill' from a Judaeo/Christian point of reference. You will indeed have to answer to God.

There is always a time for precedents and this is your opportunity to have this case reviewed and deliver your Irish people from a flawed judgement of their Constitutional wish, the equal protection of mother and baby. But on this occasion let the 'airbrushed out of the picture man' be brought firmly back into the picture, so that each man is brought to face up to his responsibilities, financially and socially.For your precedents may I refer you to the famous Judgement of Solomon in 3 Kings:3:16-28 on the two women who claimed the child as their own (Douay-Challoner text) and the Book of Daniel, 13: 1-64 with reference to Susanna and the Judgement of Daniel.

If it is rape let it be only financial, with no parental rights and with a long prison term and not a revolving door! If it is rape within marriage you will work out a response to that as well. Ask yourselves, Why is the woman depressed/suicidal in the early stages of pregnancy? It is mainly because this is from an illicit relationship and the man in question turns away from his responsibilities, not wanting to know about the baby. There are other factors, .e.g. the reactions of the women themselves, their families and society but if the principal cause for their depression/suicidal reactions is dealt with by law requiring the man to accept his responsibilites,FINANCIAL AND SOCIAL this will ease the burden. I do not by the way advocate illicit relationships.

Both Mother and child have to be equally cared for while understanding that if the mother's life is in danger her treatment may cause the termination of the baby's life. What is intended through this legislation is completely different, giving the green light to deliberately terminate the baby. NOT ONE LIFE MAY YOU TAKE AND DEFINITELY NOT IN MY NAME. By agreeing to permit this legislation, you are de facto excommunicating yourself from the Catholic Church, if you are a Catholic! Any priest who tells you differently can google Vatican Teaching on the subject. Is power worth your eternal soul as life definitely goes on after your death? Medical guidelines is the only legitimate option. True Justice and Mercy are within your remit.

This is my submission: Medical guidelines as the only legitimate option.

Nollaig M. Ní Mhaoileoin M. Theology
Maynooth

75 Rail Park
Maynooth
Co. Kildare
01 6292813

I do not require privacy of my submission but my address and phone number are private.

Nora McDonagh <noraandpeter36@gmail.com>
08/05/2013 15:20 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Fwd: Submission to Oireachtas Committee

---------- Forwarded message ----------
From: Margaret McNamara <kevinandmargaret@gmail.com>
Date: Wed, May 8, 2013 at 2:48 PM
Subject: Fwd: Submission to Oireachtas Committee
To: noraandpeter36@gmail.com

---------- Forwarded message ----------
From: Margaret McNamara <kevinandmargaret@gmail.com>
Date: Wed, May 8, 2013 at 2:45 PM
Subject: Fwd: Submission to Oireachtas Committee
To: noraandpeter36@gmail.com

---------- Forwarded message ----------
From: Margaret McNamara <kevinandmargaret@gmail.com>
Date: Wed, May 8, 2013 at 2:43 PM
Subject: Fwd: Submission to Oireachtas Committee
To: eileen.mcguire@hotmail.com

---------- Forwarded message ----------
From: Teresa Masterson <teresa-achill@hotmail.com>
Date: Wed, May 8, 2013 at 2:13 PM
Subject: RE: Submission to Oireachtas Committee
To: Margaret Murphy-McNamara <kevinandmargaret@gmail.com>

ok M sent it back to you

Date: Tue, 7 May 2013 20:54:45 +0100

Subject: Fwd: Submission to Oireachtas Committee
From: kevinandmargaret@gmail.com
To: teresa-achill@hotmail.com

---------- Forwarded message ----------
From: Margaret McNamara <kevinandmargaret@gmail.com>
Date: Tue, May 7, 2013 at 8:54 PM
Subject: Fwd: Submission to Oireachtas Committee
To: murlan@eircom.net

---------- Forwarded message ----------
From: Edward Donaghy <edwardjdonaghy@eircom.net>
Date: Mon, May 6, 2013 at 7:47 PM
Subject: Fwd: Submission to Oireachtas Committee
To: Margaret McNamara <kevinandmargaret@gmail.com>
Cc: Mary Keating <marygkeating@gmail.com>

----- Forwarded Message -----
From: "Attracta Coleman" <info@dsoe.ie>
To: edwardjdonaghy@eircom.net
Sent: Monday, 6 May, 2013 5:23:21 PM
Subject: FW: Submission to Oireachtas Committee

Hi All,

Please review and revert if you want me to include your names (and e-mail address) and those of any others who approve of the following.

I understand that this needs to be submitted by Wednesday this week.

Regards

Liam Coleman

Dear Oireachtas Committee Members,

We write to you as an Oireachtas Committee member and public representative as we believe that it incumbent on us (as citizens of Ireland) to advise you of our views on the matter of the proposed abortion legislation.

The founding fathers of the Irish Republic proclaimed that "The Republic guarantees equal rights and equal opportunities to all its citizens, and declares its resolve to pursue the happiness and prosperity of the whole nation and of all its parts, cherishing all the children of the nation equally…" (Proclamation of the Provisional Government of the Irish Republic)

Our Irish Constitution in its preamble (its overriding objective and basis) commits the people of Ireland to "….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, true social order attained ……"

Article 40.3.3 of that Constitution clearly and unambiguously (as approved by the Irish People in 1993) requires that "The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right."

Our concern is the fruit of our fundamental principle of Love – for all beings and for our environment including our culture.

We consider that:
1. as a fundamental principle that everyone has the equal right to life – from conception to natural death;
2. laws shape publicly held values and the proposed introduction of abortion legislation will cause a fundamental shift away from consideration of the good of society as a whole to the growing culture of the supremacy of one's personal rights over the equal rights of others – a shift away from the 'common good' as set out in the Irish Constitution;
3. from the moment of conception, there are 2 lives and every possible effort should be taken to preserve the lives of both mother and child as is the current medical practice in the Republic of Ireland.

The following points (by way of some examples) demonstrate the rationale underpinning our view that the proposed introduction of legislation to legalise abortion (the direct and intentional killing of a child in the womb) is wrong and should be opposed:

i. The current medical practices have served this country well notwithstanding the attempt by some to use the unexpected and sad death of Savita Halappanavar to misguide us as citizens and you as legislators. Where doctors require further clarity and assurance regarding the permissibility of medical interventions to save the life of the mother, these can be best be provided from revised and augmented medical guidelines 1 . The tragic death of Savita demonstrates the extreme rarity of such an event. Her death highlights the need for the Irish Medical Profession to examine, amend and publish its revised Guidance to medical practitioners in this medical area. The Medical Profession are best placed to identify appropriate guidance which should be reviewed and updated at least every five years to allow for continuing developments in obstetrics. The Irish Government should take this opportunity to ensure that Ireland's safety for the expectant mother and baby is enhanced. Legislation should not be introduced based on the flawed X Case (see below) or because of the unfortunate death of Savita. " Great cases like hard cases make bad law. For great cases are called great, not by reason of their importance... but because of some accident of immediate overwhelming interest which appeals to the feelings and distorts the judgment " 2 The European Court of Human Rights judgment in A, C and C v Ireland requires only that clarity be provided to Irish citizens regarding the correct legal position on abortion, not the right to abortion;

ii. The Oireachtas Hearings earlier this year clearly established that abortion is not a solution to the threat of suicide. Indeed Irish psychiatrists are fundamentally opposed, arguing that in such situations, "permanent and irrevocable" 3 decisions are not appropriate when a pregnant woman is suicidal. The evidence provided by the psychiatrists at the Hearings is at variance with the legal finding in the X case and with the current Government's own Expert Group recommendation. Based on the Oireachtas Hearings' evidence, it would clearly be unsafe and inappropriate to legislate to give effect to the legal decision in the X case which failed to adduce appropriate medical evidence before making its decision. The Supreme Court decision is clearly flawed. To legislate on that basis is contrary to the Irish Constitution (its Preamble) which sets out the purpose of the following Constitution "..to promote the common good, with due observance of Prudence, Justice.." Where is the Prudence and Justice is legislating for something which has been clearly shown to be wrong? Indeed as a legislator, it may be appropriate for you to consider the need for a Referendum to redress this unsafe precedent established by the Supreme Court;

iii. There is no evidence that abortion reduces mental health risks. 4 By contrast, there is some evidence to indicate that women who have abortions may be more likely to commit suicide that women who continued with their pregnancies. 5

iv. Abortion legislation will legalise the killing of the child in the womb. On the other hand, medical guidelines currently in place allow for medical interventions to save the life of the mother which regrettably may expose the child in the womb to risk of death due to the termination of the pregnancy. It is estimated that up to 30 such terminations may be occurring each year in Ireland 6 , thereby proving conclusively that all medical assistance is provided to safeguard the life of the mother in the Republic of Ireland. The Savita Halappanavar report and inquest clearly showed the criticality of many factors in her untimely and sad death, primarily the management of sepsis which is now the leading cause of maternal deaths in the UK. It should also be noted that 'there are many

well-documented fatalities from sepsis in women following termination of pregnancy' 7 ;
v. The introduction of legislation to allow abortion is not a legal codification of the current medical practice guidelines. Abortion is the intentional killing of the child in the womb and is therefore not analogous to the current medical practice of safeguarding the life of the mother. Unlike legislation, medical guidelines can be readily updated and enhanced as medical knowledge and practice continues to develop. Medical guidelines are therefore far superior to legislation in that they represent best practice and support a doctor's 'first law .. do no harm." 8 They do not depend on the legal interpretation of legislation in the Irish Four Courts but on best medical practice worldwide.
vi. While legislative safeguards may be introduced to attempt to minimize the volume of abortions, anyone deemed to meet the criteria for a legislatively approved abortion will be facilitated by the State (all of us, its citizens) to have one. We have only to consider the experience of our nearest neighbour, the UK, since the introduction of the 1967 Abortion Act. Mr. David Steel (now Lord) who introduced it as a Private Member's Bill has admitted that he "never envisaged there would be so many abortions" 9 . There are now almost 190,000 abortions in the UK annually (of which approximately 3,000 are to women providing Republic of Ireland addresses). 97% of UK abortions are performed on mental health grounds 10 .
vii. Dr A. Clare (psychiatrist - RIP) stated in evidence to the previous Oireachtas Hearings on Abortion and the Constitution (2000) that in his experience the threat of suicide grounds for an abortion was widely exploited. He considered that this placed the psychiatrist in an impossible position. Legislation for abortion on grounds of suicidal feelings would require psychiatrists to practice defensive medicine – with the best will in the world, how many psychiatrists will risk confirming that the woman in front of them claiming to be suicidal, is not suicidal when, if wrong, they will be liable to litigation and claims of clinical malpractice.
viii. With the passage of Abortion legislation, medical staff with pro-life views will find it increasingly difficult to practice their profession in medical areas where they will be required to assist in the abortion process. When new medical positions become available preference will be given to medical staff who are prepared to assist in the abortion process – this will inculcate the acceptability of abortion into publicly held values.

We ask you as legislators to take our views on this matter into account and act as required by the Irish Constitution with Prudence, Justice and Charity in the common good – not the good of individuals as individuals but as individuals as part of a just and caring society.

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1 : The suggestion by Dr. R. Mahony that she felt threatened by the current legal position (1861 Offences Against the Person Act) was countered by Dr. S. Smith who stated "I am not aware of any situation in which the lack of legal clarity prevented appropriate care" (Oireachtas Hearings). A doctor who acts in good faith in conformity with the current medical guidelines will not be exposed to prosecution. In any event the continuation of Sections 58 and 59 of the 1861 Act (still operative in the UK) or alternative provisions would still be required to prevent a breach of any new legislation that would be introduced. Therefore any perceived fear on the part of Dr. Mahony will not be eliminated by the introduction of abortion legislation.

2. Oliver Wendell Holmes Jr., Associate Justice of the United States Supreme Court for over 30 years;

3 : Dr. J. Sheehan, evidence to Oireachtas Hearings 2013;

4 : Professor D. Fergusson, British Journal of Psychiatry (2008);

5 : Gissler, M. et al., European Journal of Public Health Vo 15, Issue 5, 2005;

6 : calculated from evidence given by Masters of Dublin Maternity hospitals;

7 : The Irish Times 01-05-13 referring to a letter from a group of obstetricians to the newpaper;

8 : Irish Independent 13-01-13;

9 : Irish Independent 21-12-12;

10 : Abortion Statistics, England & Wales: 2011, National Statistics, Department of Health, May 2012 pp8-9;

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Carmel Donaghy

Norma Morrison <norma.morrisoncahill@gmail.com>
07/05/2013 23:50 To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Proposed bill on abortion

Dear sir / madam
I am not accustomed to writing letter such as these but what I write, I wrote from my heart.

I urge you to please get the paper that proposed bill is written on and throw it in the bin!

Countries like America and England brought in abortion on the premise of saving women's lives but it has done the very opposite. Women end up MORE depressed and suicidal after abortions.

The man who wrote the legislation in England has said that he had no idea it would lead to so many abortions.

40 years after Roe vs Wade many states are trying to reverse this law. We know so much more about life in the womb and its development now than we did back then so we have NO EXCUSE for saying we don't know how the child feels. Because the FETUS FEELS PAIN. And this is based on fetal pain science. One congressman is trying to reduce abortion based on this SCIENCE.

Do we always have to copy everything everyone else does. Can we not learn from their mistakes BEFORE we make them ourselves. That would be the sensible and intelligent thing to do !

Mr Kenny has not given any comfort in the fact that he is backing a bill that essentially has NO TIME LIMITS WRITTEN IN. So a child that is a week before delivery can be torn to pieces inside his mothers body and then get vacuumed out. This is barbaric. No one deserves this execution. And if the doctor deems that crushing the baby's head before evacuation is too dangerous for the woman and the baby gets sucked out and is still alive.... What then is to happen this defenseless human being. No provisions for this either.

As you might guess I am pro life but I am also pro woman and abortion does nothing but ruin two lives.

This bill is totally flawed in word and in deed.

The women who find themselves in difficult circumstances need support. This country will be a better place with support and without abortion.

Let's keep Ireland on the map for the right reason.... It's the safest place in the world to have a baby and the safest place in the world to be a baby in your mothers womb.

You were given this right (otherwise you would not be sitting at your desk reading this) Please afford it to every other person.

Our children's lives are in your hands.

Protect them please

God bless

Norma Morrison

Sent from Norma's iPhone

"Olive Mullen" <olivecmullen@gmail.com>
08/05/2013 03.16 p.m. To
<healthandchildren@oireachtas.ie>
cc

bcc

Subject
abortion bill

Attention Paul Kelly
I am just an ordinary mother and grandmother who is most upset and sorely disappointed with the governments intention to legalise abortion. Abortion is wrong. It is evil and murder of the innocent who have no say in this situation.Abortion does not help women. It hurts them more. I know. I have heard them say so.
Please please please listen to the experts and do not make matters worse for people who are depressed or suicidal.Treat the problem as stated by the experts with the necessary medication but please do not kill their baby.This does not solve the problem but makes matters worse. Men do not really understand the guilt and sadness felt by a woman who aborts a baby every day of her life.
I beg you not to follow in the footsteps of the other countries who murder thousands of innocent babies in a most cruel way. And they are babies right from the moment of conception.Even the scientists admit this. Don't let our politicians destroy our wonderful reputation as per WHO as the safest place in the world to have a baby.
I trust and pray that common sense and the will of the ordinary people will prevail and not political pressure of people who do not respect the right to life from conception to natural death.
Thank you
Yours in distress and sadness
Olive Mullen.

"Olive O'Shea" <olive.oshea1@gmail.com>
07/05/2013 18:34 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Submission on the proposed bill/legislation on abortion - deadline 8th May, 2013.

Dear Mr. Kelly,
I would like to submit my concerns to the current proposed legislation.

No. 1:

Why is the Government pressing ahead to legalise abortion on suicide grounds against all the expert evidence at the Joint Oireachtas Committee hearings. I understood that it demolished the case that abortion is a treatment for suicide - The Government must listen to the psychiatrists, obstetricians & gynecologists.
The Government should take action - providing clarity to doctors by drawing up guidelines in collaboration with medical experts, based on best medical practice, thus ensuring a duty of care to mother and her unborn baby. There is a big difference between medical staff intervening to save the mothers life even if that means the unintentional death of the child and the direct intentional killing of an unborn baby.
No. 2:

The manipulation of language in the bill - why are the words 'mother' and 'baby' left out of the bill? Is it designed to weaken people's opposition to abortion. The attempt to avoid speaking of mothers and babies dulls peoples awareness of what is truly at stake. Please explain.

In conclusion:

Ireland is one of the safest places in the world for a mother to have a baby, why would any government who genuinely cares for women want to change that? This is an opportunity for Mr. Enda Kenny, An Taoiseach to show that he has the courage to protect life.
The right to life is the first among human rights, to abort a child is to kill someone who cannot defend themselves.

Yours sincerely,

Olive O'Shea

oonagh mccartney <oonaghmccartney@hotmail.com>
08/05/2013 03.20 p.m. To
"." <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Paul Kelly

Dear Mr Kelly,

We write to you as an Oireachtas Committee member and public representative as we believe that it incumbent on us (as citizens of Ireland) to advise you of our views on the matter of the proposed abortion legislation.

The founding fathers of the Irish Republic proclaimed that "The Republic guarantees equal rights and equal opportunities to all its citizens, and declares its resolve to pursue the happiness and prosperity of the whole nation and of all its parts, cherishing all the children of the nation equally…" (Proclamation of the Provisional Government of the Irish Republic)

Our Irish Constitution in its preamble (its overriding objective and basis) commits the people of Ireland to "….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, true social order attained ……"

Article 40.3.3 of that Constitution clearly and unambiguously (as approved by the Irish People in 1993) requires that "The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right."

Our concern is the fruit of our fundamental principle of Love – for all beings and for our environment including our culture.

We consider that:
1. as a fundamental principle that everyone has the equal right to life – from conception to natural death; 2. laws shape publicly held values and the proposed introduction of abortion legislation will cause a fundamental shift away from consideration of the good of society as a whole to the growing culture of the supremacy of one's personal rights over the equal rights of others – a shift away from the 'common good' as set out in the Irish Constitution; 3. from the moment of conception, there are 2 lives and every possible effort should be taken to preserve the lives of both mother and child as is the current medical practice in the Republic of Ireland.
The following points (by way of some examples) demonstrate the rationale underpinning our view that the proposed introduction of legislation to legalise abortion (the direct and intentional killing of a child in the womb) is wrong and should be opposed: i. The current medical practices have served this country well notwithstanding the

attempt by some to use the unexpected and sad death of Savita Halappanavar to misguide us as citizens and you as legislators. Where doctors require further clarity and assurance regarding the permissibility of medical interventions to save the life of the mother, these can be best be provided from revised and augmented medical guidelines1. The tragic death of Savita demonstrates the extreme rarity of such an event. Her death highlights the need for the Irish Medical Profession to examine, amend and publish its revised Guidance to medical practitioners in this medical area. The Medical Profession are best placed to identify appropriate guidance which should be reviewed and updated at least every five years to allow for continuing developments in obstetrics. The Irish Government should take this opportunity to ensure that Ireland's safety for the expectant mother and baby is enhanced. Legislation should not be introduced based on the flawed X Case (see below) or because of the unfortunate death of Savita. "Great cases like hard cases make bad law. For great cases are called great, not by reason of their importance... but because of some accident of immediate overwhelming interest which appeals to the feelings and distorts the judgment"2 The European Court of Human Rights judgment in A, C and C v Ireland requires only that clarity be provided to Irish citizens regarding the correct legal position on abortion, not the right to abortion; ii. The Oireachtas Hearings earlier this year clearly established that abortion is not a solution to the threat of suicide. Indeed Irish psychiatrists are fundamentally opposed, arguing that in such situations, "permanent and irrevocable"3 decisions are not appropriate when a pregnant woman is suicidal. The evidence provided by the psychiatrists at the Hearings is at variance with the legal finding in the X case and with the current Government's own Expert Group recommendation. Based on the Oireachtas Hearings' evidence, it would clearly be unsafe and inappropriate to legislate to give effect to the legal decision in the X case which failed to adduce appropriate medical evidence before making its decision. The Supreme Court decision is clearly flawed. To legislate on that basis is contrary to the Irish Constitution (its Preamble) which sets out the purpose of the following Constitution "..to promote the common good, with due observance of Prudence, Justice.." Where is the Prudence and Justice is legislating for something which has been clearly shown to be wrong? Indeed as a legislator, it may be appropriate for you to consider the need for a Referendum to redress this unsafe precedent established by the Supreme Court; iii. There is no evidence that abortion reduces mental health risks.4 By contrast, there is some evidence to indicate that women who have abortions may be more likely to commit suicide that women who continued with their pregnancies.5
iv. Abortion legislation will legalise the killing of the child in the womb. On the other hand, medical guidelines currently in place allow for medical interventions to save the life of the mother which regrettably may expose the child in the womb to risk of death due to the termination of the pregnancy. It is estimated that up to 30 such terminations may be occurring each year in Ireland6 , thereby proving conclusively that all medical assistance is provided to safeguard the life of the mother in the Republic of Ireland. The Savita Halappanavar report and inquest clearly showed the criticality of many factors in her untimely and sad death, primarily the management of sepsis which is now the leading cause of maternal deaths in the UK. It should also be noted that 'there are many well-documented fatalities from sepsis in women following termination of pregnancy'7; v. The introduction of legislation to allow abortion is not a legal codification of the current medical practice guidelines. Abortion is the intentional killing of the child in the womb and is therefore not analogous to the current medical practice of safeguarding the life of the mother. Unlike legislation, medical guidelines can be readily updated and enhanced as medical

knowledge and practice continues to develop. Medical guidelines are therefore far superior to legislation in that they represent best practice and support a doctor's 'first law .. do no harm."8 They do not depend on the legal interpretation of legislation in the Irish Four Courts but on best medical practice worldwide. vi. While legislative safeguards may be introduced to attempt to minimize the volume of abortions, anyone deemed to meet the criteria for a legislatively approved abortion will be facilitated by the State (all of us, its citizens) to have one. We have only to consider the experience of our nearest neighbour, the UK, since the introduction of the 1967 Abortion Act. Mr. David Steel (now Lord) who introduced it as a Private Member's Bill has admitted that he "never envisaged there would be so many abortions"9. There are now almost 190,000 abortions in the UK annually (of which approximately 3,000 are to women providing Republic of Ireland addresses). 97% of UK abortions are performed on mental health grounds10.
vii. Dr A. Clare (psychiatrist - RIP) stated in evidence to the previous Oireachtas Hearings on Abortion and the Constitution (2000) that in his experience the threat of suicide grounds for an abortion was widely exploited. He considered that this placed the psychiatrist in an impossible position. Legislation for abortion on grounds of suicidal feelings would require psychiatrists to practice defensive medicine – with the best will in the world, how many psychiatrists will risk confirming that the woman in front of them claiming to be suicidal, is not suicidal when, if wrong, they will be liable to litigation and claims of clinical malpractice. viii. With the passage of Abortion legislation, medical staff with pro-life views will find it increasingly difficult to practice their profession in medical areas where they will be required to assist in the abortion process. When new medical positions become available preference will be given to medical staff who are prepared to assist in the abortion process – this will inculcate the acceptability of abortion into publicly held values.
We ask you as legislators to take our views on this matter into account and act as required by the Irish Constitution with Prudence, Justice and Charity in the common good – not the good of individuals as individuals but as individuals as part of a just and caring society.

1: The suggestion by Dr. R. Mahony that she felt threatened by the current legal position (1861 Offences Against the Person Act) was countered by Dr. S. Smith who stated "I am not aware of any situation in which the lack of legal clarity prevented appropriate care" (Oireachtas Hearings). A doctor who acts in good faith in conformity with the current medical guidelines will not be exposed to prosecution. In any event the continuation of Sections 58 and 59 of the 1861 Act (still operative in the UK) or alternative provisions would still be required to prevent a breach of any new legislation that would be introduced. Therefore any perceived fear on the part of Dr. Mahony will not be eliminated by the introduction of abortion legislation.
2. Oliver Wendell Holmes Jr., Associate Justice of the United States Supreme Court for over 30 years;

3: Dr. J. Sheehan, evidence to Oireachtas Hearings 2013;

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5: Gissler, M. et al., European Journal of Public Health Vo 15, Issue 5, 2005;
6: calculated from evidence given by Masters of Dublin Maternity

hospitals;

7: The Irish Times 01-05-13 referring to a letter from a group of obstetricians to the newpaper;

8: Irish Independent 13-01-13;

9: Irish Independent 21-12-12;

10: Abortion Statistics, England & Wales: 2011, National Statistics, Department of Health, May 2012 pp8-9;

regards
Oonagh Fernandes Da Silva

PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013

SUBMISSION TO THE OIREACHTAS JOINT COMMITTEE ON HEALTH AND CHILDREN

FROM

ORLA SHEEHAN

B. Pharm Hons. , M. Med Sci, Clin. Dip. Pharm, Dip. Ther

INDIVIDUAL SUBMISSION

1 INTRODUCTION and RELEVANT EXPERIENCE

My name is Orla Sheehan. I am a pharmacist with a specialist interest in healthcare of babies, children and expectant mothers. Much of my professional career has focused on the protection of life during pregnancy in Ireland, North and South. In light of this, I wish to make this submission to the Oireachtas Joint Committee on Health and Children for consideration with respect to the Outline Heads of the Protection of Life During Pregnancy Bill 2013.

The Bill title "Protection of Life During Pregnancy" heralds high hopes of new government legislation committed to protecting the lives of mothers and babies in Ireland. Hurrah! Indeed reading such a title, one would hope, as a health-care professional committed to protecting life, to find inspired thinking informing even better models of obstetric care, peppered with gold standards to drive good practice through quality standards of clinical excellence. Indeed, such a Bill would, one hope, serve to enhance Ireland's reputation as the country most recognised as the safest place in the world to have a baby, a reputation recently torn to shreds by our own media. Sadly not so, this legislation is lead by politicians who have betrayed their own electorate, choosing to dance instead to the tune of more powerful nations and unions united in destruction of life during pregnancy.

Good law legislates for the common good of people including the most vulnerable in a society. Legislation based on extreme cases makes for bad law and destruction of the most vulnerable in society. This bill, entitled protection of life in pregnancy, paves the way for a holocaust of Irish babies. The legislation proposed is confusing, in its wording, even the most astute of medical experts and does little to enlighten those of us who are committed to protecting life in pregnancy. What hope then for Ireland's unique treasure of mother and child? This legislation strongly opposes the very sanctity of their lives. Furthermore, it is an insult to the many health-care professionals who have dedicated their expertise to keeping Irish women and babies safe during pregnancy. Ireland can boast millions of healthy babies delivered by the very best physicians and midwives in their field. For my own part, the contribution was always advisory, albeit equally passionate and always committed to excellence. For a government to show such a blatant disregard for the people it is elected to serve, is a matter of national shame. For a government to expect all of its health-care professionals, including its leading professors of obstetrics and gynaecology and psychiatry, to adopt and implement this legislation, unacceptable. How can quality health care professionals be expected to work for the common good within such a flawed framework? The end result will be a downward spiral of death, untold human misery and a health service with a heart that has lost its very beat. As for standards of good practice in protecting life in pregnancy, these will go to the wall, giving way to poor clinical practice and the potential for rogue practitioners, as the experience of other countries who have gone down this road.

Across Ireland there are many shining examples of excellent practice in protecting life in pregnancy – physicians, be they professors of obstetrics or general practitioners, nurses be the midwives or theatre nurses or community midwives, pharmacists be they clinical pharmacists or local chemists. All share a core value of protecting life in pregnancy. Not so, it seems, those elected to lead our country forward. Our health-carers and government legislators are at opposite poles and have never been more opposed.

For my own part, my first venture into protecting life in pregnancy was working as a neonatal intensive care pharmacist designing intravenous parenteral nutrition to keep premature babies alive. The sheer joy of parents when the life of their baby was saved, the sheer devastation when they had to let go of their dream. Women at risk of early delivery were given antenatal steroids to mature the lungs of their baby in utero and to give a better of chance of survival after birth. The proposed legislation on protecting life in pregnancy seems to have given no regard to protecting babies risk of losing life through unplanned early delivery.

My Masters in Child Health at the Royal Maternity Hospital in Belfast, Queen's University Belfast, focused on preventing early mortality of babies from respiratory distress syndrome. Babies born too early, suffer respiratory distress, a common cause of death; their lives can be protected by 2 doses of antenatal steroids to the mother and postnatal surfactant replacement therapy for the baby. Again, there is no mention of this strategy in the legislation proposed for protection of life in pregnancy? Why? In abortion, there is zero chance of survival, all babies suffer extreme distress, as they are ripped from the womb, be that by medical or surgical abortion. Abortion is the most violent of deaths. Abortion does not protect life in pregnancy.

Later my interest developed into safe use of all medicines in pregnancy, advising Irish GPs on risk management of prescribing for pregnant women thereby preventing untoward effects of medicines in pregnancy e.g. teratogenic effects, adverse effects or malformation in the baby. And for women who choose to breastfeed advising also on compatibility of medicines with breast milk. I FIRST published for Irish health care professionals in these areas inn1997 as well as a number of publications in the irish medical literature promoting patient safety in a range of patient groups. In 2003, I was appointed national director of continuing education and training of pharmacists in Ireland. During this tenure, I rolled out a national strategy for keeping Irish children safe from medicines in 2005 as well as many other initiatives geared towards protection of vulnerable groups in Irish society e .g. pregnancy, breast-feeding, children, elderly, mental illness, learning difficulties, ethnic minorities, terminally ill, amateur and elite sport. I also ensured that all community pharmacists had the training and resources to ensure babies and children were kept as safe as possible from medicines as well as handbooks for safe use of medicines in management if mental ill health. Now we have medicines that can kill in pregnancy and a government that is prepared to condone the use of medicines to destroy life in pregnancy and to recommend abortion as a reasonable treatment for a woman at risk of suicide.

On the issue of the government's keen wish to legislate for risk of suicide, abortion is not an appropriate treatment for a woman at risk of suicide. Abortion kills one life and permanently damages the life of the other. Such damage leads to a real risk of suicide in 30 percent of cases. Medical experts in psychiatry have already advised the Houses of The Oireachtas on this, yet this legislation seems to have chosen dismiss their expert advice.

Apart from killing life at the most vulnerable time of our existence, women who have had abortions, in my considerable experience as a pharmacist, suffer terribly later, with depression, post-traumatic stress and a melancholy that can linger for years. Anti-depressants seldom touch this sort of depression for it is the very soul of the woman that is deeply scarred. Many women live haunted lives, no medicine can heal or touch their pan. Can you imagine how these women are suffering during all this media coverage and while the abortion debate continues to rage with no regard for the sanctity of life by many elected public representatives? Why has the government not thought to legislate for the care of these women in this Bill? What about fathers or aborted babies? Has the government stopped to consider the pain this push for abortion legislation is causing women who have lost babies or couples who have are unable to conceive due to unexplained fertility? Many elderly people in Ireland are deeply distressed about plans to legalislate for abortion? Have those in government leading this agenda given any consideration to their heartache and turmoil over the issue? As for Ireland's teenagers, why has the government not taken time to listen to their views on abortion? This is their future.

I currently work in the international humanitarian sector where my remit is aid support of the poorest of families including expectant mothers, babies and children. I have witnessed wrongful policies of abortion forced on the poorest and most vulnerable of women with devastating consequences, cloaked in the name of good practice and protecting life in pregnancy. I have met many women living in the most dire conditions, few here could hack, yet they would seldom choose abortion, such is their instinct for survival of their babies. Such choices are generally pushed by organisations and external agencies alien to their culture, preying on their vulnerability.

This new legislation planned for Ireland is no different. Shame for those in the government of Ireland for pushing it their own agenda. Ireland has a wonderful opportunity to continue to shine as an example to the world in its protection of life in pregnancy and in its quality of obstetric care. Ireland is very blessed in this unique opportunity to lead all others countries by example. For years the pro-abortion lobby has wanted to destroy Ireland's reputation as the safest place in the world for a woman to have a baby. There is no need to enforce this legislation on Ireland, it is not needed here. If women want to procure an abortion, let them go out of Ireland, north and south. Media lament about the inconvenience this causes having to travel out of Ireland. What is inconvenience in comparison to the most violent of all deaths against the most defenceless in our society. A violent horror with no scream as it is carried out in the silence of the womb. As for those women who are carrying babies that have no chance of survival outside of the womb, legislate for these by providing fetal hospice care funded by the government.

Regardless of inviting submissions on this legislation, it seems clear, this government is intent on bullying through this legislation against the wishes of the majority of people living on this island.

2 EXECUTIVE SUMMARY

The Protection of Life During Pregnancy Bill outlines the Irish government's draft legislation for management of women in Ireland seeking abortions. As a clinical pharmacist with a specialist interest in protection of life in pregnancy , the proposed bill outlined in the Protection of Life during Pregnancy Bill is flawed and contrary to what the name of the bill suggests, will do little to protect life during pregnancy. Abortion is unlawful killing of life, it is illegal, it has always been illegal. There is no need to legislate for it.

Current law already allows for Irish obstetricians to intervene to save the life of the mother if there is a risk of loss of maternal life. This bill will only serve to put Irish mothers and their babies at grave risk. Furthermore, it will open the door to unlawful killing of the unborn in Ireland, as is the experience of other countries who have legislated for extreme cases.

Ireland is currently recognised as one of the safest places in Ireland for a woman to have a baby. The standard of our obstetric care is among the best in the world and our country can boast some of the best experts in obstetric practice.

There is no crisis in pregnancy that abortion is a valid or acceptable treatment for. In the case of risk of suicide, a termination will not resolve the mental illness of the mother. Indeed, women who have had abortions are much more likely to go on to attempt suicide. Irish psychiatrists have clearly stated that 30 percent of women who have had an abortion will go on to develop severe depression that may result in suicide.

In the recent tragic death of S.H. in Galway, her death was due to poor management of ESBL E coli a potentially fatal infection for any woman, pregnant or otherwise. Under the current and existing law in Ireland, any obstetrician could've intervened to save her life. Her cervix was already dilated and miscarriage was inevitable. S.H. did not die because an abortion was not performed. She died from a serious infection that significantly increased the risk of mortality. ESBL E coli is a potentially fatal micro-organism that may not respond to appropriate choices of IV antibiotics. Furthermore, no clinician can fully predict the course of active infection.

RECOMMENDATIONS

The following are a list of recommendations for consideration by the Committee as outlined in the guidance for submission. These are summarised on a "Head by Head" basis as outlined.

It is important to note that the consultation time provided is inadequate for health-care professionals to adequate submit responses. The language and presentation is obtuse. Legislation put to public consultation should be clear, concise and easy for all to digest, most of all members for members of the public. Those with experience in the area tend to be individuals committed to protection of life during pregnancy either those working in health-care, Christian organisations committed to upholding the sanctity of life, or pro-life organisations. Ordinary people from all walks of life do not have the legal expertise to respond within one week. Health-care professionals, such as myself are struggling to respond to the legislation within the time frame. Also, the guidance overlooks many keys areas, crucial to a draft bill for protection of life during pregnancy. Nothwithstanding the clear intent to confuse the reader with legal jargon, and request non-legal responses to a legally prepared document, I will now endeavour to comment head by head as directed.

Head 1 Interpretation

Use and definition of unborn

The term unborn – this term should be changed throughout the legislation to "unborn baby" or "baby in the womb". A baby is the same inside the womb (in utero) as outside of the womb (ex utero). It is only a baby's environment that changes. The use of the term "unborn" makes babies in the womb sound like a different species not yet living! Babies are babies so refer to them as babies.

Subhead 1 Appropriate Location

The relative medical treatment , therefore, may only be provided in public obstetric units.

The exception clause "except in emergencies for the following reasons", as listed, all requires deletion. Emergencies should only be managed in a hospital obstetric unit within a recognised centre of excellence. In countries where this has not been adhered to, illegal abortions have been performed in clinics deemed appropriate and regulated. For example, in Zambia, Marie Stopes International performed 452 illegal abortions between Jan and May 2012, notwithstanding the country's strict legislation on abortion.

Definition needed

There is no reference throughout this legislation for sustaining life in a baby born prematurely. Definiton is needed of "pre-term" and "pre-term neonate" as well as neonate. Babies born prematurely often face the greatest fight for survival and so should be included in any protection of life in pregnancy bill.

Head 2 - Risk of loss of life from physical illness

The current law already legislates for this. Currently obstetricians can intervene to save the life of the mother where there is a risk of loss of her life from physical illness.

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

The current law already legislates for this. Current obstetricians can already intervene to save the life of the mother in an emergency e.g. ectopic pregnancy, liver rupture, thrombosis.

In the case of S.H her death was due to chorioamnionitis caused by active ESBL E coli, not because an abortion was not performed. The hospital was slow to diagnose and respond to the active pathogen in her body. Had the hospital acted swiftly to identify and treat the infection, her life may have been saved. As her cervix was dilated, miscarriage was already inevitable. Sadly, our media and the active pro-choice lobby in Ireland turned this most tragic death into an international media circus that not only undermined her death but globally damaged the

excellent reputation our country has for quality obstetric care. Errors happen daily in every field of medicine, what is important is to learn from them through root cause analysis and put systems in place to prevent them from recurring again.

National guidance is needed for management of pregnancy in chorioamnionitis informed by specialists in obstretrics, microbiology, emergency medicine, midwifery and clinical pharmacy. Standard protocols should be agreed for the effective management of this presentation and adopted nationwide. Microbiological sensitivities and appropriate antibiotic regimens for treatment should be reviewed annually. Legislation should dictate that national guidance is implemented and adhered to thereby promoting clinical excellence in protection of life in pregnancy.

Equally, national guidance should be developed for the management of all high risk conditions in pregnancy e.g. pre-eclampsia, gestational diabetes, auto-immune disease, with appropriate multi-discliplinary input from all key stakeholders in protection of life in pregnancy e.g. specialist, physician, midwife, anaesthetist, clinical pharmacist.

National guidance is also needed on the management of chronic conditions in pregnancy that require on-going effective management for protection of life in pregnancy e.g. asthma, epilepsy. For example, many women stop therapy during pregnancy for fear of it harming their baby, with potentially fatal consequences e.g. asthma. The risk of an uncontrolled asthmatic attack is much greater to the life of both mother and baby than managing asthma with inhalers and medicines. Similarly, management of epilepsy in pregnancy needs to be carefully planned and managed to prevent status epilepticus and minimise risk of teratogenic malformation from prescribed medicines available for management of epilepsy, accompanied by high dose folic acid supplementation. The risk of uncontrolled asthma and uncontrolled epilepsy is just as great a risk to the life of both mother and baby as the risk of suicide, yet there is no mention of either of these common chronic diseases in this debate. Risk of suicide due to mental illness can be effectively managed in pregnancy with appropriate medicines in the same way as life threatening conditions such as an acute asthmatic attack or epileptic fit.

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

This head needs to be deleted. It has no place in the legislation for protection of life in pregnancy in any country. There is no evidence to support abortion as an appropriate intervention in a pregnant woman who is suicidal. A woman who is suicidal, should be treated with appropriate psychiatric care, in a psychiatric unit, with the specialist using medicines with a good safety profile in pregnancy. Safe prescribing of medicines for management of acute psychosis should also be supported by quality care and counselling. Medicines for the management of acute psychosis / risk of suicide should be chosen with regard to their evidence base for efficacy of treatment and safety data in pregnancy. Specialist centres such as the National Medicines Information Centre at St James's Hospital has the expertise to support physicians in the best choice of medicine for protection of life of both mother and baby in cases of risk of suicide. To suggest abortion as an appropriate treatment is completely unacceptable. Furthermore to insist on this demonstrates a real indifference on behalf of the government to protecting life in pregnancy, as the proposed name of this bill suggests. Abortion does not protect life; it kills one life and permanently damages another.

Irish specialists in psychiatry have clearly stated that abortion is not a valid treatment for a woman who is suicidal. Indeed they have advised the Houses of the Oireachtas already on this, so it is seems that their expertise has been overlooked. Also, in suicide, people have no insight and are not capable of making rational decisions. Furthermore, it is well recognised in the medical literature that women who have abortions, are 30 percent more likely to suffer severe depression from the trauma of an abortion and be suicidal. I know of no consultant psychiatrist, who would recommend to a pregnant woman considered to be suicidal to have an abortion. Such an approach would only serve to put her life in greater danger, not protect it. It is also wrongful to expect a health-

care specialist or group of health-care specialists to make this decision on behalf of a woman in no fit state to make a rational decision.

Also, it is noteworthy that pregnancy generally has a beneficial effect on women suffering from depression. Symptoms of depression tend to improve considerably during pregnancy. It is the post-natal period, after a baby is born, that the risk of depression and ultimately suicide increases. If the government is genuine in its wish to protect lives of mothers and babies, it should set up systems for better support of women in Ireland suffering from post-natal depression. It should support women with other young children in the family by putting more funding into family benefits rather than cutting them.

National guidance is needed for quality management of pregnancy in women who are suicidal that will protect both the life of the mother and the baby in pregnancy. They are two unique human beings, each with an equal right to life. Guidance is also needed for effective management of post-natal depression when the risk of suicide is greatest. Women suffering depression who wish to breast-feed their babies should also be supported by national guidance recommending medicines effective for the mother that do not pass into breast milk and so are safe for the baby.

The government should legislate for a national centre of excellence for protection of life during pregnancy to promote health and well-being of Irish mothers and babies. This centre should inform all physicians, nurses and pharmacists and any allied health-care profession involved in obstetric care and protection of life during pregnancy.

Equally, there is a need for quality advice to women who are pregnant and a national helpline through which expectant mothers can ask questions and raise concerns with appropriately trained staff on all aspects of their pregnancy e.g. safety of seat belts in pregnancy, foreign travel advice in pregnancy, alcohol intake in pregnancy, safety of herbal and OTC medicines in pregnancy, alternative therapies in in pregnancy, safe management of common ailments in pregnancy, stress management in pregnancy. Such a specialist centre should use internet and social marketing tools to promote protection of life in pregnancy. Equally there is a need for education of GPs, pharmacists and nurses working in primary care in promoting quality care of mother and baby in pregnancy and ultimately protection of both lives. These primary health-care professionals are the first port of call for protection of life in pregnancy and they should be appropriately supported.

Counselling services also need development for management of crisis pregnancies. Such services should be evidence based, standardised and adopted nationally with appropriately trained counsellors.

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

Medical opinion should be informed by standards agreed by the General Medical Council

Head 6 Formal Medical Review Procedure

Protection of life in pregnancy may be compromised by the personally held beliefs of individual practitioners. The decision to approve abortion should never be taken out of the hands of the written law. Abortion is currently illegal in Ireland and it should remain so. Currently, under the law, an obstetrician may intervene to save the life of the mother if at risk from physical illness and so the law does not need to change. If obstetricians have any concerns, as to in what circumstances they are permitted to intervene, legislation needs to clarify this for them.

The specialist care of mother and baby in pregnancy has always been remit of the obstetrician and gynaecologist. Where a psychiatric opinion is needed, the GP or obstetrician may arrange for specialist opinion from a psychiatrist and management in a psychiatric unit, if necessary. Again, again, abortion is not an appropriate

treatment for suicide and this should so this should not be legislated for. Furthermore, psychiatrists should not be called upon to approve an abortion; no good psychiatrist would ever recommend abortion as a viable treatment where there is risk of suicide.

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

Current medical practice already allows for this through the referral system from a patient's GP to a specialist obstetrician and other specialities e.g. oncology.

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

Again abortion is not a suitable treatment for suicide (see notes on head 4 above). This item therefore should be deleted from the heads of bill

Head 9 General provisions for Committee

No comment

Head 10 Formal medical review reports to the Minister

Data should be forwarded monthly to the minister so as to protect life in pregnancy. The recent experience from Zambia should inform this where 452 illegal abortions were performed over a 4 month period notwithstanding strict legislation on abortion. The EU requirements for data protection may also block full inmshould also be removed when communicating this information.

Head 11 Notifications

No comment

Head 12 Conscientious Objections

Head 13 Travel and Information

An abortion referral clinic is currently operating in Dublin referring women seeking abortions to N.Ireland and elsewhere. The legislation should state that no such clinic may operate that recommends abortion elsewhere may operate within the state. Furthermore, the people of Northern Ireland do not want Irish women travelling north to procure abortions. There has been enough unlawful killing and blood shed over recent decades.

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

Head 18 Repeals and consequential amendments of other Acts

The issue of killing of babies in the womb by procurement of internet medicines or hospital only medicines sold on the black market needs further elucidation.

The government needs to legislate for greater control of medicines and supplements that may be procured directly over the internet with the view to intentional killing of the unborn baby in the womb.

The government needs to legislate for greater control of hospital only medicines that bring on early labour that can be procured on the black market

The government needs to legislate for greater control of some herbal medicines and supplements that can be purchased in health food stores that may be of compromise the protection of life in pregnancy for both mother and baby.

Head 19 Offence

No comment

Head 20 Commencement

Good law legislates for the common good. Laws made based on legislation for extreme cases makes for bad law.

It would be a tragedy for Irish life and culture if this Protection of Life in Pregnancy Bill is introduced to our country in this format. It is imperative that head 4 and head 8 are deleted from this draft bill. It is imperative that the government do everything within its power to protect life in pregnancy. This bill, in its current format is contrary to do that. Indeed there is a gaping lack of good recommendations to protect life in pregnancy.

3 FURTHER RECOMMENDAIONS NOT COVERED BY HEADS OF BILL THAT NEED CONSIDERATION

Fetal Hospice Care

In the same way that adults who are dying have access to hospice care, mothers carrying babies that have no chance of survival outside of the womb (e.g. baby without a brain) should have access to fetal hospice care. Often these women prefer to give birth in the normal way, let their baby die and then mourn the loss of the baby. However, this can be particularly distressing for a mother who really wants to have a baby. These women should be referred for specialist counselling to a fetal hospice unit in Ireland and the government should pay for this service.

A head of bill is required for consideration of fetal hospice care

Protection of Life in pre-term delivery

Many babies in Ireland are delivered very prematurely. Where is the legislation to ensure excellence in neonatal intensive care practice to support life for these babies. All mothers going into early delivery should receive antenatal steroids as standard practice to mature the lungs of the in utero infant so as to promote the chance of survival on early delivery. Legislation is needed for optimal support of babies born prematurely in Ireland to sustain their lives e.g. antenatal steroids for the mother, surfactant replacement therapy or the pre-term neonate.

A head of bill is required for protection of life of both mother and infant in the case of pre-term delivery

Fast track services from primary care to acute care

Primary health care professionals e.g. GPs, community pharmacists and community midwives should be appropriately trained in identifying women who are suffering from both depression and post-natal depression and refer through nationally care pathways agreed by specialists committed to protecting life. This should not be confused with pathways produced to contravene life.

A head of bill is required for fast tracking pregnant women in crisis pregnancies to appropriate specialist treatment and support

Promoting mental health and well-being - removing the stigma

The government needs to look for ways to remove the stigma of suffering a mental illness and remove prejudicial barriers to good care of women suffering from depression. The government also needs to examine ways in which prejudicial barriers are removed from health care providers charged with the care of women with mental health issues.

A head of bill is required for promotion of mental health in pregnancy so as to protect life in pregnancy.

National Centre of Excellence for Protection of Life in Pregnancy

Establishment of a national centre of excellence for protection of life in pregnancy for dissemination of national guidance for Irish health care professionals involved in quality obstetric care in the acute hospital and primary care settings. Advice should be informed by multi-disclipinary input from specialists in respective fields developing standard guidelines for every scenario arising in pregnancy.

The national centre should also provide information services for women who are pregnant to promote protection of life in pregnancy, give advice and reassurance. Such a centre should operate a confidential telephone line service for pregnant women staffed by appropriately trained staff with clearly defined referral and follow-up pathways. A national database to record statistical data on service users and advice given to the healthcare professionals and the public alike.

The national centre for protection of life in pregnancy should develop as an organisation with a memory. A national database to record statistical data on service users and advice given to health-care professionals and public alike should be developed with appropriate quality assurance systems and outcome data. Annual statistics should be reported to the Minister for Health.

The national centre should link into designated regional centres of excellence for protection of life in pregnancy and more robust services for counselling women in crisis pregnancies.

A head of bill is required to establish a national centre of excellence that will promote protection of life in pregnancy

Bereavement Counselling

Regional counselling services for women who have travelled outside of Ireland to seek an abortion. It is these women who are at greatest risk of suicide and they have been overlooked in this legislation. Furthermore, bereavement counselling services for parents who have lost a baby in pregnancy through miscarriage, stillborn birth are needed. Fetal hospice care for mothers and babies where babies have no chance of survival outside of the womb e.g. baby without a brain are also needed.

A head of bill is required for provision of bereavement counselling for women who have had abortions is crucial to life and for parents who have lost a dearly expected baby.

External funding streams and conflict of interest

The legislation needs to include a clause that the Irish government or any political party or politician serving therein or any individual or group charged with the remit of discharging a bill for protection of life in pregnancy may not receive monetary payment from any external government or association already actively involved in funding of abortion legislation and abortion clinics elsewhere.

A head of bill is required to ensure that elected representatives in positions of leadership, andr political parties elected to govern the country, may not receive funding, be associated with any conflict of interest that would promote abortion in Ireland.

4 SUMMARY

Abortion is the intentional killing of the unborn baby in the womb. Abortion is illegal and needs to remain so in Ireland. Abortion is bullying to the extreme. Ireland has everything to lose and nothing to gain from introducing this legislation in its current format. Indeed the legislation proposed will do little to protect life in pregnancy as the name of the bill "Protection of Life in Pregnancy" suggests. Rather this legislation will work for the destruction of life in pregnancy.

Where the life of a pregnant woman is at risk, either due to physical illness or an emergency physical illness , obstetricians in Ireland, under current law, are already permitted to intervene to save the life of the mother. Legislation needs to clarify this more clearly so that obstetricians, emergency care physicians, anaesthetists, parents and the public clearly understand the level of intervention that is appropriate. High risk pregnancies should continue to be managed by specialists in specialist obstetric units. Emergencies should continue to be managed in public hospitals in the best interests of protecting both lives in a pregnancy.

Abortion as a treatment for suicide does not protect life in pregnancy. Abortion kills one life and permanently damages the other. Termination of a pregnancy is not an appropriate intervention for management of risk of suicide; such women should be treated in a psychiatric unit under the care of a consultant psychiatrist. All psychoses can be managed with appropriately prescribed medicines following risk benefit evaluation of safety of medicines ie: maximum benefit to the mother and minimum risk to the baby. Treatment approaches and prescribing should be informed by nationally agreed guidelines developed with the view to excellence and promoting good practice nationwide. The number of women at risk of suicide who are pregnant together with health outcomes from appropriate medical and pharmaceutical interventions should be forwarded to the Minister for Health.

There is a paucity of recommendations that would serve to protect life in pregnancy that have been overlooked in this draft legislation and need to be considered e.g. national centre of excellence for protection of life in pregnancy, national guidelines of clinical excellence to promote protection of life during pregnancy, protection of life of babies born prematurely, fetal hospice care.

Orla Sheehan

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Subject
input on draft headings for upcoming abortion bill

Dear Mr. Kelly,
In response to the current call for written submissions in relation to the heads of the upcoming bill legalising terminations in limited circumstances, I wish to make the following observations for consideration by the Department and Oireachtas.

1. There is no obligation on Ireland to change its current legal position vis a vis abortion. This has been confirmed to me personally by Mr. Jerry Buttimer, T.D. (private email correspondence, Jan 18, 2013). In light of this fact, the impetus for changing the current law needs to be compelling and evidence-based.
2. The scenario of suicide in pregnancy is presented as evidence for the need of the current legislation. However, in no other area of law is the threat of suicide is sufficient to make legal, what would otherwise be illegal. Therefore, the current proposal stands on very shaky legal footing and is ripe for judicial challenge.
3. Medical practice requires evidence to support clinical decision making. During the recent Oireachtas hearings chaired by Mr. Buttimer, there was unanimous agreement that, firstly, that no maternal deaths have occurred as a result of any deficiencies in the existing law; secondly, that no doctors have been prosecuted under the 1861 Act, which outlaws the procurement of an abortion; and, thirdly, that there is no body of international medical or psychiatric evidence that suggests abortion is a cause, treatment or cure for suicidal ideation. The only logical conclusion is that that 'straw-man' of suicide is being presented because the real reasons for the introduction of the legislation is more sinister.
4. The reasoned alternative to the current proposal, as outlined by Mr. Bruton, is either to address the medical decision-making process relating to physical threats to the life of the mother, but leave suicidal intent out as a ground for abortion, and let anyone, who wants to test the present constitutionality of this aspect of the X Case, apply directly to the courts.
5. The tragic case of Savita Halappanavar, who died at Galway University Hospital due to septicaemia following a miscarriage, has, somewhat mysteriously given the vague details available, catapulted the abortion question to the front pages of main stream media. The emotionally charged public discourse has revolved about questions of clinical judgement, legal rulings and a woman's "right to choose" life or death for her unborn child. Notably absent is an analysis of the uncomfortable moral conundrum posed by child abortion. Instead, the entire debate is framed by a European Court of Human Rights ruling from 2010 (Ireland versus ABC) which states that "Article 8 [of the European Convention on Human Rights] cannot … be interpreted as

conferring a right to abortion." In spite of this, the ruling has been interpreted by many as a carte blanche for a change to the Irish constitution which would legalise abortion within the republic. Troublingly, the notion of right and wrong, a moral imperative, or any reasoned philosophical argument is lacking, admittedly on both sides of the debate. Instead, abortion is reduced to clinical calculus. This was lacking in the recent hearings and has been absent to date in the Oireachtas debate. Abortion is a moral question of what is right or wrong.

I believe that these thoughts offer compelling reasons why the current proposal needs to significantly amended or abandoned. I am available to answer any further comments or questions that arise in light of this submission.

Sincerely,

Pádraig Cantillon-Murphy PhD(MIT) SM(MIT) BE MIEEE
Lecturer

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Submission to Oireachtas Joint Committee on Health and Children
by Paolo Albanese, 08/05/13

Dear members of the Committee,
please review the below points in relation to the Protection of Life During Pregnancy Bill 2013:

1) Terminology - In the introduction of the Bill, no distinction is made between "abortion" and "life saving treatments" for pregnant women. Abortion is the direct killing of the unborn child, for its own sake, and is not part of any medical procedure aimed at preserving the life or health of the pregnant woman. Life saving treatments, on the other hand, address the medical condition or illness and are aimed at the wellbeing of the pregnant woman, and although in extreme cases may have the unintended consequence of the loss of the life of the unborn child, that is not their primary end. "Termination" is an undefined term used throughout the Bill with ambiguity. It should be specified that a termination of pregnancy does not coincide with abortion. A termination may happen in the form of a happy of childbirth, or under the unfortunate circumstance of miscarriage, or worse still in case of procured abortion. At not point is made clear whether "Termination" is intended as voluntary killing of an unborn child, or whether it may involve safe delivery and/or attempts to preserve the life of the unborn, before or after she/he is removed from the mother's body.

2) Risks other than self destruction - Head 2 of the Bill provides that a termination of pregnancy may be carried out where there is substantial risk to the life of the mother other than self destruction, but does not mention which procedures will be implemented. This vagueness would allow the use of any procedure, including those in effect in other countries where abortion is legal, that target the life of the baby directly. The Heads do not include or even mention, much less enshrine, the current best medical practice, which are aimed, primarily, at treating the pregnant woman, and involve, at times, the premature delivery of the unborn, or have the side effect of the loss of his/her life, which is not directly sought. "Termination" should have been explicitly and clearly differentiated form abortion, and included only is so far as it is intended to be safe childbirth or part of a life saving procedure currently adopted by Irish Doctors and Practitioners. Abortion, on the other hand, should have been explicitly rejected and banned from the scope of the law.

3) Suicidality - Heads 4 & 8 make provision of the carrying out of termination of pregnancies for women who believe there is a risk of self destruction should the pregnancy be brought to its natural end. Psychiatric evidences given to the Oireachtas unanimously excluded that such suicidal ideation could be prevented or averted or even mitigated by an abortion or termination. Further to that, abortion is a likely factor in suicide. Dr. Monaghan stated in his written submission to the Oirechtas, "Psychiatric evidence suggests the possibility that suicide risk increases after abortion" and Professor Kevin M. Malone: "there is a greater likelihood that this legislation may contribute to an increased risk of suicide in Irish males through foregrounding "suicidality" within the State for females, consequent to this legislation – an amplified cultural suicide signal through a normalization effect". Far from preventing suicide, this law may in fact foster it and the State be liable for any instances attributable to its enacting, since It had prior knowledge of the risks. No provision for termination/abortion should therefore be formalized in Law on the grounds of self destruction, or entirely different approaches to suspected instances of suicidal or self harm ideation should be taken, primarily investigating the underlying cause of distress allegedly linked to or affecting the pregnancy, such as economic or social concerns, particular life circumstances, etc. The proposed remedial measures should not in any way include an unnatural termination of pregnancy or procure the death of the unborn child, but rather tackle the fundamental causes of distress appropriately for the specific cases, for example by granting financial or material support to the mother/couple, housing, psychological

counseling, or make it possible to explore ways to adoption and foster care, etc.
4) Conscientious Objection - Head 12 does not provide a full right to contentious objection: a Doctor or Health Professional would be forced to ensure that another colleague would take over in performing the objected course of actions and thus enabling and facilitating, and in that sense participating in what He firstly objected. No right to objection is recognized to Institutions and Organization where there is a conflict with their ethos and professed values, forcing them to engage in what their were not set up for or are firmly against.
5) Repeal of Sections 58 & 59 of the Offenses to the Person 1861 Act – such repeal de facto allows abortion, as direct killing of the unborn, by means of instrument and drugs or poisons for the purpose of procuring a miscarriage. Instead of clarifying and enshrining current medical practice, which do not break the above mentioned articles, this repeal will introduce, for the first time in Irish History, the permission to carry out direct killing of unborn children, and since the articles state that it is an offense to unlawfully use drugs or instruments to such aim, their removal will bring into effect a permission to commit those acts whether in or out of the Law, including the proposed law in object.
6) Offenses – Head 19, subhead(4) provides that a prosecution for infringement or abuse may be brought only by or with the consent of the Director of Public Prosecutions. The explanatory notes state that this is to avoid "frivolous or mischievous" cases be brought before the Courts. This leaves open the possibility for a Public Official to dismiss any case based solely on his personal preference or views on the issue of life during pregnancy. Whether a case is legitimately brought forth should be established in the course of the Court proceedings, with procedures codified in laws and regulations.
Best regards,
Paolo Albanese

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Subject
Submission Re - Protection of Life during Pregnancy Bill 2013

To --- Mr Paul Kelly, Principal Clerk, Joint Committee on Health and Children

Submission Re - Protection of Life during Pregnancy Bill 2013

Head 4 Risk of loss of life from self-destruction should be removed from the legislation

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Head 4 Risk of loss of life from self-destruction, The procedure stipulated by head 4 may appears at first glance restrictive. One obstetrician and two psychiatrists must jointly certify (i) "a real and substantial risk of loss of the pregnant woman's life by way of self-destruction" and (ii) that "in their reasonable opinion this risk can be averted only by [a medical procedure ending unborn human life]". Furthermore, the concept of a "substantial" risk in the context of threatened suicide also lacks clarity (with the explanatory notes dismissing any need for an opinion that "the risk to the woman's life is inevitable or immediate") and also the duty towards preserving unborn human life as far as practicable governs the actual medical procedure – the termination of pregnancy only, thus sundering the current two patient model when treating women in pregnancy

Psychiatrists can use reasonable opinion, which is means an opinion, formed in good faith, which has regard to the need to preserve unborn human life as far as practicable.
The certifying obstetrician/gynaecologist who has no technical competence in this area, it would appear, is merely the conduit through which the abortion is arranged and executed. ("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.")

The explanatory notes, acknowledging the "recognised clinical challenges in accurately assessing suicidal intent, and the absence of objective clinical markers", also, the concept of a "substantial" risk in the context of threatened suicide also lacks clarity (the explanatory notes dismisses any need for an opinion that "the risk to the woman's life is inevitable or immediate"). The level of latitude afforded to the psychiatrists is very considerable and wide.

In reality these clinical challenges referred to are not challenges but impossibilities bearing in mind the by now well-known statistics in relation to suicide. Dr Joanne Fenton psychiatrist puts the predicted suicide rate during pregnancy at 1 in 500,000 (speaking on Drive Time 1st May).

A review of all maternal deaths in the three Dublin maternity hospitals between 1950 & 2011 covering 1 million pregnancies by Dr Patricia Casey reveals one pregnant woman died during pregnancy by suicide. The suicide rate in for 16 to 44 year olds in the general Irish population is 15 per 100,000 or 75 times higher than for pregnant mother in the same age group.

It is also widely known in the public domain that prediction of suicide among existing mentally ill patients is enormously inaccurate. Out of every 100 predicted suicides using the best selection criteria less than 3 will eventually commit suicide. If psychiatrists are not able to identify any of the 500 suicides per annum that are taking place in the general population how are they to predict the 1 pregnant woman in 10 years that statistically will commit suicide. More importantly how many abortions will be carried out in that vain endeavor?

Head 4 is attempting to identify the pregnant mother who will commit suicide, an event, which will take place possibly once every 10 years, using predictive techniques, which are wrong 97 times out of 100. All this in a vain attempt to improve the mothers mental health status when the evidence points to the fact that the result of the state sanctioned killing of her child will likely push her over the edge and be the final factor which will cause her suicide.

Head 4 Risk of loss of life from self-destruction should be removed from the legislation.

Pat Cummins Ballaghaderreen Co Roscommon

Rivendell
Dublin Road
Shankill
Dublin 18
Ireland.

Tel: +353 1 282 3014
Email: pjdriv@gmail.com.
7th May 2013.

To the Oireachtas Committee on Health

I write, personally, as someone who has over 25 years experience and involvement in Life Pregnancy Care and over that time a number of things have become abundantly clear:

1. A pregnancy which began as a crisis frequently becomes manageable once the woman is offered the supports, emotional, social and financial, that she needs to deal with the situation.

2. Clients who come to Life for a second opinion following counselling in agencies which consider referral for abortion as the decision of choice, are amazed and delighted to find that there is the realistic option of keeping the pregnancy to term and that there are supports available to assist in that endeavour.

3. For that significant proportion of women who have had abortions and now realise what a catastrophic mistake it was, post abortion counselling can help relieve the pain but it is a long term and painful process requiring total acceptance for the responsibility for the decision to proceed with the abortion. The pain is not something one would wish on anyone, and of course it can be avoided by refusing the abortion in the first place. Post abortion counselling cannot be effectively given by agencies which facilitate referral because they were part of the original decision.

I appreciate that you, the legislators have an intractable situation to deal with in respect to the Supreme Court decision which was so flawed, because no expert psychiatric opinion was taken, as to be totally unsuited to being the basis for a major change in the law of the land. But if abortion is established on foot of that opinion as an appropriate treatment for suicide, which medical and psychiatric opinion broadly denies, it is imperative that you take account and responsibility that law defines morality in the public psyche and that therefore and as a direct consequence, abortion will become acceptable as a way of 'solving' an unwanted pregnancy.

Although initially this will apply to the restricted case of possible suicide, it will generate a more general demand for abortion in all cases of unplanned pregnancy and this is well understood by those who are keen to introduce abortion on demand into Ireland, with all the attendant pain and suffering that this will cause, much of it hidden because once abortion is accepted as a legitimate response it becomes much more difficult to speak out about negative personal consequences.

How can the Government of Ireland be tied to the Supreme Court decision made twenty years ago? The Court took no cognizance of expert opinion at the time and that expert opinion has developed substantially in the intervening years and is now much more clear about the damage that abortion can cause to vulnerable persons and most particularly in this present case that abortion is not a treatment for women threatening or talking about the possibility of suicide.

Recommendation: That a referendum is established to reverse the Supreme Court Judgement in which the choices are made absolutely clear and the following information is given:

Medical necessitated termination of the pregnancy in order to save the life of the mother is fully justified, is normal practice and is not at issue. Though the guidelines evidently need clarifying.

In the case of Savita Halapinava it is clear from the inquest that she died because of failures in procedures in the hospital which failed to identify as early as possible that she was suffering from a dangerous and antibiotic resistant infection and which could then have been treated in time to save her life.

Abortion is the direct and intentional killing of an unborn baby at some stage of development prior to natural birth, that it is not a treatment for suicide ideation nor for any other personal problems since other remedies are available which preserve the life of both mother and child.

Signed,

Patrick Davey

Patrick Desmond <patrickjdesmond@gmail.com>
08/05/2013 10:31 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Submission on Protection of Life During Pregnancy Bill

A chara,

My name is Patrick Desmond and I live on Dorset Street, Dublin 1.

I am writing to voice my concern at the proposal to legislate for abortion which is currently being considered. It is a very delicate topic and can be very divisive. Tensions often run high and rightly so - it is a huge question that goes right to the core of how we as a society value life. By their very nature because there are two people directly involved, that is both a mother and her unborn child, complicated pregnancies do not lend themselves easily to legislators. There is much tragedy and emotion and many difficult scenarios to be considered. The issue is further complicated by varying degrees of support ranging from moderate to extreme on both sides of the debate.

I worry that amid all the furore the reality of abortion is getting lost. On what grounds can we as a society condemn an innocent person to death? That is the question being discussed. All sorts of circumstances are being proposed, some borne out by real life tragedies, but the question remains. I do not think the destruction of innocent life is a good thing for Irish society.

There is good reason from the evidence in other countries that there is no such thing as a limited amount of abortion. It is all or nothing. The U.S, the U.K, Spain and many other countries have seen abortions increase rapidly once the fundamental regard for life was undermined. The English Government Minister who championed the introduction of limited abortion in 1967 said 'he never thought it would result in so many abortions' - a sentiment shared by the lady at the centre of the Roe v Wade case in the States. It is false to suggest that abortion in limited circumstances will stay that way.

There is ample evidence from the medical Professionals to suggest that abortion is not a solution for suicidal ideation. The IMO recently rejected various abortion proposals at their conference. It is difficult to see logically, why Ireland would want to change its attitude to abortion when it is statistically one of the safest places in the world for a woman to be pregnant. Why do our politicians not trumpet this success from the rooftops? It is a strange thing. The legislation, as currently outlined offers no timeline, therefore allowing the possibility of abortions at any stage as well as little hope for conscientious Medical Professionals who want no part in performing abortions.

Condemning Ireland's unborn children to a death sentence is something I cannot support. It is strange that only 6 months ago we had a referendum on children's rights and now we are denying them the right to life. Why can we not clarify procedures in hospitals and resource them adequately so

that current best practice guidelines can be enforced and the best care can be provided to our women? Legislation is not the only option at our disposal; not even the EHRC demanded that of us, despite what some have claimed.

Please pass on my sentiments to the decision makers when they discuss this. Abortion is not the solution.

Regards,
Patrick.

Mary Hanrahan <knockaneanmary@gmail.com>
08/05/2013 03.18 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Paul Kelly re Abortion Bill

We are concerned about the draft legislation on abortion.Over one hundred psychiatrists submitted a statement to leinster house stating that there was no evidence in medicine that abortion was a cure for suicide so we would like to have that clause removed from the constitution.We do believe that the constitution as it stands gives adequate protection to both mother and baby and the various EU treaties have a clause written in, that Ireland will not be forced to legalise abortion.We do hope the committee will listen and take account of the concerns of the people.We would like an aknowledgement for this e mail please.
Yours Hopefully,
Patrick &Maura Hanrahan.
Caheraphuca,
Crusheen,
Ennis,Co.Clare

Paul Cahill <p.patrickmaria@gmail.com>
08/05/2013 04.59 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Conscientious Objection should be allowed.

Dear Paul,

I am a 34 year old Irish citizen. I am proud of my country and it's history and the high standard of medical care we receive here.

The fact that the proposed bill requires that every maternity unit in the country must be willing to perform 'lawful terminations' regardless of their ethos without any exemption for hospitals with a religious ethos is very saddening. If we believe in the intelligence of the electorate, should the not be allowed to refrain from doing something which goes against their conscience? We have seen how contentious an issue it is. There are many in this country who do not want abortion. Legislators should represent their views too by allowing individuals of institutions to refrain from the direct and deliberate killing of a baby to save the mother's life while still providing all necessary medical care to save both.
Even countries with much more permissive abortion laws than our own rarely go this far.

For example, Britain does not require hospitals with a religious ethos to perform abortions, nor does British law, so far as we can ascertain, require pro-life doctors to refer patients seeking an abortion to pro-choice doctors.
It allows doctors not to perform abortions unless they are presented with a 'medical emergency'.

However, the right of conscientious objection recognised by the proposed law is limited in other ways. For example, if a patient seeking 'a required medical procedure' (that is, an abortion) goes before a pro-life doctor, the pro-life doctor must refer her to a pro-choice colleague.

In this regard it is relevant to refer to a Resolution passed by the Parliamentary Assembly of the Council of Europe in 2010. The European Court of Human Rights is another of the institutions of the Council of Europe.

The resolution is called 'The right to conscientious objection in lawful medical care'.
Paragraph one is a sweeping and robust statement of the right of conscientious objection both of individuals and institutions.

It reads: "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 or embryo, for any reason."

The explanatory note to Head 12 describes how the European Convention on Human Rights must be balanced against other rights. This is fair enough.

But the proposed law does not balance it properly, very far from it. The above quoted resolution, which will have taken into account the Convention on Human Rights as well, strikes the balance in a very different way.

In fact, Head 12 is extreme in its philosophy and its scope and as mentioned goes much further than other countries with more permissive abortion laws than our own.
This is simply one more reason to reject the proposed bill.

Yours sincerely,

Paul Cahill

Paul Kelly <kellypaul2010@hotmail.com>
08/05/2013 02.32 p.m. To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
RE: Human Life in Pregnancy

From: kellypaul2010@hotmail.com
To: healthandchildren@oireachtes.ie
Subject: Human Life in Pregnancy
Date: Wed, 8 May 2013 14:17:18 +0100

Presently in Ireland in this age of "enlightenment"!!! we are now in the surreal position where our most "intelligent" !!! people are plotting the way forward for the killing of unborn boys and girls by abortion.Ireland is presently a world leader in maternal health care for both mother and child and is the envy of many countries that use abortion to "protect womens health"!!!!
This is the most serious attempt to destroy future generations of Irish people .
Arguments for abortion legislation re suicide are a total sham as proved by our esteemed medical
doctors and psychiatrists during the oireachtes hearing.
How many women have died in Ireland in past 50 years because of the unavailability of abortion?
Medical intervention to save mothers life as presently available and which may result in death of baby is a completely different situation to proposed legislation.
History of abortion shows the destruction of human life:60 million in America since first introduced,200,000 in Britain each year.
Womens health is being used shamefully as an argument to kill .
No politician has the moral right to introduce laws to decide who will live and who will die.
Please take careful notice of the very serious concerns and anger of the Irish people about this most serious issue.
Irish people love their children and will not accept the killing of unborn boys and girls to placate any political ideologies.
Political gangsterism has left our country bankrupt.
Politicians plotting murder of unborn is a step TOO far.
The next debate will concern the justification of civil war.

Yours:Paul Kelly,0719647181

Paul O'Callaghan <pocallaghan02@qub.ac.uk>
08/05/2013 12.07 p.m. To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Submission on Protection of Life During Pregnancy Heads of Bill 2013

Mr Paul Kelly,
Principal Clerk,
Joint Committee on Health and Children

Dear Mr Kelly,

My name is Paul O'Callaghan and I'm a Child Psychologist from Dublin. I'm currently living in Northern Ireland and working in the Education Psychology Service in County Tyrone. Prior to working for the Southern Education and Library Board I worked with victims of gender-based violence in the Democratic Republic of Congo and Uganda. It was there also that I saw first-hand the impact of rape and violence on women and the stigma and mental health problems associated with raising a child born as a result of sexual violence.

And yet, what truly amazed me was that in all of my interactions with some of the most brutalised women in the world, not one of the girls or women I met and worked with, ever considered an abortion or thought they would be better off without the child they had conceived. This struck me as incredibly odd for these women had been traumatised by rape and then frequently stigmatised by their communities for having given birth to a 'rebel's' child. And yet, remarkably in the most harrowing of situations, the women described their child as a gift and despite the societal and community discrimination they faced, claimed this new life gave them a sense of purpose and meaning in continuing their own lives.

I thought of this experience when I read through the Protection of Life During Pregnancy Heads of Bill 2013. The one part of the Heads of Bill I would like to concentrate on is Head Four - Risk of Loss of Life from Self-Destruction.

This section states that it will not be an offence to carry out a medical procedure which results in the death of unborn life if two psychiatrists jointly certify that there is a real and substantial risk of loss of the pregnant woman's life by way of self-destruction and this risk can only be averted by that medical procedure.

However, one of the challenges of working with people experiencing psychological and mental health difficulties is that it is just not possible to predict with any certainty how a person presenting with suicidal ideation will act in the future. Secondly, as it well known in psychiatric hospitals all over the country, suicidal ideation is not a permanent state but is transition and responds well to specialised support. However, this support involves round-the-clock care and medication. It does not involve significant and life-changing medical procedures. It is well common practice to discourage the patient to make major life-changing decisions at a time of intense mental distress,

particularly one so serious and irreversible as an abortion.

It gravely concerns me that abortion would be used as a treatment for suicide when there is no evidence in peer-reviewed suicidology or obstetric and gynaecological journals that abortion is a suitable treatment for suicide. This is all the more concerning giving the growing research evidence of the negative impact this medical procedure can have on some women.

Thus, I would like to add my voice to the IMO and countless other mental health practitioners who have voiced their strong concerns that medical procedures resulting in the ending of unborn human life would be legalised in this country on the grounds of suicide.

Yours sincerely,
Paul O'Callaghan

Paul O'Callaghan (Dr)
Educational and Child Psychologist
The School Psychology Service
Southern Education and Library Board
Dungannon County Primary School
DUNGANNON
BT71 6BE

TEL: 028 8772 6430 (Work) 07501 43 46 32 (Mob)

Corconia <corconia@gmail.com>
06/05/2013 16:56 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Maternity Bill Submission

Dear Mr. Kelly

I would like to submit my concerns to the current proposed legislation.

Before I voice my concern I would like to remind you of the opening of The Irish Constitution:

It says:

CONSTITUTION OF IRELAND

In the Name of the Most Holy Trinity, from Whom is all authority and to Whom, as our final end, all actions both of men and States must be referred,
We, the people of Éire, Humbly acknowledging all our obligations to our Divine Lord, Jesus Christ, Who sustained our fathers through centuries of trial,
Gratefully remembering their heroic and unremitting struggle to regain the rightful independence of our Nation, And 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, true social order attained, the unity of our country restored, and concord established with other nations,
Do hereby adopt, enact, and give to ourselves this Constitution.

I put it to you that the proposed legislation is unconstitutional in that it is contrary to the opening lines of our great Constitutional. Our Constitution acknowledges our obligation to God and as such, by introducing abortion, including the threat of suicide' we are in direct violation by allowing the deliberate and direct killing of our unborn. Our obligation is to adhere to the wisdom, word and Love of God. We are specifically told by God himself that 'Thou Shalt not kill", yet by introducing abortion, including the threat of suicide, we dispense with the wisdom of God and our obligation by allowing the direct and intentional killing of our children.

Abortion is not a cure for suicide! This has been confirmed by over 100 of our finest psychiatrists who work in the field on a daily basis. The government has chosen to ignore them. Why? I ask you where is the 'observance of Prudence' in perusing something that medical and psychiatric evidence suggests otherwise? Where is the observed 'Justice' to the unborn child who is currently protected under the constitution? The government is ignoring the 'freedom of the individual', in this case the unborn child, by its intended legislation. How can this proposed legislation bring unity as outlined in the opening of our Constitution above?? The proposed legislation has already shown to be divisive not just with the public but also within political parties and if made into law

will prove more so.

If clarification to our medical staff is necessary then clarification guidelines should be determined by expert medical professionals rather than making it acceptable, in law, by non medical personnel ignoring medical advice, to kill our unborn children in a direct way.
As far as I understand it if a woman's life is in immediate danger then it is permissible for medical staff to intervene to save the mothers life even if that means the unintentional death of the child. This is NOT an abortion and is in the spirit of our constitution and within Catholic teaching.

Will you force Catholic hospitals to commit abortions that goes against Catholic teaching? This, I believe, is also unconstitutional as the constitution is based on a Catholic ethos and no doubt the government will feel a backlash should they try and force abortions in our Catholic Institutions.

One thing of note is that the current proposed maternal legislation does not mention the word 'Mother' or 'Child'. How odd! This omittance of such fundamental wording in a maternal bill, I would suggest, may leave the door open for a more liberal agenda in the future. For any proposed bill I would have expected such fundamental wording to be included.

Yours in Respect

Paul O'Shea

Date: Wednesday May 8th 2013

Submission for: *PROTECTION OF LIFE DURING PREGNANCY*

Intro

I would like to say that I find it very worrying that the Governement are proposing abortion in Ireland, which does not protect the life of the unborn during pregnancy. I am concerned for both mother & child, and both lives should be protected. I am sending my submission because my local td who is in government has not met me in person despite my requests for an appointment. I feel my voice is not being heard.

Executive summary

Abortion will only engender a killing industry that cannot be erradicated

Recommendations

I recommend no abortion in Ireland, and an an improved pre-natal healthcare unit for unplanned pregnancy be implemented.

I recommend that suicide as a grounds for abortion be rejected.

Main body

There is no need for abortion in Ireland, and there is no need to engender an abortive culture in Ireland. I find it worrying that the government want to legislate for abortion on the grounds of suicide. This will encourage women to lie about their emotions to obtain an abortion. It will also create an abortive business ethic with doctors who are pro-abortion. Pro abortion doctors will benefit from consultancy fees obtained from women claiming suicide. This easy money business ethic will engender a more proliferate abortion industry that will only take root in Ireland with the passing of time. Couple this with full term abortion, the result will be abortion tourism Ireland. This is where pregnant mothers travel to Ireland from England, France, Germany and elsewhere seeking third trimester abortions where they are not permitted (if this is the case under their legal juristiction). Ireland will thus have gone from a nation that cherishes life from the womb to the tomb, to a nation of baby killers.

Abortion does not always save women's lives and certainly results in the loss of an unborn child. A medical termination will try provide the unborn child a chance to live in an incubator. A medical termination offers the mother and child a chance to live where both situations are possible. Abortion directly targets the mother's unborn child at the fetal stage, whereas a medical termination does not target the unborn directly. An abortion discards the dead fetus into a bucket or bin. Whereas a medical termination would offer more dignity & compassion to both bereaved mother and her lost unborn child.

Abortion creates spin off businesses which are difficult to erradicate. One such business is the cremation of dead fetuses, another is the transporting of dead fetuses, and worse again a despicable business of the selling of dead fetuses for beauty products at the high end market trade. To say then that abortion effects only a mother and her unborn child is not true. Abortion affects the doctor performing the death sentence of the unborn child whether he or she understands or feels this or not. Abortion affects the midwives who have to deal with the horible reality of abortion over their career span. Abortion affects those in the manufacturing industry who produce instruments to target the unborn child. Abortion affects those employed in health care, who work alongside gynacologist who may also be doubling as an abortionist within the health care premises. Abortion benefits only those who make a lot of money from this industry.

To claim that a girl who was raped should be given an abortion shows for lack of wisdom. If her abortion goes wrong, she might die herself. Abortions do go wrong sometimes. Abortions may damage her uterus, and she might not ever ba able to concieve again. This does happen as well at times. Her womb maybe damaged from the abortion which may give rise to complications to her next pregnancy, and if her GP is not aware of her prior abortion, then this might lead to serious life threatening complications. But most of all, her rapist gets away with his crime unpunished and a child is killed in the process (double whammy).

Abortion is never necessary, and Ireland is safer without it.

Regards,

Paul Spaine

Paul Spaine.

Petra Conroy

Submission to Oireachtas Committee on Children and Health on Proposed Abortion Bill

1st May 2013: I've just finished a review of the Heads of Bill of the proposed abortion law. I can't see anything in it that led to media reports earlier that it would address concerns of pro-life TDs – quite the opposite. My concerns are outlined below:

In the case of a woman with suicidal ideation:

• **The key issue:** which makes this bill bad law is that by legislating to end the life of a child where his mother has suicidal intent, direct abortion is introduced into Ireland for the first time. International evidence shows that abortion does not help the mother in this situation, and the life of her child is lost. We're used to hearing these words and these arguments and we can forget what we are saying but under this proposed law, a woman certified to have an abortion in this situation will walk into an Irish maternity hospital in physically good health and with a healthy baby, and a doctor will carry out a "medical procedure" the sole aim of which is to take her child's life. This is simply not acceptable. As long as that remains in the Bill it will remain an unjust and cruel law.

• **Babies born alive:** There was some question in the media earlier today around care for a baby who is already viable and is born alive. However, while "reasonable opinion" is to include "due regard for the need to preserve unborn human life", the procedure described in the Bill is one "in the course of which or as a result of which unborn human life is ended." "Termination of pregnancy" which could leave open the possibility of a live birth is only used in this context in the explanatory notes. The Heads of Bill make it clear that the procedure will be to end the life of the child.

• **Effectively two doctors, not three:** While the bill requires three doctors to certify an abortion for a pregnant woman with suicidal intent, one of these three will be an obstetrician / gynaecologist and therefore not qualified to assess appropriate responses to suicidality: this assessment will be made by the two psychiatrists, so effectively two, not three doctors.

• **Reasonable Opinion:** The standard for certifying an abortion is not "research shows" that this risk can only be averted only by a procedure ending the life of the child, but only "in their reasonable opinion" it cannot be averted in any other way. We've already seen two psychiatrists in the media reject the international evidence and say that they would certify in some situations – that's their reasonable opinion: this would not be a high bar to pass.

• **Review / appeal process:** if the three doctors don't agree that a woman should have an abortion, the woman can appeal. This appeal will be considered by three doctors (as before two psychiatrists and one gynaecologist/obstetrician) from a panel established by the HSE. This does not inspire confidence: the HSE is headed by former head of the

IFPA who has a strong pro-choice ideology. If doctors originally consulted by a woman seeking an abortion don't certify it, a small number of doctors will review all cases. Add to this the reality that doctors who are convinced that taking a life is not a solution to crisis in pregnancy will not participate in such panels. The Bill also states that the panel members must be "independent" – an interesting word, wide open to interpretation as to what they must be independent of.

• If it transpires that all certification arises from the HSE review panel, the only consequence envisaged by the Bill is that further guidance will be required from professional bodies (Explanatory Notes p 21).

Women with physical illness which may threaten their life:

As a woman, mother and sister, it hardly needs to be said that I'm completely supportive of women getting all medical treatment we need for any physical illness which threatens our lives, and I support any measure which helps clarify this, once it maintains the current Irish medical practice of recognising that there are two patients to consider. However, I feel that the heads of Bill may allow direct abortion even in these situations:

• **Direct taking of life possible under Heads of Bill, even apart from suicidal intent:** In case of risk to life from physical illness (not being a medical emergency) my key concern is that the term "in the course of which or as a result of which unborn human life is ended" is the same as that used in the case of suicidal intent. In the case of the latter, it can clearly mean directly taking the life of the child, so there's no reason it could not also be understood to mean direct taking of life when the risk is not related to suicide. This would allow a further departure from the current two patient model and it is very different from a necessary medical procedure in which a child may die as an unwanted consequence and where every effort is made to save his life where possible. e.g. in the UK at present, where a pregnant woman has cancer and needs treatment, an abortion is often carried out first. In Ireland, the woman is treated but every effort is made to save the child if possible.

Other Concerns:

• **No gestational limit:** Directly taking the life of an innocent person is wrong at any stage of a child's development, but this Bill offers no time limit on when an abortion can be carried out, right up to birth. Putting a time limit in the Bill does not stop it from being a law that directly takes innocent human life, but even in very liberal abortion regimes, there are some limits on stage of gestation – perhaps because as it gets closer to birth the reality that only a change of location will occur becomes increasingly hard to avoid.

• **Ideology in Language:** "Child" isn't mentioned at all in Heads of Bill and only once in explanatory note: "unborn human life" or "the unborn" is used. "Mother" isn't used at all in Heads of Bill and only a handful of times in explanatory notes: "woman" is the preferred term. In both the Supreme Court ruling in the X case ruling and the ECHR ruling on the A, B and C cases, "mother" and "unborn child" are used.

• **Conscientious Objections for Institutions and Organisations:** While individuals can have conscientious objections, organisations or institutions can't: "the right to conscientious objection is a human right

and, as such, applies only to individuals and not institutions." Catholic and other organisations with a clear ethos of respect for all human life would no longer be able to run maternity hospitals in Ireland.

This law does not "protect life during pregnancy" – it introduces abortion:

My key concern however remains that this law for the first time in Ireland, allows the direct taking of innocent life. As long as that remains the case, the law is fatally flawed. If introduced it will lead to many unnecessary deaths and won't save women's lives. Like all law, it will also, I believe, have a profound affect on how our society views and values human beings.

I believe human rights are just that: rights we have by virtue of simply being human. Introducing a law that legalises the removal of human rights from one group of human beings is simply wrong.

We can still stop this, and instead look for better ways to deal with tragedy and crisis caused by rape, illness and social conditions.

Petra Conroy
47 Moanbane Park
Kilcullen
Co Kildare
087 294 1003
petraconroykildare@gmail.com

This submission is sent in a personal capacity. Petra Conroy is a mother, filmmaker, catechist, and currently project coordinator for Catholic Comment, an organisation which offers speakers to the media on issues relating to Catholic Church mission and teaching. The views in this submission reflect a Catholic understanding of the value and dignity of every human person, an understanding shared by people of many faiths and none: human rights are an issue of concern to all who understand them as rights we have simply because we are human.

Philip Prendeville <prephil2005@yahoo.co.uk>
08/05/2013 02.40 p.m. To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Abortion legislation

Dear Sir/Miss,

I want to express my wishes that abortion is not legislated for by the present government or any future governments for that matter. There has been a lot of research conducted by experts for abortion on the grounds of suicide and they deem it not be beneficial. This article(http://www.irishtimes.com/debate/letters/savita-halappanavar-inquest-1.1378062) written and signed by leading obstetricians sums up my feelings.
Yours sincerely,

Philip Prendeville.

PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013

Submission from the

Christian Medical Fellowship (UK and Ireland)

Introduction

The Christian Medical Fellowship (CMF) is an interdenominational Christian organisation with more than 4,000 British and Irish doctors as members, practising in all branches of the profession. Through the International Christian Medical and Dental Association we are linked with like-minded colleagues in over 100 other countries.

CMF regularly makes submissions on ethical and professional matters to Government committees and official bodies.

One of CMF's aims is 'to promote Christian values, especially in bioethics and healthcare, among doctors and medical students, in the church and in society'. Many of our members are directly involved 'on the front line' in diagnosing, treating and caring for pregnant women, Many of our members are directly involved 'on the front line' in diagnosing, treating and caring for pregnant women, as well as people with disabilities. As a Christian organisation, we encourage our members to be advocates for those who are weak, sick, marginalised and handicapped and seek to love and care for them to the utmost of their abilities.

CMF believes that abortion, understood as the direct and intentional destruction of an unborn baby, is gravely immoral in all circumstances. This is different from medical treatments which do not directly and intentionally seek to end the life of the unborn baby.

We support current law and medical guidelines in Ireland which allow nurses and doctors in Irish hospitals to apply this vital distinction in practice.[85] This has been an important factor in ensuring that Irish hospitals are among the safest and best in the world in terms of medical care for both a mother and her unborn baby during pregnancy. The nation consistently boasts one of the lowest maternal mortality rates in the world (1st in 2005, 3rd in 2008[86]).

As a country this is something Ireland should cherish, promote and protect.

[85] Section 21.4 of Ireland's Guide to Professional Conduct and Ethics for Registered Medical Practitioners: *'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.'*

[86] http://www.unicef.org/infobycountry/ireland_statistics.html

Executive summary and Recommendations (Head by Head)

Thankfully bringing a pregnancy to a premature end in order to save the life of the mother is rare. In the UK it was reported in 1992 that in the first 25 years of the operation of the Abortion Act 1967 only 0.013% of all abortions were performed 'to save the life of the mother' and it is even questionable whether many of these required such radical action. The 2009 Abortion Statistics for England and Wales do not report a single case meaning this is a scenario that the vast majority of doctors, and even most obstetricians, will never face in a lifetime of medical practice.

We believe that there is no necessity for any relaxation or change in the law and professional guidance in Ireland when the existing law and guidance do not prevent doctors intervening to save a mother's life.

CMF supports current law and medical guidelines in Ireland which allow nurses and doctors in Irish hospitals to intervene to terminate the pregnancy (while making every effort to preserve the life of the baby) only in order to treat and protect the life of the mother. Where a real and substantial risk to a pregnant woman's life exists, clear procedures and explanations are provided for everyone involved. Section 21.4 of Ireland's Guide to Professional Conduct and Ethics for Registered Medical Practitioners: *'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.'*

The medical certification process is framed around ethical principles and constitutional requirements that place a duty on doctors 'to preserve the life of the unborn as far as practicable'.

We have deep concerns with Protection of Life during Pregnancy (Heads of) Bill which would, if approved, make the direct and intentional killing of unborn children lawful in Ireland.

1. Head 1 Interpretation

The formal definition of unborn used is scientifically incorrect. 'Unborn life' does not begin at implantation but at fertilisation.

Recommendation: The definition of 'unborn' should be scientifically accurate. Head 1 should therefore read: 'unborn' as it relates to human life means following fertilisation until such time as it has completely proceeded in a living state from the body of the woman.

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

The bill makes suicide an explicit, statute-level ground for abortion. However medical evidence and data does not indicate that abortion is a safe or reasonable treatment for suicide. This also puts doctors in the position of deciding what degree of suicide risk qualifies for legal protection and what does not.

Recommendation: suicide as a ground for abortion should be removed

3. Head 12 Conscientious Objection

Head 12 of the draft bill states that a doctor with a conscientious objection to assisting or carrying out an abortion *has a duty* to ensure that another colleague takes over the care of the patient. There should be no duty to refer.

Recommendation: The Bill must be amended to ensure that institutions with an objection to abortion, as well as individuals, do not have to participate in abortions.

4. Head 18 Repeal and Consequential Amendments

Repealing Sections 58 and 59 of the Offences Against the Person Act 1861 will offer less protection to the unborn child.

Recommendation: if sections 58 and 59 of the Offences Against the Person Act are not retained, the Bill should include a clause specifically tailored to protect the life of the unborn child.

Detailed Comments on the draft Bill

Head 1 Interpretation

The formal definition of 'unborn' used in this draft bill is scientifically incorrect. The Bill defines 'unborn life' as beginning when a 'fertilised egg' implants into a woman's uterus. However implantation occurs 5-7 days post-fertilisation and occurs at the blastocyst stage. This is not when a new distinct individual human life begins to exist. Science concedes that human life begins at fertilisation, thus every new human being begins to exist at this point. This is clearly stated in medical text books:

'*Human development begins at fertilisation, the process during which a male gamete or sperm (spermatozoon development) unites with a female gamete or oocyte (ovum) to form a single cell called a zygote. This highly specialized, totipotent cell marked the beginning of each of us as a unique individual.' 'A zygote is the beginning*

of a new human being (ie. an embryo).'[87]

'*Human embryos begin development following the fusion of definitive male and female gametes during fertilization... This moment of zygote formation may be taken as the beginning or zero time point of embryonic development*.' [88]

Our concern with the Bill definition is that it explicitly removes protection for the human embryo before implantation in the womb, by creating an arbitrary point from which to state that human life begins. The definition must be scientifically and medically correct for the purposes of the bill.

Head 4 Risk of loss of life from self-destruction

The draft bill goes beyond both the permitted grounds of Britain's 1967 Abortion Act and of British case-law (such as the 1938 Bourne judgment) by making suicide an explicit, statute-level ground for abortion.

The draft bill assumes that there is evidence that abortion for suicide is beneficial. However there is no research evidence that abortion is a treatment for women who are suicidal, because this has not been investigated. Therefore it would be misleading for anyone to state emphatically that abortion **does or does not** help suicidal women, until better data is available.

We note that recently 113 of 127 psychiatrists in Ireland who took part in a survey organised by four of their peers, agreed with a statement that they were 'deeply concerned' about plans to legislate for suicidality as grounds for an abortion being carried out: '*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*.' (emphasis added). One Psychiatrist, Prof Patricia Casey, Mater Hospital and UCD, adds:

'*In my work as a psychiatrist, I run the attempted suicide service in the Mater Hospital in which we see and assess more than 400 attempted suicides in women per year. I have never seen a pregnant woman who was suicidal for whom an abortion was the only answer*.' [89]

The most recent major review of all recent reviews on the relationship between abortion and mental health, published only last month, has concluded that '*there is no available evidence to suggest that abortion has therapeutic effects in reducing mental health risks of unwanted or unintended pregnancy.*' Furthermore, it found that abortion was associated with a moderate **increase** in the risk of suicidal behavior (AOR 1.69, 95% CI 1.12-2.54; p<0.01).[90]

We recommend, from a medical perspective, that the treatment for suicidality in a pregnant woman is not

[87] Keith L. Moore, *The Developing Human: Clinically Oriented Embryology. 7th edition*. Philadelphia, PA: Saunders, 2003. pp. 16, 2.
[88] William J. Larsen, *Essentials of Human Embryology*. New York: Churchill Livingstone, 1998. pp. 1, 14.
[89] http://www.thelifeinstitute.net/current-projects/abortion-and-suicide/#SUPredict
[90] Fergusson DM et al. Does Abortion reduce the mental health risks of unwanted or unintended pregnancy? A reappraisal of the evidence. *ANZJP* 4 April 2013. DOI: 10.1177/0004867413484579.

abortion but is to make sure that the patient is on the appropriate medication and receiving appropriate psychological treatment, support, intervention and nursing support.

Moreover we are very concerned about the pressure that would be put on Psychiatrists by this draft Bill. It would put psychiatrists in the unenviable position of deciding what degree of suicidality qualifies for legal protection and what does not. Medical judgements can be wrong and psychiatrists should not be asked to adjudicate in these cases. Suicidal intent is an easily fabricated condition and it is very difficult for psychiatrists to **prove** that a woman who says she is not suicidal is not, nor is it their job to do so.

The explanatory notes to the proposed Bill state that the risk to life need not be immediate or inevitable. So doctors are being asked to predict who, on the balance of probability, will take their lives sometime in the future because of the pregnancy.

Inevitably there will be an over-prediction of suicide, since doctors always err on the side of caution where threats of suicide are concerned.

Including suicidal risk in forthcoming legislation is not consistent with Article 40.3.3 which protects the life of the unborn child. We strongly recommend that the parts of the draft bill permitting abortion where there is a risk of suicide should be removed.

Head 12 Conscientious Objection

Head 12 of the draft bill suggests that a doctor with a conscientious objection to assisting or carrying out an abortion **must refer** the woman to a colleague:

'*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 addition, the draft Bill appears to impose a duty on all hospitals, including Catholic hospitals and any with an objection or abortion, to provide abortions, without exception. The following Resolution by the Council of Europe states that:

*'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 or embryo, for any reason.'*[91]

Religious hospitals or organisations which may find themselves being pressurised to agree to abortion services could theoretically use the resolution to allege that they were being discriminated against.

[91] The right to conscientious objection in lawful medical care'. The Council of Europe, http://assembly.coe.int/ASP/APFeaturesManager/defaultArtSiteView.asp?ID=950

The Bill must be amended to ensure that the legitimate autonomy and religious ethos of faith-based institutions, as well as individuals, is fully respected, and to ensure there is no **duty to refer**. Doctors with a conscientious objection must tell patients of their right to see another doctor, and ensure they have sufficient information to exercise that right.

The scope of conscientious objection is also too narrow applying only to '*assisting or carrying out an abortion*'. However doctors who object to the procedure should be excused from all **'participation'** in the abortion process (apart from attendance in emergency). This has been helpfully clarified in a recent high profile British Court ruling last month as extending '*not only to the actual medical or surgical termination **but to the whole process of treatment** given for that purpose*.'[92] (emphasis added).

Head 18 Repeal and Consequential Amendments

This Head provides that (1) Sections 58 and 59 of the Offences Against the Person Act 1861[93] are repealed and replaced by the provisions in Head 2 of the Bill.

The 1861 Act protects the unborn child. Any substitute legislation would be less than the protection which the 1861 Act affords.

The constitutional protection has in fact been reduced to an 'Explanatory Note' in Head 2 as follows: '*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…'* (emphasis added).

We note that in the 2002 abortion referendum the Irish people **rejected** a proposal to repeal sections 58 and 59 of the Offences Against The Person Act 1861.

We recommend that the Bill should include a clause specifically tailored to protect the life of the unborn child.

Conclusion

The unborn child is a living human being from the moment of conception, and is entitled to all of the same rights as other members of the human family.

[92] http://www.scotcourts.gov.uk/opinions/2013CSIH36.html

[93] Sections 58 and 59 of the Offences Against the Person Act 1861 provided for life imprisonment for a doctor who performs an 'intentional miscarriage'.

Any legislation which has any exception in its text would be an open door for liberalising abortion in Ireland.

We believe that there is no necessity for any relaxation or change in the law and professional guidance in Ireland when the existing law and guidance do not prevent doctors intervening to save a mother's life.

Philippa Taylor

Head of Public Policy

Christian Medical Fellowship

May 2013

Presentation Sisters,
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Phone/Fax: 01-628 0305
Mr. Jerry Buttimer
Health Committee
Oireachtas
Leinster House
6th May, 2013.
EMail: pbvmmo@gofree.indigo.;e
Dear Mr. Buttimer and Members of the Health Committee
Re: Tbe Heads of the Bill for the Protection of Life during Pregnancy
I would like to make the following submission to the Health Committee that Head 4 be removed from the above proposed legislation.
Head 2 and Head 3 where more clarification is given to medical personnel as to how to do life saving medical procedures to protect the life ofthe mother even if this leads to the death of the foetus, would seem to be necessary
Head 4, dealing with procedures if a woman has suicide ideation allowing termination of a pregnancy is where one obstetrician/gynaecologist and two psychiatrists, jointly certified in good faith that -
(i) there is a real and substantial risk ofloss 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,
While under the proposed legislation, the best of intentions is to perform an abortion only if absolutely necessary to save the mother's life, it is open to being abused. The intention is to be very restrictive but this part of the legislation would
a) Very soon be found to be unworkable and would be challenged, leading to more liberal interpretations.
b) eventually lead to widespread claims for abortion. There are already about 4,000 women travelling out of the country to avail of abortions. An increasing number of these women will surely take the option of claiming abortion within Ireland on mental health grounds.
c) The personnel in charge of monitoring these claims of suicide ideation will be put in an impossible position as it is very difficult to ignore a woman's statement that she is suicidal and that only an abortion will save her life.
d) The crossing of the line in providing abortion on grounds of mental health, will slowly normalise the idea of abortion. It may erode the support system of a woman in a crisis pregnancy who depends on family, partner and society to support her if she is

going to have a baby who is unplanned or who may be disabled.
e) In relation to the change of culture, I refer to the recent Supreme Court judgement on Assisted Suicide, which looked at how this was operated in other jurisdictions and which decided against the claim saying it would change the culture within Ireland
I propose therefore that Head 4 be removed from the legislation
Yours sincerely
Josephine M. Murphy

Submission by the Pro Life Campaign to the Oireachtas Joint Committee on Health and Children on the Protection of Human Life During Pregnancy (Heads Of) Bill 2013

8th May 2013

PRO LIFE CAMPAIGN

The Pro Life Campaign is a non-denominational human rights organisation, drawing its support from a cross-section of Irish society. The Campaign promotes pro-life education and defends human life at all stages, from conception to natural death. It also campaigns for resources to support and assist pregnant women and those in need of healing after abortion.

The Pro Life Campaign was established in 1992. The founding members were key members of the Pro Life Amendment Campaign which organised and campaigned successfully for the Eighth Amendment of the Constitution (Article 40.3.3) in 1983.

The Pro Life Campaign has special NGO consultative status at the United Nations.

EXECUTIVE SUMMARY

Based on the Pro Life Campaign's experience over twenty years of fielding medical and legal expertise at national and international level, we believe that the proposed Bill is dangerous, unjust and irretrievably flawed.

The brutal lesson of legislation like this in other jurisdictions is that once it is introduced, even on supposedly restrictive grounds, it inevitably leads to abortion on demand.

The heads of the Bill introduced by the Government are sure to repeat these mistakes.

By allowing abortion on the ground of a risk to life based on a threat of suicide, the Government proposes to legislate for a 'treatment' that is not evidence-based. The evidence available links abortion with mental health risks for some women. It is generally accepted that there are no clinical markers for suicidal intent, and that for some women abortion exposes them to future mental health problems.

There is no other situation in our lives where a threat of suicide makes legal what would otherwise be illegal. It would be unjust to allow this to happen where the consequence will be the killing of an innocent child.

Our laws exercise an important educative effect in society. Without abortion, Ireland is among the safest places in the world for a woman to be pregnant. At the same time, our legal culture prohibiting abortion has had a positive effect on our culture. Our abortion rates are a fraction of those in Britain, taking our different population sizes into account. More children with disabilities, e.g. Down Syndrome, are born in Ireland than in Britain because of our different attitudes to abortion.

If abortion is introduced, our culture will change. Countless lives will be lost and more women will suffer for years after their abortion decision. There will be a hardening of our culture. Policy makers will pay lip service to the need to reduce abortions but in practice little will be done to discourage abortion or to address the emotional needs of the women and families affected.

To sum up, Ireland can find the means of supplying the necessary legal and regulatory clarity without legislating for the X case. For 21 years, we have not had abortion in Ireland precisely because we did not legislate for the X case. Once the principle has been conceded, once it is legally permissible to deliberately destroy an innocent life, from that point on, no innocent human life can be sure of the protection of the law.

RECOMMENDATIONS

- That the proposed legislation should be set aside because it allows for the direct targeting of the life of the unborn child, and because in the case of abortion for threatened suicide would expose many women to heightened risk of mental health problems

- That Guidelines should be introduced in consultation with the relevant bodies of medical expertise, best medical practice, addressing the requirement of clarity on medical treatment for women in pregnancy

- That the Government and Oireachtas should take time to study the research on the management and treatment of suicide, and take on board the psychiatric evidence that abortion is not a treatment for suicide

- That the Government should give a commitment that the difficulties associated with the X case ruling will be examined and that the options for clarifying them identified, and that the Government will revert to the Committee of Ministers of the Council of Europe on their progress on this at a later stage

HEAD 1 Interpretation

"implantation" and "unborn"

Taken together, these two terms could enact into legislation a significant delimitation of the Constitutional acknowledgment and protection of the humanity and right to life of the unborn in line with R v R.

If the purpose of these definitions is only to have consequences for this Bill/Act, then the definitions should make this explicit in each case – adding before each definition "for the purposes of this Bill/Act, and only for it, implantation/unborn means …"

"medical procedure"

The definition of medical procedure includes 'medical treatment'. But induced abortion is not a medical treatment for any condition. The Bill deliberately blurs the distinction between medical interventions that are medically appropriate to particular life-threatening conditions and induced abortion, and it does so in order to confer illegitimate 'medical' status on induced abortion and establish an abortion regime under the pretence that this is a medical intervention.

If the purpose of the Bill/Act is the protection of life during pregnancy, then a definition of medical treatment should have been included explicitly stating the double duty of care in medical interventions to preserve the life of the woman in pregnancy. In medical interventions to preserve the life of women in pregnancy, there is a duty of care also to preserve the life of the unborn child as far as practicable.

Since the deliberate and intentional targeting of the life of the unborn child in abortion is incompatible with the equal right to life of the baby in Article 40.3.3, and since there is no evidence that abortion is a medical treatment for suicidality, the entire Bill is flawed.

"reasonable opinion"

The definition of "reasonable opinion" says that the opinion has regard to the "need" to preserve unborn human life as far as practicable".

If the purpose of the Bill/Act is the protection of life during pregnancy, then the definition of "reasonable opinion" should be expressed in terms of obligation rather than need, in order to express the Constitutional obligation to defend and vindicate the right to life of the unborn child as far as practicable, '"reasonable opinion" means an opinion formed in good faith which has regard to the obligation to preserve the life of the unborn child as far as practicable'.

The title of the *Protection of Life during Pregnancy Bill 2013* gives the impression that its purpose is the protection of human life. In reality, however, as currently drafted, the Bill provides for the induced abortion which directly targets the life of the baby.

HEAD 4

This Bill activates the major 'suicide' exception, created by the Supreme Court in the X case, to the prohibition on abortion. Suicidal ideation is the most imprecise, unpredictable area for psychiatrists to deal with.

Including suicide as a ground for abortion ignores the evidence of psychiatrists to the effect that abortion is not a treatment for suicidal ideation. There is international evidence pointing to certain mental health risks associated with abortion.

Abortion on the basis of suicidal ideation can never be restrictive. Psychiatrists will be put in an impossible situation where they cannot refuse abortion at any stage, because there is no way of predicting whether the woman will carry out her threat.

It will come down to the opinion of psychiatrists or their fear of liability, or guesswork. Where there is no evidence of a prior mental illness capable of treatment, some may feel they have no option but to believe that the women involved will take their own lives and certify accordingly. Real or imagined fears of legal liability, unawareness of or refusal to examine evidence that abortion can be associated with increased risk of mental health problems, personal opinions, ideological outlook or guesswork – none of these ought to be a basis for certifying the death of an unborn child.

Where there is mental illness there is no evidence that abortion has any beneficial effect. The Health Committee hearings heard from a perinatal psychiatrist that sudden, life-changing decisions are not advisable. Psychiatrists will have a role in treatment here but it should not be legal to prescribe abortion.

Where there is no underlying mental illness, abortion is even more controversial. There is no evidence that abortion will benefit women in this situation. There are no psychiatric treatments which can first be tried. So it is difficult to see why psychiatrists have a role under the law. In such cases, psychiatrists will be free to consider abortion as the first and only option, not as an extreme option of last resort.

There is nothing in the heads of the Bill to prevent psychiatrists who view abortion as harmless from seeking like-minded colleagues to affirm the certification for an abortion. The result is that healthy pregnant women, who do not suffer from any mental illness, will have access to an abortion where they threaten to kill themselves and their case is handled by psychiatrists who do not believe abortion has any adverse consequences or who believe abortion is a woman's right.

To be clear, these psychiatrists and these women would be doing nothing illegal under the terms of the Bill. In essence this part of the Bill amounts to abortion on request. Under the terms of this Bill such a demand can be sufficient to ensure access to an abortion.

The requirement of two psychiatrists and an obstetrician to certify an abortion will not prevent abuses.

It will be sadly easy to find two psychiatrists who will agree to allow abortion. It is unlikely that the obstetrician would challenge their expert opinions. (The Bill provides no framework for the selection of the two psychiatrists. It provides no protection against the possibility of like-minded psychiatrists choosing routinely to work together).

Some psychiatrists are on record as supporting abortion as a matter of choice. And since the basis for the psychiatrists' decisions cannot be second-guessed, their recommendation of abortion could not be questioned.

According to New Zealand's Abortion Supervisory Committee, the permissibility of abortion on the ground of serious danger to mental health was very precisely defined in New Zealand law, "but the wording has come to have a de facto liberal interpretation."

In California, the number of abortions skyrocketed once abortion was permitted on the supposedly restrictive ground that "the woman is dangerous to herself or to the person or property of others or is in need of supervision or restraint".

Within three years, 98.2% of abortions (61,572) were on this ground.

Post-viability abortions

In Head 4 (page 11), the Bill states:

> 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.

This gives the impression that the child will be protected post-viability at least. However, the Bill sets no time-limit within which an abortion may be performed. Secondly, in the case of a suicide threat it may be the very existence of the baby which is the basis of the woman's stated suicidality. The heads of the Bill provide that the obligation on doctors to make efforts to sustain life after delivery does not oblige them to disregard a real and substantial risk to her life. So where there is a suicide threat based on the child's continued existence, the X case and the heads of the Bill could give freedom to terminate life and not just the pregnancy. This is another strong reason why there should not be legislation for the X case.

In the case of suicidal ideation, the mother's life-threatening concern may not be the physical location of the child but rather the child's very existence. If this is the basis for the mother's suicidality, it cannot be addressed by re-location of the child, i.e. by delivery and attempted preservation of life. Therefore under the X decision abortion, i.e. death of viable children, is authorised. The Bill doesn't say anything about this other than talk about preserving the child post viability but the Bill subjects this obligation to the X case test. The child may have to die or be let die – it will depend on the nature of the suicidal ideation as presented. This makes nonsense of any suggestion that this Bill would avoid the spectre of late-term abortions where the mother is suicidal.

The Expert Group said only termination of pregnancy, not of life, is what the X case requires. But this misrepresents the X case. The proposed legislation does not and cannot do anything to prevent post-viability termination of life once it sets out about implementing the X case.

An attempt to put in a viability clause wouldn't solve the problem while the X case stands. Therefore legislation for the X case, as opposed to some other legal mechanism of responding to the European Court decision, cannot rule out termination of life, post-viability, in certain circumstances. As said above, this is another strong reason for the Oireachtas to exercise its prerogative not to legislate for the X case.

The Minister for Health has completely ignored this aspect of the proposed Bill. Instead, he has rather fancifully suggested that viable babies who are not wanted by their mothers could be taken into care. This conjures visions of premature babies being taken from neonatal intensive care units by the State perhaps to spend the rest of their lives in institutional care because of injuries consequent upon an early termination of pregnancy. The timing of the termination would be dictated by the subjective decision of a psychiatrist to terminate a pregnancy, in circumstances where there is no evidence of any beneficial effect of the procedure on the mother's suicidality, and no medical indication that the procedure is necessary to save the mother's life.

HEAD 8

(See also commentary from Head 4)

The review panel cannot prevent abuses because it only has a role when abortion has been refused. There is no appeal on behalf of the life of the unborn. So, if anything, the review panel will mean that extra abortions take place.

HEAD 11 There is no justification for excluding the Freedom of Information Acts from the Bill

HEAD 12 If the intention of the Bill were to respect the right of conscientious objection, it would have stated that nothing in the Bill would be construed as obliging any medical practitioner, nurse or midwife, or any institution, organisation or third party to carry out, or assist in carrying out, an induced abortion, or to facilitate or provide services for the provision, or support, of induced abortion, or as obliging any medical practitioner, nurse or midwife or other health professional with a conscientious objection to involvement in induced abortion to ensure that the colleague who takes over their responsibility is a person who does not have a conscientious objection to involvement in induced abortion.

As it stands, however, the provisions in the Bill regarding the right of conscientious objection are radically flawed and incomplete.

HEAD 18 The repeal of Sections 58 & 59 of the *Offences Against the Persons Act 1861* in its entirety is unwarranted.

Submission on Protection of Life during Pregnancy Bill 2013

Oireachtas Health Committee May 2013

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 suicide, 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 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.

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.

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.

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.

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 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. 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 usage.
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 suicide. 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. It suggests on the one hand that life sustaining treatment may be provided for the baby but on the other hand that the primary duty is to protecting the life of the mother (page 12 last paragraph). This suggests that this is abortion without time limits and could thus be performed up to birth.

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. 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 in unconscionable and induces 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 reports.
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 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.

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.

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.

Suicide intent in those without mental illness

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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07/05/2013 23:05 To
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cc

bcc

Subject
Protection Of Life During Pregnancy Bill

The Government has No mandate from the people to introduce abortion. In our estimation if the current debate were honest and evidence based, the government would be proposing guidelines to ensure best practice for mothers and babies. Not introducing legislation to satisfy the ideological 656 demands of the Labour Party in Government.

the Fine Gael's refusal to honour pre-election commitment not to introduce abortion legislation is a betrayal of the trust of the Irish Electorate and
sad day for mothers fathers and babies.

Rachel Doyle Submission

Re: PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013 – REQUEST FOR SUBMISSIONS

Introduction.

Having read the Protection of Life During Pregnancy (Heads of) Bill 2013, I am writing to you as a Consultant Physician (previously in UK and currently in Ireland) and having worked in Obstetrics and Paediatrics. I am a proud Irish Citizen and the mother of three young children. I am not a member of any political party or organisation. My observations and recommendations are as follows:

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

Issue: Absence of time limits

1.The absence of any time limits in the case of self-destruction removes legal safeguards for the unborn which could result in disablement if the foetus is delivered prematurely

Crisis pregnancies sometimes present late when it is more difficult to give an accurate gestational age of the foetus. Their lives can now be terminated up until term. If the state through the public obstetric hospitals intervene what happens to the newly born "unwanted" babies that survive medical termination procedures? NHS figures show 66 babies survived abortion procedures in 2008 in the UK and 491 babies were born alive in Canada (2002-2009).

What rights as newly born Irish citizens do they have?
Does the state take over care?

The state may have directly caused severe disability (in what would have been an otherwise healthy baby) by virtue of induced prematurity. This would represent a new low in Irish healthcare.

2.Promotion of 'abortion tourism' due to absence of time limits in cases of self-destruction

Persons from other EU countries (who can produce an Irish address) and wish to avail of a late termination for a crisis pregnancy can travel to Ireland and seek a termination the grounds of suicidal intent. Doctors do not ask patients for proof of identity or proof of residency. Many young and healthy females do not have GP's. This could potentially open the door to 'abortion tourism' .

Recommendation:

A time limit to recognise potential viability, improvements in medical practices and technology to be introduced for risk of loss of life from self-destruction.

Head 11: Notifications

Recommendation:

The Irish Medical Council who are the regulatory body for Doctors and are independent of the HSE should play a role in the development of guidelines (as per coroner Dr. Ciaran MacLoughlin following the inquest into the death of Savita Halappanavar), monitoring and review of termination practices.

Thanking you in anticipation

Yours sincerely

Rachael Doyle

_____

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Subject
SUBMISSION REGARDING PROTECTION OF MATERNAL LIFE BILL 2012, FAO: PAUL KELLY

FOR ATTENTION OF:

PAUL KELLY

CLERK TO THE COMMITTEE

OIREACHTAS COMMITTEE ON HEALTH AND CHILDREN

REGARDING: PROPOSED PROTECTION OF MATERNAL LIFE BILL 2013

Dear Sir,

I would very much like to address the following to the Committee on Health and Children regarding the proposed Protection of Maternal Life Bill 2013.

I have been involved with Cork Pro-Life for over twenty years. This is a coalition of pro-life groupings in the Cork area composed of people of all faiths and none, as well as all political parties and none. Many of our members give selflessly of their time counseling women with crisis pregnancies, as they have done over the course of very many years.

We emphatically reject the current Government's assertion that abortion is necessary to treat threatened suicide in pregnancy.
The psychiatrists who addressed the recent Oireachtas hearings on the proposed Bill were unanimous that abortion is not a treatment for suicidal ideation. Peer-reviewed international studies confirm there is no proof whatsoever that abortion reduces the mental health risks of unplanned pregnancy. However, there is evidence that abortion can greatly increase mental health problems for a significant number of women. We cannot agree with a law that directly targets the life of the Constitutionally-protected unborn child and also puts the lives of women at risk. Passing legislation based on the X-Case would mean that for the very first time in Ireland psychiatrists would be asked to propose a procedure
which is not justified on psychiatric grounds.

The X-Case ruling goes totally against the spirit of the Constitution as expressed by the people when they voted for the Eighth Amendment. The X-Case
ruling was handed down very hastily at a very fraught moment politically in the history of our nation. It was the decision of four lawyers, not of professionals with daily experience of working in our maternity hospitals. It is because the X-Case so cuts against the democratically endorsed Eighth
Amendment that previous Governments have rightly refused to attempt to legislate for it. It is a abhorrently poor basis for national law on this issue. There

is a good history in our nation of referring an issue of such fundamental importance to the people, and contrary to reports in the media, referenda on abortion have in actual fact been very few and far between since 1983. IT IS THE PEOPLE'S RIGHT THAT THEY ONCE AGAIN HAVE A SAY ON THIS MOST CRUCIAL ISSUE.

In practically every Western democracy where abortion has been introduced, it was brought in initially on narrow grounds and these were later inevitably widened. WE ARE NOT SO UNIQUE IN IRELAND THAT WE CAN TURN THIS TRAGIC HISTORY ON ITS HEAD. Lord David Steel, who authored Britain's 1967 Abortion Act, has recently spoke regretfully about how he had never intended for abortion to become so widespread.

Finally, I would like to comment on the Government and media treatment of The European Court of Human Rights (ECHR) judgments in relation to A,B and C v. Ireland.
The Government has repeatedly stated that Ireland is "obliged" to enforce the ECHR ruling, and many journalists have repeated this claim in their copy.
THIS IS A FALSEHOOD. THE ECHR JUDGMENT DOES NOT OBLIGE IRELAND TO INTRODUCE ABORTION BY WAY OF X-CASE LEGISLATION, REGULATION OR ANY OTHER MEANS. The ECHR ruling only requires that Ireland have accessible procedures where its citizens know the law and where they stand. The Government can respond to the judgment by giving a commitment to the Committee of Ministers of the Council of Europe that GUIDELINES (an option offered by the ECHR) will be drawn up in consultation with the appropriate bodies of expertise within the medical profession, addressing the requirement of clarity for women in pregnancy. It is not disrespectful to take great care in responding to the pronouncements of the ECHR. By its own admission, the ECHR understands that time and clarity are needed to resolve issues that are "complex and sensitive."

PLEASE ACKNOWLEDGE RECEIPT OF MY SUBMISSION.

Yours sincerely,

Ray O'Regan
6 St.Joseph's Gardens,
Bishopstown,
Cork city.

Tel. (087) 6016750

Protection of Life during Pregnancy Bill 2013

Executive Summary

My submission outlines **2 concerns** (under Head 4 and Head 12):

a. The difficulty or impossibility to distinguish between a real or contrived threat, where a woman is adamant that she is going to terminate her life; and

b. Threats to conscience: a risk to democracy;

My submission contains **2 questions** (under Head 4):

1. Why does the Bill not deal with the treatment of suicide as a way of protecting the unborn?

2. How terminations will be carried out?

Recommendation:

Head 4: Introduce treatment for the mother rather than termination of the pregnancy. This measure would diminish concern 2.

Raymond M. Keogh
27 Loreto Grange
Bray, County Wicklow

8th May 2013

Protection of Life during Pregnancy Bill 2013 (main submission)
I have two concerns and two questions regarding the Bill:
Concerns:

1. (Head 4) It is difficult or impossible to distinguish between a real or contrived threat, where a woman is adamant that she is going to terminate her life. This situation is independent of the number or type of health professionals involved in a particular case. In due course, practitioners will be **forced** to err on the side of caution (i.e. allow for a termination) where a woman continues to insist or demand to have one because of her threat of suicide. This is **the weakest area of the Bill** and is likely to lead to unintended consequences: that is, a liberal approach to abortion. This is a glaring loophole in the Bill. Besides, termination is **likely to increase the risk** to the mother where suicide is a genuine threat (see article from Ferguson, Horwood and Boden (2013) below). **The Bill is based on questionable science**.

2. (Head 12) Threats to conscience are a risk to democracy. The fact that the Bill demands that all relevant institutions carry out terminations of life under all circumstances outlined in the Bill prevents any relevant individual, body or organisation with a conscientious objection to any part of the Bill from ever establishing an institution that deals with the protection of life during pregnancy. As a result, the ethos of existing medical institutions will - in the long run - tend to diminish the right to life of the unborn as established by Article 40.3.3 of our Constitution. Unintended consequences are likely to be more liberal attitudes to other fundamental issues in medical ethics that will face our society in future and **encourage further restrictions against conscience in medical practices**.

Question:

1. (Head 4) Why does the Bill not deal with the treatment of suicide as a way of protecting the unborn?

2. (Head 4) How does the Bill propose that a termination be carried out in the case of a suicidal threat? Disturbing footage has come to light in the USA about how abortion clinics there carry out terminations (see: http://www.liveaction.org/).

Raymond M. Keogh
27 Loreto Grange
Bray, County Wicklow
8th May 2013

Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence

David M Fergusson; L John Horwood; Joseph M Boden (2013)
Department of Psychological Medicine, University of Otago, Christchurch, Christchurch, New Zealand
David Fergusson, Christchurch Health and Development Study, University of Otago, Christchurch, PO Box, 4345, Christchurch, New Zealand. Email: dm.fergusson@otago.ac.nz

Abstract

Objective: There have been debates about the linkages between abortion and mental health. Few reviews have considered the extent to which abortion has therapeutic benefits that mitigate the mental health risks of abortion. The aim of this review was to conduct a re-appraisal of the evidence to examine the research hypothesis that abortion reduces rates of mental health problems in women having unwanted or unintended pregnancy.

Methods: Analysis of recent reviews (Coleman, 2011; National Collaborating Centre for Mental Health, 2011) identified eight publications reporting 14 adjusted odds ratios (AORs) spanning five outcome domains: anxiety; depression; alcohol misuse; illicit drug use/misuse; and suicidal behaviour. For each outcome, pooled AORs were estimated using a random-effects model.

Results: There was consistent evidence to show that abortion was not associated with a reduction in rates of mental health problems ($p>0.75$). Abortion was associated with small to moderate increases in risks of anxiety (AOR 1.28, 95% CI 0.97−1.70; $p<0.08$), alcohol misuse (AOR 2.34, 95% CI 1.05−5.21; $p<0.05$), illicit drug use/misuse (AOR 3.91, 95% CI 1.13−13.55; $p<0.05$), and suicidal behaviour (AOR 1.69, 95% CI 1.12−2.54; $p<0.01$).

Conclusions: There is no available evidence to suggest that abortion has therapeutic effects in reducing the mental health risks of unwanted or unintended pregnancy. There is suggestive evidence that abortion may be associated with small to moderate increases in risks of some mental health problems.

Submission to the Oireachtas Committee on The Protection of Life during Pregnancy Bill 2013 by D. Vincent Twomey, former Professor of Moral Theology, St Patrick's College, Maynooth.

EXECUTIVE SUMMARY:

Head 12 dealing with conscientious objection is inherently flawed because:

- It fails to take into consideration staff other than medical staff.
- Conscientious objection (Subhead 1) is in contradiction with Subhead 4: the obligation ("duty" is the term used) to ensure that another colleague perform that same procedure .
- The understanding of conscience found in Head 12 is exclusively subjective, which would, if enacted in law, undermine society.
- The positivist understanding of law that informed the Expert Report and now enshrined in the proposed Bill poses a serious threat to the common good of society.

SUBMISSION:

(1) Subhead 1 is, of course, to be welcomed: "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." According to the explanatory Notes, however, it only applies to medical and nursing professions as well as pharmacists. This assumes that auxiliary hospital staff have no conscience or moral responsibility with regard to their material co-operation in what they know to be morally repugnant. That is, of course, not acceptable. We are told in the Notes that Subhead 1 is "adapted" from section 3 of the Twenty-fifth Amendment of the Constitution Act (2001), which reads: " Nothing in this Act shall be construed as obliging any person to carry out, or to assist in the carrying out of, any medical procedure 40 referred to in *section 1* of this Act." The key term used in the proposed Bill is "adapted". In the first place, instead of "any person", Head 12 restricts conscientious objection to professional medical personnel and pharmacists.

(2) Secondly, the proposed Bill's adaptation of section 3 of the 2001 Act would have the effect of cancelling the meaning of the principle enunciated in the 2001 Act (and now found in Subhead 1). This is because Subhead 4 effectively cancels Subhead 1. Subhead 4 stipulates the duty (or moral obligation) of the health professional, who objects to the medical procedure on conscientious grounds should ensure than a colleague provides the required procedure. This makes a mockery of the whole notion of "conscientious objection", as I hope to indicate by taking a closer look at the Medical Council's Guide on which the proposed law is based.

(3) According to the Notes, Head 12 ("Conscientious Objection") is to be understood in terms of the Medical Council's Guide # 10.2 and #10.3. This, in fact, is exactly what the Expert Report suggested. It is interesting that the Expert Report (and following it, Head 12) omitted the introductory statement (#10.1), which in fact is the key to understanding what the Medical Council now understands by the term "conscientious objection". The introductory #10.1 states: "As a doctor, you must not allow your personal moral standards to influence your treatment of patients." This extraordinary statement seems not to have raised an eyebrow when the President of the Medical Council quoted it in his statement to the Oireachtas Committee. In effect, it affirms that doctors should ignore their own sense of right and wrong. It would signal the relegation of morality to the sphere of feelings and the irrational; in a word, it would amount to the abolition of morality. Consequently, the term "right to conscientious objection" used by the Medical Guide (#10.1), the Expert Report (6.9) and now Head 12 of the Bill implies that conscience is something entirely subjective, merely a personal preference, and therefore not binding on anyone but oneself. Both the Medical Guide and the Expert Report thus logically insist on the obligation of referral. And so the proposed Bill now proposes to write this into the law of the land.

(4) But is this true? Is conscience -- like morality -- something purely subjective? These questions cannot be avoided, in particular by legislators. Common human experience - as encapsulated by the wisdom of humanity -- perceives morality as being essentially about those objective limits which define our common humanity: what is right and wrong. Conscience is our innate sense of right and wrong, which can be either developed or deformed by one's upbringing and immediate environment, the *polis* (the political, cultural and economic community in which we live). But even when deformed, our primordial sense of right and wrong, though stifled, can never be obliterated entirely, and so remains the pre-condition for a change of heart and so the recovery of our humanity. It is what jurisprudence means by having moral responsibility for our actions. Negligence as a criminal office includes failing to seek what one ought to do or avoid dong, i.e. what is objectively right or wrong.. The development of one's conscience depends on many conditions, but two are essential: help from outside (such as communal values rooted mostly in religious tradition and legal prescriptions) and help in the depths of one's being from a transcendent source (even when one may be agnostic about God's existence). One's sense of right and wrong matures to the extent that one remains alert to what one observes or hears, one is critical of common assumptions, and, above all, one tries to be self-critical. Primordial conscience of its nature is restless to know the truth. "A conscience is what hurts when all your other parts feel so good." (Stephan Wright). Humility is a hallmark of authentic conscience. Another is moral courage – the readiness to stand up and be counted, irrespective of the negative consequences for oneself.

(5) But even when conscience errs - or even, if one were to accept the subjective notion of conscience proposed by the Medical Council - even then, the person involved would have to act according to his or her subjective conviction. And, if they were to be consistent, they could not in conscience ask a colleague to perform the medical procedure which they find morally repugnant.

(6) As already mentioned, according to Head 12, those medical practitioners who object to certain practices on conscientious grounds are obliged to refer the patient to other medical personnel who they (= the referring medical practitioners) know will provide the same morally objectionable (but now lawful) medical treatment. Such guidelines offend against another common moral perception articulated in the ethical principle of co-operation. Put simply, this means that one should not knowingly co-operate in what will cause serious harm to another person which you can foresee will undoubtedly happen, as happens when one refers the patient to another doctor for an abortion. Should a doctor decide not to refer the patient seeking such a "treatment" that is sanctioned by the law, he or she can be charged with failing in his or her medical duty – and struck off the register. This is one of the many consequences of the proposed law. What are the implications of the proposed Bill for those training to become doctors or nurses? What if they have conscientious objections to being instructed on the various abortion methods? All these need to be given serious consideration.

(7) The Expert Report, on which the proposed Bill is based, it seems to me, is an exercise in pure legal positivism, that is, it assumes that laws derive their binding force from the mere fact that they have been approved by the legislature – irrespective of whether or not they are just or moral. That is a recipe for the moral disintegration of society.

Signed D. Vincent Twomey
Maynooth, Co Kildare Dated 8th May 2013

columba carrick <stcolumbascarrick@gmail.com>
05/05/2013 21:36 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
addenda

Furher to the comments sent a few moments ago,I have made these comments on "The Heads" in the hope that the right to life of both mother and foetus would be preserved in all circumstances

Name :Francis Mac Ateer(Rev)

The Parochial House,
Carrick,
Co.Donegal

074 9739008

stcolumbascarrick@gmail.com

My recommendation is that the proposed bill be redrafted ,giving equal right to life to both mother and child

Signed:Francis Mac Ateer(Rev)

5--5--2013

f

Submission to the Oireachtas Joint Committee on Health and Children on the Outline Heads of the Protection of Life During Pregnancy Bill 2013

Richard Boyd Barrett TD

I support fully the submission from the group Action on X which I believe the committee has received.

At the very least, appropriate legislation that gives full effect to the 1992 judgement of the Supreme Court in the *X Case* must be enacted by this Government.

The legislation must contain:

- The risk of suicide as grounds for abortion
- No more than the opinion of two doctors is enough to approve an abortion
- Publically funded, state-wide access – near to women's homes
- Provisions for abortion if a foetus has a fatal abnormality and cannot survive
- The decriminalisation of abortion

I note with concern that the proposed bill fails to legislate for minors, fatal foetal abnormality and rape and incest and hope these can be taken into account during the amendment stage.

8 Trabeg Ave.,
Sth. Douglas Rd.,
Cork.
5th May 2013.

Re Abortion Legislation.

Dear Mr Buttimer,

We have been asked to submit our opinions, so I am doing so, with respect.

a) I have worked for 17 years on a Suicide Help Line, and never in that time have I answered a call from a woman who was suicidal because she was pregnant. I have, on the other hand , answered a call from a woman who was suicidal because she had had an abortion. She dwelled on the irrevocable nature of what had been done..

b) I have answered many calls from people who were suicidal because of abusive and/or violent partners . We know that such people cannot ask that their abusive partners be killed, and rightly so. Are we to have a law that respects the right of a provedly violent and abusive person to live,(while manifestly causing risk to a partner's life), but doesn't respect the right to life of a completely innocent and helpless baby? Could you, personally, live with such an anomaly?

c) As many more learned people have said before me, the diagnosis of suicide ideation can never be an exact science. It has been found countless times (unfortunately not always) , that someone who presents as suicidal, even extremely so, when afforded the chance of being listened to without judgment, will find that there are other preferable options.

d) Noone has explained to me why a faulty judgment arrived at 21 years ago by three out of five Supreme Court judges should command more respect than the will of the people, or be more sacrosanct than life itself. Some politicians have repeatedly said that it is the responsibility of democratically elected Representatives to legislate. We didn't elect the Supreme Court judges, yet are held to ransom by their decision.

e) I hope that politicians realise that there is a an infinite gulf between legislating so as to clarify the doctor's position when there is a *physical* threat to the life of the mother, as distinct from a thought in her mind.

Thank you, if you have read this letter. I hope we can still be proud of the fact that our Country respects human life, in a few months' time.

Sincerely,

Rita O Connell

Robs Rob <bobertsoft@gmail.com>
08/05/2013 02.46 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Abortion legislation submission FAO Paul Kelly

Dear Mr Kelly,

I wish to make this submission regarding the proposed abortion legistlation. After consideration I have come to believe that this legislation is fundamentally flawed and should not proceed. Following are my reasons...

Ample provision already exists in Irish law regarding medical interventions that may be needed to save the life of a mother. Therefore further legislation is unnecessary and any claims to the contrary are not supported by logic.

Secondly, the proposal to allow for abortion in the case of a woman who is suicidal is not only illogical but dangerous.
Expert after expert in the field of mental health have given testimony that abortion is not a treatment for suicidality. Abortion, in the case of a suicidal woman, far from being a 'treatment' constitutes instead another trauma with which she will have to cope. This is not a matter of opinion but a matter of record for those who have come forward.

Given, then, that ample provision already exists to take all necessary action to save the life of a pregnant woman, and given that abortion does not constitute a treatment of any sort for mental health problems, including suicidality but rather imposes a further trauma on an already traumatised mind, one has to ask the question..... On what logical, demonstrable, medically necessary grounds is this legislation being introduced?

Having considered the above, it seems clear that the basis for introducing this legislation is neither medically necessary, nor logically demonstrable but ideological.

This is, it would therefore appear, a legislative move motivated purely by political ideology.

I would not want this on my conscience, would you?

The logic, therefore, seems inescapable, does it not.

This legislation is being proposed under false pretences and must not proceed.

Sincerely

Robert Hurley B.A.Th. H.Dip.Ed

rosemary watters <rosemarywatters3@yahoo.com>
08/05/2013 01:19 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
GENERAL SCHEME OF THE Protection of Life during Pregnancy Bill 2013

Rosemary Watters
19, University Rd.,
Galway.

0879539493

rosemarywatters3@yahoo.com

I would like to comment on the PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013

Introduction:

My experience of women who have had abortions is that they live with guilt and grief. I am not a health professional, but any woman in this country knows someone who has had this trauma. The vast majority of our psychiatrists tell us that there is nothing to indicate that an abortion is a treatment for suicide or any mental health problem. If anything there is much evidence to suggest it causes trauma, and often results in depression, substance- abuse and self -harm.
As a woman I would like to express my opinion and to have my voice heard: I think the proposal to legalise abortion and make it available in this country is a retrograde step in Women's Healthcare- mental and physical. Our women need support and adequate care and reassurance when they are vulnerable, not a choice that they will regret.
The Government organised the Oireachtas Hearings in January. The evidence they heard there from the experts indicates clearly that there is NO CASE for introducing abortion ON THE GROUNDS OF SUICIDE IDEATION. I wonder what they did not hear or understand from those sessions? It is clear to everyone else what the opinion of the medical experts is, (even to the vociferous minority who do not agree... they are trying to contradict it) and it is based on scientific evidence, research and factual experience with patients. Abortion is not a treatment for any illness, mental or physical. As is currant practice, a patient may need a treatment which may harm or may indirectly cause the death of the unborn child, but this is not what one commonly understands by the term "abortion". This is an unfortunate and sad result which may occur in the effort to treat both patients (the mother and child). Abortion is usually understood to mean directly killing the unborn child under whatever pretext.

As regards the bill itself:
It's presentation is confusing, ambivelant and at times seems to be contradictory, e.g.
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.

I would agree with this statement, but it seems to contradict many of the previous passages of this bill.

I would also like to point out that there is no referance to a limit of age at which the unborn child may be aborted. The heart is beating from about 10 weeks. The child is viable outside the womb from about 24 weeks. What is the proposal What will happen if an eight months pregnant woman presents herself as "suicidal"?

This bill is being proposed as restrictive. There is absolutely nothing restrictive, just as there is absolutely nothing to indicate its justification.

Direct reference to heads of Bill:

Head 2: Risk of loss of life from physical illness
Head 3: Risk of loss of life from physical illness in an emergency situation
I think the proceedures to be put in place have been adequately clarified in the conclusions and suggestions made from the Savita Hallapanaver case.

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

I have discussed this in the introduction above. There is NO CASE for introducing abortion ON THE GROUNDS OF SUICIDE IDEATION, as witnessed in the Oireachtas Hearings in January of this year, and supported by reliable scientific and healthcare research. As recently as this morning in the media
"Professor Fergusson clearly distinguished the issues on the programme and confirmed the accuracy of the quotations used during the Oireachtas Hearings which quoted the evidence in the context of mental health effects on woman. He also confirmed the dearth of evidence in regard to abortion and suicidality."

Head 5

"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."
If this paragraph is applied, de facto, according to the evidence of our medical experts at the Oireachtas Hearing in January, there will be no need for abortion. Abortion is not a life-saving treatment. This is why I am convinced that the Government has no case to bring in abortion, and that they do not realise how much they are contradicting themselves in this bill.

Head 12: Conscientious Objection(3)

I strongly object to the proposal that an institution cannot make a conscientious objection.

I also object to: "However, an individual’s right to conscientious objection is not absolute and often has limitations."

Head 19 Offence
(1) It shall be an offence for a person to do any act with the intent to destroy unborn human life.
"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."
"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."

These statements are contradicted on several occasions in the other Heads of Bill, as stated in the introduction.

Rosemary Watters
May 8th 2013

Salvador.Ryan@spcm.ie
08/05/2013 02.13 p.m.
Please respond to
Salvador.Ryan@spcm.ie To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Protection of Life During Pregnancy Bill 2013

Dear Mr Kelly,

I am writing to express my concern at the manner in which the government has approached the Protection of Life During Pregnancy Bill (which is something of a misnomer, in my view). While in favour of all necessary treatment to be administered to women whose lives are endangered during pregnancy, I do believe that this can be provided for by way of appropriate guidelines rather than legislation for the X-Case. Please keep in mind the following points (which I am sure you have already received in many emails from the large numbers of the electorate who have grave concerns surrounding this issue).

1. Legislating for abortion on the suicide ground is not required by the European Court judgment. We could provide the necessary clarity by introducing guidelines which would protect women in pregnancy by re-affirming that they receive all necessary life saving treatments in pregnancy and requiring that we also exercise a duty of care towards the unborn.

2. Legislation for abortion on the suicide ground is not required by the X-case. When he was Taoiseach, John Bruton said he would not introduce legislation in line with the X-case because that would have the effect of bringing abortion into Ireland. The Oireachtas has the prerogative of not legislating for a Supreme Court decision if it believes it would be harmful to do so.
3. This legislation will not be about 'life-saving' treatment but, in fact, the opposite. The Government has produced no evidence to show that abortion is ever beneficial in the treatment of the mental health of women. We know from the latest review of the evidence (Fergusson et al.) that abortion is not associated with any mental health benefit for women. In fact, it is associated with a low to moderate increased risk to women's mental health. And, of course, we know a child always dies. So it is dishonest to pretend that this proposal is about saving life.

4. That is why over 100 psychiatrists last week signaled their opposition to being involved in certifying women as needing abortion because this is not evidence-based medicine. International experience shows that provision for abortion on the mental health ground will be abused. It is hard to see how things could be different in Ireland, given the nature of what is proposed today.

Sincerely yours,

Salvador Ryan

Prof. Salvador Ryan

Professor of Ecclesiastical History
Faculty of Theology
St Patrick's College
Maynooth
County Kildare
IRELAND

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http://itq.sagepub.com/

Submission to Oireachtas for Protection of Life During Pregnancy Bill 2013

Sarah Roche M.A. Vis

8th May 2013

Cruachan

Sarsfield Court

Glanmire

Co. Cork

Ph: 087 4108165

Sorcha3@gmail.com

INTRODUCTION

I am writing this submission as a concerned Irish citizen. Out of my concern for this area of social justice I have engaged in independent research of this area since 2005. My training and area of expertise is in contemporary visual art and in traditional music. I have been involved in volunteering and raising public awareness in this area of right of life of the unborn since about 2005.

EXECUTIVE SUMMARY

This submission includes recommendations on Heads 2, 3 and 4 of the Bill.

Head 2:

This section looks at the unclear wording of the Head points and the need for clarity. It also looks at questions relating to medical evidence. It proposes an alternative approach to the proposed legislation

It also looks at problems arising out of the proposed X-based legislation

Head 3:

Head 3 concerns echo those stated in Head 2

Head 4:

Head 4 notes look specifically at issues regarding medical evidence in cases of suicidality

HEAD 2

1. The wording of Point (1) does not make clear whether this Head is referring to what is already legal: i.e. the provision of lifesaving medical treatments to expectant mothers, even if it risks the life of the baby, or whether it intends to allow for abortion.

   If indeed this Head is referring to the legalisation of abortion, it is obsolete since

a) Lifesaving medical treatments are **always** given by Irish doctors, even if it risks the life of the baby
b) The Medical Council is very clear in this regard and doctors will be struck off if they do not act to save the life of the mother
c) Medical experts have publicly testified that there were zero instances where abortion was medically necessary
d) A major review of Irish medical practice has shown that Irish women are never denied lifesaving treatment in Ireland, regardless of our ban on abortion

2. If this Head is intended to only tighten up and clarify the existing Medical Council guidelines, then the wording needs to make this very clear. The inclusion of the wording 'procedure…as a result of which human life is ended' is inappropriate here in this case, as it points towards making legal the deliberate and intentional killing of an unborn child. There is a clear difference between a lifesaving medical procedure which might risk the life of the baby and an abortion, the goal of which is to end a human life.

3. Since medical evidence shows that abortion is never medically necessary to save the life of a mother[94], then what is needed is a clarification of the existing Medical Council guidelines regarding the provision of (already legal) lifesaving treatments, which may risk the life of the child. It would seem best that any such guidelines be reviewed and drawn up by the appropriate medical experts.

4. In this Head, as with Heads 3 and 4, no legal time limit is outlined which, if these Heads are intended to allow for legal abortions, would make abortions legal up to 9 months, which, as outlined below seems contrary to the desires of the Irish people.

Re: Explanatory Notes:

1. It is extremely problematic to propose legislation based on X, a case that heard no medical evidence, when abortion is never necessary to treat any medical condition arising in pregnancy, in particular suicidality. It is clear that for this reason it would make bad law to legislate based on the X case. X based legislation is medically unnecessary, imposes no gestational limit and opens the door for abortion on demand up to birth.
2. The UN has heard expert medical evidence that indiscriminate practice of abortion is significantly correlated with coercion, a history of sexual abuse, violence during pregnancy, intimate partner violence, and with psychological consequences that may lead to suicide. In the light of this research, the proposed Bill would seem extremely retrogressive, ill-advised and unjust
3. Recent interviews and media exposes made very clear to the Irish people that the intention behind X-based legislation is to allow for the introduction of abortion on demand. Article 40.3.3, the 'Pro-Life' amendment, was adopted by a 67% majority in 1983. The European Court of Human Rights has acknowledged that there is no reason to believe that the wishes of the Irish People have changed in this regard.

4. **Point 2** which talks about risk to the life of the mother that can only be averted by the termination of her pregnancy is not valid since abortion is not needed to treat any medical condition arising in pregnancy

[94] Evidence presented at 'Public Policies to Reduce Maternal Mortality' meeting at UN event, March 2013

5. The wording ‘except in emergency circumstances’ is lacking clarity. Who will define the parameters of this and safeguard against possible abuse?

6. Regarding: ‘a termination of pregnancy will most likely be carried out by, or under the care of, an obstetrician/gynaecologist’:

a) Term ‘most likely’ is vague
b) No clause is mentioned here regarding safeguarding the positions of those practitioners, including support staff who, for reasons of conscience, do not want to get involved in performing or providing abortions.

HEAD 3

Regarding the wording of point (1) the same recommendations apply here as in Head 2

HEAD 4

1. As stated in recommendations for Head 2, clear, unequivocal evidence has been presented by medical experts in January during Oireachtas Committee hearings stating that **abortion is not an appropriate treatment for suicidality**:

a) All of the medical experts agreed that abortion is never a treatment for suicide
b) Not a single case was known of by experts where an Irish woman had died by suicide because abortion was not available
c) A woman who is profoundly depressed and mentally ill would be advised **not** to take any major life decision at that time and that abortion was not a treatment for such cases
d) The notion of doing even an emergency abortion here was deemed ‘obsolete’.
e) Evidence was given that women who undergo abortions **are six times more likely** to die by suicide
f) On May 1st 2013, 113 psychiatrists signed a statement saying that legislation, which would allow for abortion as a treatment for threat of suicide, has no basis in medical evidence.

The treatment for suicidality is:

a) Make sure the woman is safe
b) Provide appropriate support, medication and psychological treatment

In the light of this evidence, it is very clear that proceeding with legislation as it is proposed in this Bill is not only nonsensical but seeks to make legal that which endangers women’s health and potentially their

lives. It would also compromise the professionalism of doctors and psychologists since it goes against medical evidence.

The final paragraph of the explanatory notes in this Head, as with the preceding Head is obsolete, since abortion is never needed to treat any medical condition arising during pregnancy

SEAN O SHAUGHNESSY <oshaughnessyglanmire@me.com>
07/05/2013 09:14 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Att: Mr. Paul Kelly - RE: Maternity Bill

Dear Mr. Kelly,

My name is Sean O'Shaughnessy and I wish to make a written submission re new Maternity Bill. I am not a member of any political party or any lobby group, however I do have a very strong objection to the inclusion of suicide in the Maternity Bill.

I am not in favour of any form of legalised abortion under any circumstances as I believe the right to life of the unborn child is of great importance. After all they are the most vulnarable in our society. Abortion is the "deliberate" termination of the life of the unborn child. This can never be acceptable in a civilised society. I do however accept that there are times when the life of the mother is at risk from medical complications and every effort must be made to save both her life and that of her unborn child. The current Medical Council of Ireland guidelines permit medical intervention that allows them to save the mothers life even if this has a secondary effect of resulting in the death of the unborn child. THIS IS NOT ABORTION. As a practising Catholic I understand the churches teaching on this is as outlined above i.e., do everything to save both mother and child without unduely putting the mothers life at risk.

The recent oireachtas committee on this issue heard from many physciatrists and EVERY SINGLE ONE OF THEM stated that abortion is not an appropriate treatment for a pregnant woman with suicidal tendencies. If anything it tends to make matters worse.

I urge the government to remove the suicide clause as it will lead to a very liberal abortion culture as has happened in every other country that has introduced "limited" abortion.

Lets protect both mother and child as best we can. They both have a human right to life.

Sean O'Shaughnessy
Glanmire
Co. Cork

141, Kenora Rd
Clontarf
Dublin 3

8 May 2013

Dear Sir/Madam,

I would like to make a submission for the rejection of the proposed Bill to allow abortion in certain circumstances/on the grounds of suicide in the Human Life Pregnancy Bill as we are dealing with a matter of life and death a free vote should be given. It is grossly unfair that women who have had abortions and who regret their decision cannot make representations to the Oireachtas Committee yet the women who have no regrets are allowed to make representations, why is this so.

The Referendum of over 20 years ago did not give a true picture of the intentions of some of the voters, so the result which it produced was flawed. The Referendum at that time did not give the people a clear choice, Abortion would have been permitted after one month, so quite a percentage of people voted no for this reason. This is a fact and this should not be ignored and in reality what we are presented with now was not the will of the majority of the people at that time, this should be taken into consideration, as it is a matter of life and death. To Do use voting on.

It cannot be denyed that abortion is the direct intentional killing of an unborn human being, it is a cruel and inhumane act, it is the slaughter of the innocents, the treatment which needs to be given to a woman who is pregnant and whose life may be in dangar through illness is a different matter, there is no intention in this situation to intentionally kill the unborn human being.

Hard cases make bad law. In the case of women who may be suicidal, it is not right to take the life of the unborn child at any stage. Both lives are precious, both need to be taken care of. There is no room here for false compassion when lives are at stake two lives should be saved. God's law is above the Constitution. For those who believe in God know in their heart that abortion is gravely wrong and it is a most evil act and know in their conscience that it is actually murder. Only God has the right to take life. Those who do not believe in God have no right to take life either. We are all God's Children and should love one another so I am appealing to non believers to respect life also and appeal to them also to reject this Bill. Yours faithfully

Emailed submission already sent. — this is the original signatures

For the attention of Mr Paul Kelly, Principal Clerk, Joint Committee on Health and Children:

In response to your open invitation for concise written submissions on the Protection of Life during Pregnancy Bill 2013:

We, the undersigned second level teachers wish to formally reject the proposal that abortion should be legalised for mothers who feel suicidal, as it is morally wrong.

The principle which underlies this strategy assumes that the suicidal mother has the right to terminate the life of the child in her womb. Suicidal feelings can never be presented as the reason for justifying the taking of the life of another person regardless of that person's stage of development. Is it not true that we would all be appalled if a law was made to allow suicidal persons to kill their senile parents or any others who were totally dependent on them for survival? Yet the proposed legislation is built upon this very principle!

We reject this proposal as being totally unacceptable and we believe that our laws should protect the right to life of all persons regardless of age or stage of development.

Signed

Geraldine McGee
John Lynch
Michael McGroarke
Paula Garvey.
Brenda Crawford
Sue Mac Bride
Sean MacEoin

Elizabeth McGrory
Lisa Fitzsimons
Margaret O'Connor.
Ly McFadden
Michelle Coyle

POSTAL ADDRESS:
LORETO COMMUNITY SCHOOL
MILFORD
LETTERKENNY,
CO. DONEGAL.

EMAIL ADDRESS
careers@loretomilford.com

For the attention of Mr Paul Kelly, Principal Clerk, Joint Committee on Health and Children:

In response to your open invitation for concise written submissions on the Protection of Life during Pregnancy Bill 2013:

We, the undersigned second level students wish to formally reject the proposal that abortion should be legalised for mothers who feel suicidal, as it is morally wrong.

The principle which underlies this strategy assumes that the suicidal mother has the right to terminate the life of the child in her womb. Suicidal feelings can never be presented as the reason for justifying the taking of the life of another person regardless of that person's stage of development. Is it not true that we would all be appalled if a law was made to allow suicidal persons to kill their senile parents or any others who were totally dependent on them for survival? Yet the proposed legislation is built upon this very principle!

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Signed

Clodagh Mc Gee
Robert Mc Grath
lisa moore
Margaret -Ann Gallagher.
Orla McAteer

POSTAL ADDRESS
LORETO COMMUNITY SCHOOL
MILFORD
LETTERKENNY
CO. DONEGAL

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We reject this proposal as being totally unacceptable and we believe that our laws should protect the right to life of all persons regardless of age or stage of development.

Signed

David Edwards
Poppy Carney
[illegible]
[illegible]
Nicole McFadden
Patrick Harpur
Ciara Murray
Chloe Boyce
Shannon Shields
Ciarán Mc Tenyue
Eimear Stewart
Shannon Durning
Aisling Mc Dermott
Lorna Ryper
Feather Dougherty.

Siobhan O Sullivan <siobhanosullivan1@gmail.com>
08/05/2013 01.49 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
new maternity bill

I am very disappointed with the recently proposed maternity bill. The bill represents a drastic change to Irish law whereby the government wants to legalise abortion in Ireland on suicide grounds. This apparently would apply throughout all 9 months of pregnancy. For the first time in our Irish history it would become lawful to deliberately and intentionally kill an unborn child. The government seem to be ignoring the facts as our experts have told us - that abortion hurts women and is not a treatment for suicide. The Irish people have already voted by referendum saying No to Abortion. Our country is supposed to be a democracy whereby we the public are its legislators. Speaking on behalf of myself, my family and the majority of the Irish people young and old - we do not want abortion in our country, we value both the lives of mothers and their unborn children. As it is well known in Ireland and abroad, Ireland is the safest place for a pregnant mother and her unborn child. There is no need or requirement whatsoever to introduce abortion to our country.

Sr. Consilio Fitzgerald, Director, Cuan Mhuire, Athy, Co. Kildare

Summary of Submission to the Health Committee on Protection of Life During Pregnancy Bill 2013

Many of the distressed women that came to Cuan Mhuire, over the past 50 years, came because they were suffering distress having undergone an abortion. Our mission at Cuan Mhuire is to help them understand their own goodness and their infinite value before God. They tell us of the difficulties they encountered at the time of their decisions. Despite all of our support and encouragement to help them rebuild their lives and relationships, many find it exceedingly difficult – almost impossible to cope with their sense of loss.

It has long been accepted practice in Ireland that there are rare occasions where intervention may be necessary to save a mother's life. This sometimes results in the unintended death of the child. This causes deep grief for the parents but mothers intuitively understand the reasons and may come to accept them.

The Government seeks to make abortion available in Ireland on the grounds of a 'threat of suicide'. Medical and psychiatric evidence does not indicate abortion as an appropriate treatment for suicidal tendencies. In my experience abortion has never proved to be the appropriate response to the threat of a suicide. On the other hand we have helped many, many women that had abortions and had subsequently developed suicidal tendencies. Many of those women did not really understand the consequences of an abortion and the devastation it causes. They needed love and care and non-judgmental support.

We – all of us – will have to live with our conscience if we allow, or acquiesce, in the enactment of this legislation. It is for this reason that all political representatives should be free to follow their individual conscience in deciding how to vote. Our medical, nursing and midwifery professions are central to the values, loving culture and quality of our society. They have long protected the right of an unborn child to live and fulfil God's plan. Let us recall the words of Christ: "What does a prophet a man to gain the whole world and lose his soul".

I am writing this letter – the first such letter I have ever written – in defence of the unborn child and the welfare of the mother. Also, I will know on my death bed that I have done all that I can to speak out on their behalf and on behalf of so many more were such legislation to be enacted in our name by our political representatives.

Re: PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013 – REQUEST FOR SUBMISSIONS

Introduction.

Having read the Protection of Life During Pregnancy (Heads of) Bill 2013, I am writing to you as a a soon to be Father for the Third time, Catholic and someone with a legal background with very serious concerns over the legislation whose child is due in October 2013. I am a proud Irish Citizen and the father of two young children. I am not a member of any political party or organisation. My observations and recommendations are as follows:

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

Issue: Catholic Hospitals

1.Inclusion of suicide and its effects on ethos in hospitals

The inclusion of suicide will effectively mean the targeting of the innocent and vulnerable child for the first time. This is at odds with not just Catholic teaching but basic human rights. As a father of two young children, with a third on the way, it is extremely distressing to read that Catholic hospitals (and those under a Catholic charter) will be forced to carry out abortions.

2. Monitoring and Policing of Doctors and Psychiatrists

a) What mechanism will there be to repeal the legislation, once as many of us suspect that this will open the floodgates to abortion on demand?

b) What reassurances from politician's will the public be given that pro-choice lobby groups won't look for another referendum once this legislation gets railroaded through.

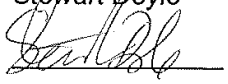
Recommendation:

Hospitals and any hospital with a Catholic charter should be allowed to opt out of having to perform abortions. Secondly if the monitoring of abortion umber s becomes too high, doctors should be named if they abuse the system and the legislation should fall away.

Thanking you in advance

Yours sincerely

Stewart Doyle



Stewart Doyle

Stuart McGovern <stumcgov@hotmail.com>
08/05/2013 11:04 To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Human life in pregnancy

Dear Paul,
I can understand why this issue is a contentious one since those who are against it feel they are defending life and those who are proposing it believe something similar.

My own concern on the issue is based on the evidence given. To date I have seen no evidence to suggest that abortion is a remedy for suicidal tendencies.

I fail to understand how the government is still going ahead with the proposed legislation when the evidence to date has been so comprehensive. I don't think there is any person on either side who want to see any more maternal deaths and I am very encouraging of clear guidelines for the medical profession in this regard.

When proof is given from a number of experts and is then blindly ignored, it's hard to understand on what grounds is this legislation being proposed.

For the record I concur with the experts that abortion is not a treatment for suicidality and I hope that the current legislation is not passed for the sake of the protection of women and the unborn child.

Ireland rates so highly in maternal health at present, I wouldn't like to see the great work of the medical profession being compromised by flawed legislation.

Kind regards,
Stuart McGovern.

"Dillon, Susan" <sdillon@revenue.ie>
08/05/2013 04.58 p.m. To
"'healthandchildren@oireachtas.ie'" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Re: Protection of Life during Pregnancy Bill 2013

Dear Mr. Kelly,

I am a 33 year old Irish woman and I would like my voice to be heard on the draft legislation dated 30/04/2013 entitled "Protection of Life during Pregnancy Bill 2013". I have read the Bill and I would plead with the Government for the sake of our future generations Not to legislate for abortion under any circumstances. I am proud to say I live in a country where abortion ie. the direct and intentional killing of an unborn child is illegal. I would ask the Governement to please listen to the Medical Experts who have told them in the Joint Committee on Health and Children, Tuesday 8 January 2013 that abortion is never a medical treatment to save the life of the mother. I would also ask the governement to listen to the advice that a life saving treatment to save the life of the mother which may unintentionally result in the death of her unborn child is completely different to abortion which is the direct and intentional killing of an unborn child.

As Head 4 deals with "The Risk of Loss of Life from Self-destruction" and focuses on implementing this legislation on the grounds of the X case I ask the governement to again please consider the fact that the X case outcome was based on the absence of hearings from medical experts in Obstetrics and Gynaecology and we now know that to now legislate for abortion on the grounds of the X case would be on the grounds of a medically false assumption.

Let's keep Ireland a safe place for a woman to have a baby and not base our legislation on medcially false assumptions.

Yours sincerly,

Susan Dillon
no. 16 Riverstown,
Glanmire,
Co. Cork.

087 2414635

suzanne mahon <suzanne.mahon@gmail.com>
08/05/2013 02.45 p.m. To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Keep Ireland abortion free

To whom it may concern,
I am deeply concerned about the recent draft legislation for the Protection of Life during Pregnancy bill. It ignores expert medical evidence demonstrating that abortion is no cure for suicidal ideation. Psychiatric experts testified to the government's committee that abortion is not a suitable treatment for suicidal ideation and only last week 113 Irish psychiatrists signed a statement saying they are "deeply concerned" about the governments' plans to legislate for suicidality as grounds for abortion.
As you well know, within this bill, there are no restrictions on gestational age limits, which would allow abortions to be carried out through all nine months of pregnancy. Doctors could act directly to end the life of the child, based only on a demand for abortion backed up by a threat of suicide.
The bill says that it "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."
There are plenty of women who have suffered the trauma of abortions and want to speak up to prevent others from repeating the experience. At what point will they have the chance to speak up and share their stories? All the evidence is not being considered.
I do not wish to see abortion introduced to Ireland, regardless of restrictions or conditions. Keep Ireland abortion free.

Yours sincerely
Suzanne Mahon

From: terry 35 [tarlach35@eircom.net]
Sent: 07/05/2013 22:04 CET
To: Paul Kelly
Cc: Jerry Buttimer; "catherine.byrne@oireachta.ie" <catherine.byrne@oireachta.ie>; Ciara Conway; Regina Doherty; Robert Dowds; Peter FitzPatrick; Seamus Healy; Billy Kelleher; Eamon Maloney; "mattie.magrath@oireachtas.ie" <mattie.magrath@oireachtas.ie>; Sandra McLellan; Mary Mitchell OConnor; Denis Naughten; OCaolain; Robert Troy; Colm Burke; John Crown; "john.golroy@oireachtas.ie" <john.golroy@oireachtas.ie>; Imelda Henry; Marc MacSharry; Jillian VanTurnhout
Subject: the protection of the life of the mother

A chara

I am writing to you about the current bill referring to the protection of the pregnant mother.

I wish to make the following comments regarding the bill.

Specifically these are:

1. There is no reference to the recent change to the constitution on the rights of the child.
2. There seems to be no cognisance taken to the equal right to life of the child. Who is going to act for the child that is to be killed (this is what is actually happening, whatever weasel words are used to describe the procedure).
3. In allowing suicide as a reason for an abortion there is no limit on the time an abortion can be performed. It seems to me that the decision of the Supreme Court would allow abortion right up to the day of delivery, if the mother insisted on her "right" to an abortion due to suicidal tenancies.
4. No reference has been made to the rights of the father in this area. The father of the child must be some rights in the matter.
5. Experience has shown that once the "door is open" whatever safeguards are introduced, and no matter what the good intentions are, sooner or later there will be few, if any, restrictions to abortion.

I appreciate the fact that this is a very contentious issue, and any decision is likely to be fraught with difficulty.
Because of the way in which society is moving/has moved, there will always be problems in this area.

I am not happy about the way in which the government has put the onus on a "non-participating " psychiatrist to find a replacement if he /she is not prepared – in conscience , or otherwise– to take part in the decision making. Finding a replacement should be a matter for the government, as they are introducing the system, but they/you do not seem to have the courage to make their own decisions.

In my opinion, one of the greatest faults in democracy is the whip system. I would like to see legislation outlawing the whip system.
To think that a few people in government can insist that all of the party should vote in any particular way (and thereby force a decision) is, in my view, a debasement of democracy, and shows how little courage/backbone the majority of members have; how frightened they are of the rulers of the

party; how easily their convictions can be traduced by a few “leaders” Particularly in matters of conscience/social affairs, which I consider this matter to be, there should always be a “free” vote, and even if there is not a free vote, members should have the courage to vote as they feel, and not as they have been ordered!

It now seems that the decision of the Supreme Court twenty years ago may have been based on inadequate foundations, and it also seems that the weight of evidence now is that abortion is no remedy for suicide.
I understand that this aspect of "remedy" was not considered when the Supreme Court originally made their judgement.
Perhaps it is time to ask the Supreme Court to reconsider the matter in the light of developments since they first gave a judgement on the matter.

However I am of the opinion that if the life of the mother can be saved only by a termination then this is what should be legislated for.

Perhaps the way in which the legislation has been drawn up is too cumbersome/complicated.
Maybe a better way would be to provide legislation which would give the medical profession “permission” to terminate a pregnancy when the life of the mother could be saved only by such a procedure. While this might be somewhat removed from the X case, it would be a truer reflection on reality.
However, there would have to be safeguards to ensure that the “permission” was not abused.

le meas

tarlach o'donnchadha.
baile atha cliath 13.

"Terry O Neill" <teranceoneill@eircom.net>
08/05/2013 05.04 p.m. To
<healthandchildren@oireachtas.ie>
cc

bcc

Subject
PROPOSED LEGISLATION

Dear Paul Kelly,
With absolute bewilderment at the government's proposal to legislate for abortion, I herewith register my total and unequivocal opposition to this proposal.
I grew up with the belief that concepts like truth, honor, integrity and justice stood for something. I also naively believed that Fine Gael represented the honest, decent, moral backbone of this country. I am dumbfounded that the Government is insanely pushing for abortion, even after the most respected and uncontestable medical evidence has been submitted by the top professional medical experts and psychiatrists in the country. The Government leaders appear to be acting as though they have somehow acquired medical qualifications higher than these highly respected doctors and psychiatrists.
As a person who was adopted as a baby, and given a chance to have lived my life , I am asking the Government to reconsider its position on abortion and keep this dark horrible Industry
 from taking up residence in this country.
Please take this seriously, the people of Ireland do not want abortion in this country.

Yours sincerely,
Terence O Neill

"Tess & Dave Casey" <tessanddave@eircom.net>
08/05/2013 03.41 p.m. To
<healthandchildren@oireachtas.ie>
cc

bcc

Subject
Abortion Legislation

Mr. Paul Kelly

I wish to convey my absolute opposition to the proposed maternal health bill, for a variety of reasons, but in particular the fact that it proposes to legislate for abortion in the case of threatened suicide. There is no evidence to show that abortion is ever beneficial in the treatment of women with mental health problems. On the contrary , it is associated with increased risk of mental health problems- it has been shown to aggravate suicidal ideation and precipitate depression, post-traumatic stress disorder, self-abuse, addictions, etc. Thus we have over 100 psychiatrists stating their opposition to the proposal that they be involved in certifying a womans need for abortion , as this would be asking them to abandon best practice, ie evidence -based medicine.

This is an obvious means of introducing abortion on a wide scale, and it is pointless to deny that this will be the outcome .
International experience shows that provision for abortion on the grounds of mental health will be abused.
This bill is not only about the protection of life, it is about putting into law the right to kill innocent human beings , principally because they pose an inconvenience . And of course , they have no voice.

This is a horrific abuse of the inviolable right to life which the unborn share with the rest of humanity and is enshrined in our Constitution. The Oireachtas has the prerogative of not legislating for a Supreme Court decision if it believes it would be harmful to do so.

This proposed legislation is not necessary for the protection of maternal health and wellbeing in pregnancy and childbirth. The clarity , as requested by the European Court judgement, could be provided by providing guidlines to re-affirm that women would receive all necessary life saving treatments in pregnancy, whilst also requiring that we exercise a duty of care to the unborn.

The legislators have no mandate to abolish sections 58 and 59 of the Offences Against The Person Act.
Abortion is and should remain a criminal offence.

As a midwife , I am gravely concerned on the limited concientious objection rights for doctors and none for healthcare institutions with a pro-life ethos. Furthermore , it is very worrying that there has been no mention of time limits. Why is this ? Of course, it is to allow for late term abortion.

I am intensely disappointed that the Taoiseach has led us to this point. He has betrayed the voters on a life and death issue.

I hope that this bill does NOT get the support it needs to be inserted into the constitution.

Thank you ,
Teresa Casey

COVER PAGE

Teresa McDonnell

To Paul Kelly
Principal Clerk
E Mail: healthandchildren@oireachtas.ie

Submission to Protection of Life During Pregnancy Bill

Point No 1.

The direct killing of anyone even the unborn is an unjust law in my opinion.

Point No 2.

I agree with Guidelines for Medical Practitioners' without changing the law.

Point No 3.

Suicidality is now proven to be a non-issue as it is so rare.

Point No 4.

My personal story

Page 1.

Point No 1.
When the Internet can give us so much information on the development of the baby in the womb and also so much information on how abortion happens I cannot comprehend how anyone can agree to having a baby pulled limb from limb, or injected with a poison to kill him in the womb, can be seen as anything other than barbaric.
When slavery was popular many couldn't see the harm it really was. The slave's records were kept in the same place as the live stock. It was regularly discussed over dinner whether they had a soul or not.
It took one man who was involved in the slave trade for his conscience to be enlightened and with the help of another man to stand up in the English Parliament to speak against slavery. It took them such a long time to get the law changed.
We would all agree that what Hitler did was so wrong.
Before him Margaret Sanger in the 1920's in America had his ideas.
She had a target for the poor, the black people with the result there are now more abortion clinics in black neighborhoods than anywhere else. I am not sure if black in the politically correct name.
I apologise if it is not.
All this is easily researched.
We can think we are in the enlightened age but we still make major mistakes and each age has its own mistakes.
Abortion in the world today is our great mistake.
Women have also died on the abortion tables, but that seems to be overlooked.

Page 2

Point No 2.

Guidelines for Medical Practitioners' made by themselves and not lobby groups. Guidelines instead of changing our now Just law.

Point No 3

Risk of suicide. Suicidality is now proven to be a non-issue as it is so rare. There is plenty of evidence of suicide after abortions but due to shame and secrecy the true figures are hard to quantify.
Our suicide numbers are very high at the moment and rising.
At one time we had very low figures and it was genuinely low even though at that time the Coroner may not have put direct suicide on the Death Certificate. The numbers were low for Ireland compared to other countries. Unfortunately this is not the case now.
Any form of killing causes more killing. Killing the unborn is not the answer. A better answer has to be found for all our citizens born and unborn.
Abortion is the direct killing of the unborn.
The dictionary says Abortion…The expulsion of a fetus prematurely.
Expulsion …..the act of expelling: forcible ejection.
So when I say killing this explains it.
In common sense terms how can getting rid of a baby help the mother?
Some would like to say blob of tissue or cells. Well if left alone it will become a baby.
A tadpole does not look like a frog but if left alone it will become a frog.

Page 3

Point No 4.

My husband took his own life and all our family had to deal with the aftermath. We leave a body behind that has to be dealt with. I found his body and that makes it even more traumatic.
Horrific death takes a long time to overcome. It takes a longer time to come out of denial.
Relationships are strained to near breaking point especially with the in laws and his relatives. The shame hits and also the anger at self and others who would have been involved.
It took nine years for me to face what had happened.
Then I began helping others who had a suicide in their family.

These feeling are very similar to women who have had abortions.
The day it dawns on a woman that she has taken a life is a very, very sad day for her and also anyone near her. She can deny it even for thirty or forty years but when that day dawns she is dealing with the death of her child.

I can see in the future that women may get brave enough to speak out, which is now happening in America and also the men are.
I can see the governments being taken to court for the cruelty being allowed to happen to their bodies.
I am not against women but I am for women wholeheartedly and also for babies. Society needs to care for both the woman and the baby and the man in the situation.

I know women who have had abortions and their lives have never taken off. Some still on medication and attending mental hospital which increased with time.
Even this issue has brought up the abortion they had and it is causing distress to them in secret.
Some women say they ‘never regret it’ and ‘it was the best choice they made.’ That is until that day dawns and they realize what really happened.

I have dealt with death by suicide and it’s not a pretty sight. However I could never agree that abortion is a solution for suicide. More than anyone I would never want a suicide to happen but killing the unborn is never the solution.

Sincerely yours,
Teresa McDonnell

If you want to print this please keep my address, e mail and phone number out of any article.

The Immaculate Heart House of Prayer <doonhop@gmail.com>
08/05/2013 13:15 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Human Life in Pregnancy Bill

The Association of the Way of the Immaculate Heart
Gurtavalla South, Doon, Co. Limerick

Dear Mr. Kelly,
On behalf of the Association, we wish to state our opposition to this Human Life in Pregnancy Bill. The Taoiseach has already stated that this bill doesn't change Irish Laws or Pro Life stance, if that is so why is the Government rushing through with this Bill?
The vast majority of Doctors and indeed many psychiatrists have already pointed out that abortion is not a treatment for suicidal ideation. Why then is the proceeding legislate for something which is treatable.
Thanking you,
Teresa Tier
Secretary for the Association of the Way of the Immaculate Heart.

Submission by TFMR Ireland To the Joint Committee on Health and Children

Regarding the Protection of Life During Pregnancy Bill 2013

Introduction:

TFMR Ireland is a group comprised of couples who have joined together for one harrowing reason. Our babies were all diagnosed with having fatal foetal abnormalities, and we were told by Irish medical professionals that our much wanted babies would not survive outside the womb. We were then told that there was nothing more that the hospitals could do for us. Our only option in Ireland was to carry on with the pregnancy, and await the day when either our baby will die inside the womb, or give birth to a baby that will die upon birth. Some of these medical conditions our babies had, such as anencephaly, carry physical health risks to the mother if the pregnancy is carried on, yet the medical profession in Ireland are unable to offer any option in any circumstances for the interruption of a doomed pregnancy due to the current legal framework.

Lethal diagnosis in pregnancy is affecting approximately two per cent of Irelands 74,000 live births which means 1,480 mothers per year are given a lethal diagnosis. (Prof. Joan Lalor, Trinity) This is not an insignificant number, and it certainly isn't insignificant when you are one of those unlucky persons facing such a diagnosis for your much wanted baby. Unfortunately the hospitals do not keep, and are not asked to keep a record how many couples in this situation chose to terminate the pregnancy. Anecdotally it has been reported that one to two Irish couples per week visit Liverpool Women's Hospital for medical terminations in cases of fatal conditions, and this is only one medical centre where couples in such a situation would turn. Fatal foetal diagnosis in pregnancy should be seen and treated for what it is, a medical issue, one in which each couple should be given the dignity and respect to make a decision as to whether or not to continue the pregnancy with the full support of their medical team. It is through the advancement of Foetal Medical Science that such diagnosis are even possible, but with such advances comes the very real impact of receiving such a diagnosis on the parents, and this is where we feel the law is lagging behind medical advances.

Our group has been advocating for over a year now for change on this issue, and countless politicians have expressed their sympathy and agreed that the legal situation should be changed to allow for a more humane treatment of couples who face this horrific situation. While we are grateful for the sympathy and understanding extended by lawmakers, what we require from them now is that they act to ensure the change in legislation will allow the full range of treatment options be available to couples who face this devastating situation in Ireland. We feel there is scope to do this without a constitutional change, and indeed Ireland argued the very same before the European Court of Human Rights in the D Case in 2006.

With this proposed legislation, the Irish Government now finally have the opportunity to rectify a wrong that has been allowed to continue for far too long. Every couple affected by this is one more too many. Nothing could have changed the fact that we were going to lose our cherished babies, but something can be done now to ensure that couples in the future do not face the added cruelty, indignity and trauma of having to leave Ireland to receive the treatment that should be available to them here. We feel that our voices must be heard as a part of the process of formulating this Bill.

Executive Summary:

TFMR Ireland's position is that the individual choice of whether to carry on with a pregnancy or to interrupt early in cases of a fatal diagnosis must lie with the parents, in consultation with a supportive and unbiased medical staff. We are the ones facing the loss of a much wanted baby. As such, those who find themselves in this tragic situation must be offered a full range of options and supports in Ireland. Forcing those who opt for a medical termination to leave Ireland for medical treatment unnecessarily compounds an already unbearable trauma. There is now scope within the current drafting of legislation to allow for the option of termination in cases of fatal foetal diagnosis.

It is our view that in years to come, especially if legislators do not take this opportunity, it could be years before the matter is legally resolved, and Ireland will look back in shame that this situation was allowed to continue for so long after so many had brought it to lawmakers attention.

Recommendation:

Regarding Head 1 Interpretations as outlined in page 3 of the act:

Recommendation: That the definition of the unborn specify the unborn as "viable and compatible with life" This would allow medical practitioners in Ireland to afford the the option of a medical termination or early induction in cases where there was a fatal diagnosis.

Submission:

As the law stands in Ireland today, losing a baby diagnosed with a fatal abnormality is compounded into a loss coupled with a breach of parents' basic human rights, which amounts to inhuman or degrading treatment. Across Ireland families are being let down by the medical services who are restricted by outdated Irish law.

With the proposed bill setting out for the first time a definition of the 'unborn' there is scope within the existing provisions of article 40.3.3 of the Constitution to bear an interpretation that fatal foetal abnormalities do not engage the equal constitute a 'viable' pregnancy. Put plainly, the right to life of the unborn is not engaged in cases where a pregnancy is diagnosed 'incompatible with life'. The Irish government itself argued in the D case which was before the ECHR in 2006 that it was possible to allow for termination in these cases without a constitutional change.

The fact it our babies were sadly never going to live, so how our cases even fall within the scope of these outdated laws is striking in its cruelty as well as its lack of logic.

We are asking the government to right this wrong which has been allowed to continue far too long already. Before another couple has to make that horrific journey, away from family, friends and medical support at the hour of their greatest need of support.

Submitted electronically on 8/05/2013

TFMR Ireland

By: Ruth Bowie Arlette Lyons

James Burke Amanda Mellet

Any legislation on the protection of human life which concerns an expectant mother and her child needs to consider the following goods:

1. The good of life; the lives protected by the Irish Constitution are the lives of both an expectant mother and her unborn child.
2. The good of medicine
3. The common good

The good of life concerns the life of the mother and the life of her child. Both an expectant mother and her child are unique persons, with inviolable dignity, and deserving of the protection of the law. For most Irish people, the dignity of the human person is discovered and experienced through both a religious sense and human reason. These are aspects of human existence, a search for a more than human source of meaning and the desire to know (see Plato, Aristotle, Augustine, Finnis). These two aspects of our existence, the religious sense and the work of reason, are evident in the Irish Constitution, particularly in its preamble, which acknowledges the destiny of the human being. This destiny is, in a sense, part of the book which is the Constitution; the law of our land recognises this as a basic part of human life. This destiny precedes it but the Constitution acknowledges it.

Just as the destiny of the human being is acknowledged by the Constitution, the good of life is acknowledged by the Irish Constitution. The good of human life precedes the Irish Constitution. The Constitution was adopted in 1937 and operated from 1938 but the good of life was something which preceded that date. The law was simply acknowledging something inherent in the human being when it acknowledged in Article 40 the right to life (see Article 40.3. of the Irish Constitution).

Positive law then seeks to ensure that aspects of human well being are respected and vindicated. For instance, laws about defamation seek to protect the reputation of a human being from being unfairly injured and ensure some measure of compensation when someone is slandered or defamed.

Positive laws protecting human life are intended to ensure that people act in such a way that they do not deliberately injure human life. They are intended to ensure that human beings can flourish. Laws prohibiting any

intentional killing of the innocent also serve to foster human equality; we are all equal before the law. No one is master of the life of another; laws prohibiting the deliberate and intentional killing of the innocent serve to remind us of this fact and to ensure that one person does not think himself or herself entitled to take the life of another. Laws serve not only to remind us but also to ensure that wayward and disrespectful attitudes and actions by the strong do not overwhelm the weak and the vulnerable.

It is possible to describe the good of life in greater detail. Professor John Finnis has articulated this good in such works as *Natural Law and Natural Rights* (Oxford: Oxford University Press, 2012). It means 'organic or bodily existence, its preservation, prolongation and transmission. It is the opposite of death, decay and sterility'.[i] In the ordinary course of events, that is in most cases, expectant mothers and their babies are looked after by their family, their friends, their doctors and nurses, and their lives are protected. There is a regular and normal functioning of human bodily life; there may be moments of anxiety but there is no crisis affecting either mother or child whether in the course of a woman's pregnancy or immediately after.

The *X* case (1992) concerned a situation in which there was a grave crisis, involving the rape of a teenage girl. Justice Declan Costello described the circumstances of the case as 'highly distressing and deeply disturbing'. Notwithstanding the circumstances, the decision made by the Supreme Court did not take adequate account of the fact that the State is impartial between lives. It is the guardian of the common good. It has a duty to protect the innocent. An unborn child is entitled to the protection of the law whatever the circumstances in which he or she was conceived. The child bears no responsibility for this.

Ms. Ann Power SC spoke to a previous Oireachtas committee about this.

"The first thing that must be said is that when a woman has been subjected to such horrendous violence and such a horrendous crime it is imperative upon every member of society to support her in whatever way they can … However, one must remember that if conception has taken place, we are now dealing with two human beings to whom the same right, to whom the same duty must be discharged. As a nonovulant, if contraception is actually administered so as to prevent ovulation, I think, in those

circumstances, clearly we are not dealing with two lives, we are dealing with one woman's life and the possibility of preventing ovulation. Where in circumstances it is established, and it can be established, I believe, that ovulation has occurred, then, I think, in those circumstances, reason requires that we deal with both human beings in exactly the same way". (Fifth Progress Report, Abortion, GPO, 2000)

How this actually works out in practice was addressed in some detail in an exchange reported in the same volume between Michael Mc Dowell SC and Ann Power SC:-

Ms. Power: I am saying the State should reflect what reason discloses as wrong and I think that every human being appreciates the value of life, that life, in itself, has a basic value – as is knowledge, as is friendship, as is play, as is sociability. These are basic values and to act to destroy a basic value is always contrary to reason so I am not saying the State should impose the particular teachings of a particular Church, I am saying the State should sit down and should ask itself: 'What does reason require in these circumstances?', and it if is unreasonable to deliberately and intentionally destroy a basic value, destroy a basic good, a self-evident good, a good that we all grasp intuitively, I think in those circumstances, if reason discloses that that is so, our laws must reflect reason.
Deputy McDowell: I cannot see that very many women would consider it always reasonable not to have an abortion in circumstances where they have just been raped. Many women would consider that a perfectly reasonable thing to do.
Ms. Power: I think sometimes, I am sure you will appreciate, that when we are in difficult situations indeed our reason does not always take pride of place or does not always hold sway. If I lose my temper, I may do something through a crisis that my reason would say 'No'. If I were to think about it in the cold light of day, you know, I would not do that. Now I think of course it is understandable a person.
Deputy McDowell: So this is an objective form of reason
Ms Power: No, I think in a crisis situation a person may well do something which his or her reasons would disclose to be unreasonable. Having said that, I think that the
obligation on the State is to look at matters in the cold light of day. The State is not in a crisis, the State must, of course, support somebody who finds herself or, indeed, himself, as the father of the child, in crisis. But, at the end of the day, in drafting the law, the law must reflect the

requirement of reason and cannot concede that, because at times we do things that may be unreasonable – very understandably as a result of crisis or highly emotional states – but that, in itself, can't become the prevailing law ... that reason must always be reflected in the documents. Because, at the end of the day, the law must be a reflection of what is reasonable in all the circumstances.

Deputy McDowell: As the Church teaches it, it's a straightforward black and white issue. For many women who might, perhaps, just be pregnant three, four, five weeks or a little bit longer who have been raped, they don't see it as being black and white. I'm not sure that the State should intervene to say that it is black and white because most of our citizens don't believe it's black and white either. People who are not themselves in that traumatic situation would, I think, easily empathise with the situation of somebody who is or somebody whose child is in that position. That's where I have difficulty with the black and white approach to it, and certainly with the approach which comes very much from the top down in terms of constitutional law, presumably – or obviously – reflected statute law.

Ms Power: Again, with respect, I wouldn't see it in terms of black and white. I don't see it in terms of black and white, but I do see the requirements of reason ... of what's reasonable in all the circumstances as being clear. I think it's always contrary to reason to arbitrarily make a distinction between people. To make an arbitrary distinction and prefer one life over another must be contrary to reason. If it's your life that I'm promoting but it's this person's life that I'm denigrating or reducing, I mean, I think this person is equally entitled to say 'It's irrational to arbitrarily exclude me from the picture'. So, I think it's always unreasonable to deliberately destroy basic value or to make arbitrary preference amongst persons. I think the requirement there is to ask ourselves 'What is reasonable in all the circumstances?'.

Deputy McDowell: I am not sure that we're going to get a meeting of minds.

Ms Power: Probably not.

Reason can see why it is not permissible to distinguish between innocent lives. The State is the guardian of the common good and it is not open to the State to decide that it is permissible to permit or to facilitate the intentional and deliberate attack on the life of an innocent human being at the expense of another. This is the position of the *X* case. The decision is plainly wrong.

The State is impartial between lives. The reason the State is impartial between lives is that there is fundamental human equality between all human beings, at whatever stage of existence. Traditionally, this is recognised by common law:-

"The common law is distinguished, and is to be commended, for its all-embracing and salutary solicitude for the sacredness of human life and the personal safety of every human being. This protecting, paternal care, enveloping every individual like the air he breathes, not only extends to persons actually born, but, for some purposes, to infants in ventre sa mere. The right to life and to personal safety is not only sacred in the estimation of the common law, but it is inalienable.

The common law stands as a general guardian holding its aegis to protect the life of all. Any theory which robs the law of this salutary power is not likely to meet with favour". (Supreme Court of Iowa).[ii]

The humanity of the child cannot be obscured, no matter the circumstances of its coming into the world. Anthony Fisher OP comments on how this is supported by reason.[iii]

The embryo is a genetically new human life organised as a distinct entity oriented towards further development as a biologically individuated member
of the human species... It commands such a degree of respect as to prohibit
destructive non-therapeutic experimentation.

- Australian Senate Committee on Human Embryo Experimentation (1986)1

From a biological point of view, there is no argument as to when life begins. Evidence was given to us by eminent scientists from all over the

world. None of them suggested that human life begins at any time other than
conception.

- New Zealand Royal Commission on Abortion etc. (1974)

Indeed, it is worth noting that Justice Hamilton was of the view that the current Offences Against the Person, Act, protected human life from the moment of conception.[iv] From that moment, the moment of conception, the child is entitled to be protected from unjust attack and defended against any lethal assault.

In terms of the Irish Constitution, reason and the religious sense it recognises lend support to the view that "the issue of life and its defence and promotion is not a concern of Christians alone. Although faith provides special light and strength, this question arises in every human conscience which seeks the truth and which cares about the future of humanity. Life certainly has a sacred and religious value, but in no way is that value a concern only of believers. The value at stake is one which every human being can grasp by the light of reason; thus it necessarily concerns everyone". *Evangelium Vitae*, § 101, par. 2 (emphasis in original)

Deliberate lethal action against a human being from the moment of conception is forbidden by the inviolable nature of the good of human life and the fact of human equality. The Supreme Court in the *X* case permitted the deliberate killing of an innocent human being. It also ignored the fundamental equality of all human beings which the 8th amendment articulated. For this reason, it is not an acceptable starting point for any legislation.

The Good of Medicine

The task of medicine is to protect life and health. The Hippocratic Oath and primary rules such as *Primum non Nocere* (First Do No Harm) are indicative of the task of protecting health and life. As John M. Dolan has observed, it is a flawed reasoning that would encourage doctors to

become involved in abortion, practising deliberate and intentional attacks on unborn children. It would be contrary to their ethos. He wrote:-

"The fact that doctors have technical skills that could, theoretically, enable them to kill people is a poor candidate as an explication. It would be a mistake to expect physicians to be especially good at killing; the task conflicts too radically with their pledged aim". [v]

To facilitate collegial structures, as the present bill does, which would involve healers in such practices would seem to be inimical to the practice of medicine.

Professor Kevin Malone's point made in his January submission touched on some other worrying concerns about the suicide risk a ground for abortion:- "Whilst the field of clinical assessment of "suicidality" in psychiatry has considerably
advanced over the past 2 decades (more-so in research than clinical practice), it has not reached any kind of validity and reliability in relation to predicting suicide as an outcome that could honestly satisfy the certainty demanded by the proposed legislation. To believe otherwise is to ignore the research evidence to date, and we educate our medical students on evidence-based research and practice. Legislation for Ireland should also draw on an evidence-based approach" and his observation that "it would be regrettable and perhaps unethical if legislation on "suicidality" were to potentially compromise the therapeutic alliance between psychiatrist and patient. Extreme caution is advised in terms of un-informed or mis-informed legislation generating unintended consequences".

The health system is not helped by uninformed and misinformed legislation made under consideration of time pressure. The X case and the bill of the Government fail to respect the ethos of medicine and would work to undermine and corrupt it in our hospitals.

The Common Good

The Constitution is a document aimed at securing the common good. This means the flourishing of individuals who are part of a community. The basic community is the family; a basic relationship in the family is between the mother and her children. This is a relationship which begins before birth. It is a mutual relationship, between two human beings, who are called to love each other. If the law permits the deliberate and intentional attack on the

good of human life of an unborn child, it is not possible to see how this can contribute to the common good. The State has a legitimate interest in prohibiting abortion for this reason.
In terms of the medical profession, a law permitting abortion would betray the ethos built up over centuries in our health systems and hospitals. Doctors would be asked to use their skills for purposes against the fundamental ethos of medicine. Cherish them both, mother and child.

[1]Anthony Fisher, "Bioethics After Finnis", *Reason, Morality and Law – The Philosophy of John Finnis* (Oxford: Oxford University Press, 2013) 272.

[1] See Robert M. Byrn, An American Tragedy: The Supreme Court on Abortion, 41 *Fordham L. Rev*. 807 (1973).

[1] See Anthony Fisher, OP, "Catholic Teaching on Abortion", *The Allen Review*,7 (Trinity 1992), 12-17.

[1] See Justice Hamilton, *SPUC v Open Door Counselling* (1988) IR 593, at 598.

[1] John M. Dolan, "Homicidal Medicine", *Suicide – A Christian Response* (eds. Timothy J. Demy & Gary P. Stewart) (Michigan: Kregel Publications, 1998) 248.

Tom Ascough <tom.ascough@ascough.ie>
08/05/2013 04.25 p.m. To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Rejection of Human Life in Pregnancy Bill (Attention: Mr Paul Kelly)

Submission on Protection of Human life in Pregnancy Bill

Dear Paul,

The proposed 'Protection of Human Life in Pregnancy Bill' is seriously flawed. It must not permit abortion on the basis of suicidal ideation.

There is absolutely no evidence to suggest that abortion is a successful treatment for suicide. On the contrary, there is much evidence linking abortion to increased mental illness. Therefore the proposed bill merely purports to protect women when in fact it can seriously harm them and most certainly destroy their unborn children.
We only have to look at the state's previously botched thinking that an abortion was needed in the 'C-case'. Now Miss C plans to sue our government for forcing an abortion on her. Her 'care' by the state she says was more horrific than the rape itself!

The other proposed measures apart from the treatment of suicide seem in order.

Yours sincerely,

Tom Ascough
17 Wyattville Park
Loughlinstown
Dun Laoghaire
Co Dublin

Sent from my iPhone

Tom Malone <tomgmalone@live.ie>
07/05/2013 15:31 To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Submission on the The Protection Of Life During Pregnancy Bill

To whom it concerns,

While I am deeply opposed to abortion and I have grave doubts about the inclusion of the threat of suicide as grounds for a termination, I am submitting proposed amendments within the parameters of the current legislation.

I propose the following amendments.

1. That there should be a time limit of fourteen weeks in which a termination can take place.
2. Based on an assumption that the normal treatment for suicidality is that the patient is given counseling I would propose that any woman threatening suicide would be required to undergo not less then six counselling sessions with a psychiatrist. At the end of these sessions the psychiatrist would be required to submit in writing to the three person panel that there is no recourse only to terminate the unborn baby before any deliberations are made.
3. That any termination carried out should not be paid for using taxpayers money and instead should be funded by the mother.

Yours sincerely
Tom Malone
Keevagh, Quin Co Clare.

Tomás Hayes <arscoil@iol.ie>
07/05/2013 19:29 To
healthandchildren@oireachtas.ie
cc

bcc

Subject
Att. Paul Kelly

Mr Kelly , a chara,
Bail ó Dhia ort!
The undue haste engaged in, in getting this abortion legislation through is truly abhorrent.
Life is precious and the loss of it abhorrent.
Festina lente.
Rath Dé ort,
Tomás Hayes

Tony Ryan Submission

Introduction

I wish to state briefly that I have read the 32 pages of the GENERAL SCHEME OF THE Protection of Life during Pregnancy Bill 2013, dated 30/04/2013, and completely disagree with the proposals contained.

Summary

All human rights are dependent on the subject being alive and recognized as human. If anyone is denied the right to life, any other rights they have cannot be enforced.

Recommendation

I have no recommendations to make, except that the law protecting against abortion should remain in place. Alternatively, a constitutional amendment could be voted on, where everyone's views can be taken into account. I see no need to make any changes to legislation.

Submission

The definition of “unborn” is incorrect, as it excludes some living humans, while at the same time recognizing that they are living. A baby's life begins at conception, and not "following implantation", or at the moment of birth. No baby could be born alive if it was not already alive, beginning at conception and not implantation. The definition also raises the prospect of partial-birth abortions.

The use of the word "termination" is also incorrect. Just a life has a beginning and an end, so to has a pregnancy. A pregnancy begins at conception (not implantation), and can terminate in various ways, e.g. live birth, still birth or accidental death. The Bill appears to use the word "termination" in cases where it should use the work "abortion." This should be clarified by the parliamentary draftsman.

Regarding Head 12 on conscientious objection, this is completely inadequate. It is like saying that slave owners who no longer want to own slaves are obliged not to set them free, but most hand them over to another slave owner.

In principle, human life must be protected by those who are already born. This Bill is incorrect in itself, and could too easily open the floodgates to abortion on demand.

Signed:

Tony Ryan

94 St Mobhi Road,

Glasnevin,

Dublin 9

Dr Ursula Nusgen MSc MRCPCH FRCPath
91 The Island
Chapelizod
Dublin 20
Tel.: 0879236559
e-mail: u2nusgen@gmx.net
8 May 2013

Mr Paul Kelly
Principal Clerk
Joint Committee on Health and Children

Dear Mr Kelly,

Re.: ***Protection of Life During Pregnancy Bill 2013.***

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

Please accept my submission regarding Head 8 of the Protection of Life During Pregnancy Bill 2013.
I am a medical doctor with many years clinical experience in both the UK and Ireland and currently work as a microbiologist in one of the Dublin maternity hospitals.
With regard to "risk of loss of life through self-destruction", the Bill should state that suicide is extremely rare in pregnancy, estimated at 1 in 500,000 pregnancies, i.e. there would be one case per 10 – 30 years in Ireland, depending on the number of deliveries.

The bill should also emphasize that any person who is suicidal during pregnancy must receive psychiatric treatment in the same way as any non-pregnant person with suicidal intention. Depending on the seriousness of intent, i.e. a life-threatening situation, admission to a closed psychiatric unit would be indicated.

Given the fact the suicidal ideation is multifactorial and termination of pregnancy is not a treatment for this, every effort should be made to establish the different factors involved and to treat an underlying medical condition, such as depression, where indicated and to find support for social problems. The response to treatment and success of other measures should be assessed before termination of pregnancy (TOP) can be considered. This process requires repeated assessments. This has to happen over a period of time, for two reasons: a) the crisis might be temporary and b) any treatment must be given time to work.

Capability of consent to TOP, which is doubtful in a suicidal person, must also be taken into account, in order to avoid litigation in future.

An alternative (preferred) suggestion would be to simply state that suicide is extremely rare in pregnancy and TOP is not a treatment for this, as has been established by the expert evidence at the Oireachtas hearings, and therefore suicidal intent cannot be a reason for TOP. Any support should be given to the mother.
Where the chance of committing suicide in pregnancy is 1in 500,000, can it be justified to take the life of the baby (i.e. certain death of one person against a tiny risk of death to the mother)?
Many thanks,
Yours sincerely,
(Dr) Ursula Nusgen

Valentine Bowen <valentinebowen@yahoo.ie>
08/05/2013 16:57
Please respond to
Valentine Bowen <valentinebowen@yahoo.ie>

To
"healthandchildren@oireachtas.ie" <healthandchildren@oireachtas.ie>
cc

bcc

Subject
Human Life in Pregnancy Bill

Dear Mr. Kelly,
I strongly object to this Human Life in Pregnancy Bill. For the past few weeks we have heard evidence from many doctors and psychiatrists that abortion is not a treatment for suicidal ideation. If this is what the experts are saying then why persist with this bill.
If Mr. Kenny insists that nothing changes in our law in its present state then why do we need this bill at all?
Thanking you,
Valentine Bowen.

Committee Clerk of the Committee on Health & Children
Submission to Committee on Health & Children on the Protection of Life during Pregnancy Bill 2013 by a Waterford City concerned citizens group.
Dated 7th.May 2013

Personal details and areas of expertise

John D Walsh: B.A. Higher Diploma in Education, MA (1st.Class Honours); Researcher in abortion trends and maternal care globally. Chairman of Waterford Pro-Life Group

Peter W Griffin: BComm (NUI Cork); FCMA - Chartered Management Accountant – Fellow of the Chartered Institute of Management Accountants; Ceard Teastas na Gaelige. Professional Practice; Self employed 25 years. Lecturer in School of Business Waterford Institute of Technology – in Accounting; Strategy; Financial Services.

Fintan J Power: Bachelor of Arts(Hatfield Polytechnic Herts, England); One Year Cert in Social Studies, St. Patrick's College, Carlow; Community Workplace Management Cert(with Distinction), National College of Ireland. Professional Practice: Freelance Journalist (formerly); Community Employment Supervisor (formerly); Estate Manager (formerly): Assessment Officer (currently) with Respond! Housing Association. Long time activist in the promotion of rights for unborn children and their parents. Formerly a member of LIFE and SPUC, both whilst in England; currently a member of the Pro-Life Campaign and Secretary of its Waterford Branch.

Daniel J Tobin: Retired Bus driver. CIE Bus Eireann 33 years 1979-2011
Waterford Representative on National Executive of NBRU National Bus & Railworkers Union
Candidate for Workers Party in Waterford Local 2009 & General Election 2011
Community Activist Vice-Chairman of Campaign against Household & Property Tax

Factual information:

Ethics:

This Bill lacks an ethical framework. The equal right to life of all must be retained as a minimum requirement of a just society. Indeed it is the definition of a Republic, where all are equal with equal rights.

The medical ethic of saving life has guided doctors since recorded history began. The intention of the doctor must remain to protect the mother and in so doing never to target the unborn. Medical Council guidelines prohibit abortion.

The Bill states "The Minister believes that the State's constitutional obligation and its responsibility to act in the common good demand that provisions of terminations of pregnancy…." There is an inherent contradiction in that expressed belief. The common good demands that as a basic human right the right to life must not be extinguished by State law. When the right to life is removed the individual is deprived of all rights. Without the right to life one cannot exercise any right.

Under Common Law this was always an inherent right. Ancient law referred to by Blackstone is best articulated by Henry Bracton (1216-1272), the renowned "Father of Common Law". Bracton categorised abortion of a "formed and quickened" foetus as a form of homicide, "the slaying of man". Wilson seems to agree with Bracton on this issue and thus affirmed that the inalienable right to life applies just as much to the unborn, quickened beings, as it does to any other human being. The fact that Blackstone emphatically characterises abortion as "a very heinous crime" suggests he sympathises with the ancient law on this matter.

With regard to the "X" judgment it must be remembered that it deems abortion legal right up to birth. Not even the most extreme advocate of abortion on demand could justify that situation.

1. Medical evidence The Finnish Study - establishes that a termination itself is a real and substantial risk to the life of the pregnant woman of between twice to six times greater than a continuance of the pregnancy. The European Journal of Public Health 2005 15 (5): 459-463, Injury deaths, suicides and homicides associated with pregnancy, Finland by Mika Gissler, Cynthia Berg, Marie Helene Bouvier-Colle and Pierre Buekens. Furthermore the overwhelming opinion of psychiatrists in Ireland is that abortion is not a treatment for a pregnant woman with a mental condition of suicidal tendencies. Previous Oireachtas Hearings established that suicide predictions were found to be 97% incorrect.

Abortion, Mental Health & Suicide

Abortion is not a reasonable treatment for suicide during pregnancy. Most Irish psychiatrists believe this as was expressed at the recent Oireachtas Committee on Health and Children. An international review published recently
by the Australian & New Zealand Journal of Psychiatry concluded:

"There is no available evidence to suggest that abortion has therapeutic effectsin reducing the mental health risks of unwanted or intended pregnancy.There is suggestive evidence that abortion may be associated with small or
moderate increases in risks of some mental health problems".

Further research as follows confirms this assertion.

Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009

1. Priscilla K. Coleman

+ Author Affiliations

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Declaration of interest

None.

Abstract

Background Given the methodological limitations of recently published qualitative reviews of abortion and mental health, a quantitative synthesis was deemed necessary to represent more accurately the published literature and to provide clarity to clinicians.

Aims To measure the association between abortion and indicators of adverse mental health, with subgroup effects calculated based on comparison groups (no abortion, unintended pregnancy delivered, pregnancy delivered) and particular outcomes. A secondary objective was to calculate population-attributable risk (PAR) statistics for each outcome.

Method After the application of methodologically based selection criteria and extraction rules to minimise bias, the sample comprised 22 studies, 36 measures of effect and **877,181** participants (**163 831** experienced an abortion). Random effects pooled odds ratios were computed using adjusted odds ratios from the original studies and PAR statistics were derived from the pooled odds ratios.

Results Women who had undergone an abortion experienced an 81% increased risk of mental health problems, and nearly 10% of the incidence of mental health problems was shown to be attributable to abortion. The strongest subgroup estimates of increased risk occurred when abortion was compared with term pregnancy and when the outcomes pertained to substance use and suicidal behaviour.

Conclusions This review offers the largest quantitative estimate of mental health risks associated with abortion available in the world literature. Calling into question the conclusions from traditional reviews, the results revealed a moderate to highly increased risk of mental health problems after abortion. Consistent with the tenets of evidence-based medicine, this information should inform the delivery of abortion services.

Yet the intent of this bill is to go against best medical practice. Given that the intent of the Bill states that it is reliant on the outcome of the Supreme Court decision given in the X-case 20 years ago in which the justices drew upon the evidence of a single psychologist

in the determination of their judgement, natural justice demands that the Government now consider what research in this area has concluded since, which is clearly at variancewith what little was available 20 years ago.

A woman may believe that an unborn child will destroy her life but ending her pregnancy does not deal with her belief and suicidal ideation. As this is a question of mental health what is needed is practical support, care and counselling which may continue for some time after the child is born.

Given that the medical evidence is against any sense that offering a termination is the course to be followed should a pregnant woman present with suicidal ideation then this element of the Bill should be removed. Instead it should be
replaced with directions as to how a woman faced with this situation can find the best of care, support and counselling that she needs to address her predicament.

Recommendations related to the specific referenced sections of the Bill.

Head 1 Interpretation

Existing definition is: "reasonable opinion" means an opinion formed in good faith which has regard to the need to preserve unborn human life as far as practicable;
Comment: The terms "in good faith" and "as far as practicable" lack clarity and are open to varying interpretations . We recommend that the following interpretation be used:
"reasonable opinion" means a non-personal professional opinion formed on best medical practice which has the need to preserve both human lives: that of the mother and that of the unborn child.

Comment: The absence of an interpretation of "emergency" is noted. In developing such an interpretation it should be clear that preparing for all emergencies in the scenario building approach of "what if …… happens?" is feasible and viable within a managed framework of decision making, resource planning and implementation.

Subhead (1) definitions.

"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).

Comment: Our comments as above under Interpretation apply here again. We recommend the following amendment.
"Reasonable opinion"
The definition of "reasonable opinion" requires that this opinion must be non-personal and formed on best practice which has the need to preserve both human lives that of the mother and that of the unborn child. The registered medical practitioner(s) will be obliged to record this opinion, with the reasoning involved in reaching a conclusion in writing if certifying a procedure that will end human life. This definition is intended to place a duty on certifying medical practitioners to preserve human life and is influenced by the Twenty-fifth Amendment of the Constitution (Protection of Human Life in Pregnancy) Bill 2001 (section 1).

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

Comment: The use of the terms "in good faith" and "reasonable opinion" and "practicable" are significant here and we have already questioned their potential for varying interpretation.
In the interests of all concerned parties the requirement of consulting with the GP of the pregnant woman and her examination is noted. The absence of balance in this section is also noted. No reference is made to examination of the unborn. Neither is there an attempt to consider the "viewpoint" of the

unborn child. Therefore we recommend that the Bill/Act should allow for the appointment of a person *In locus Infantiae* that is in place of the unborn. The concept of Devil's Advocate is relevant here. Under this arrangement such person would argue the case for the unborn who obviously cannot speak for itself.
To this end we recommend the following additional condition.

(c) In forming the aforesaid opinion both medical practitioners should consult with the person nominated to represent the unborn child.

(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.
Comment: In assisting the pregnant woman in making her decision being able to consult with the nominated person *In locus Infantiae* would be helpful and supportive.

Explanatory Notes
The following explanation to Head 2 is of concern:

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.

Comment: No definition is given of the term "inevitable or immediate". "Inevitable" indicates certainty and the absence of doubt, death for all mankind is inevitable. "Immediate" has a temporal dimension by indicating that something will occur at once. The two words cannot be substituted for each other. Their juxtaposition is confusing regardless of their origin.
Such confusion is unwarranted especially since medical practitioners are entitled to clarity in meeting their obligations to the pregnant woman and the unborn child. We recommend the following explanation be inserted.

While being cognisant of the Supreme Court judgement in the X case, the right to life of both mother and unborn should not be compromised by any decisions or actions taken in unnecessary haste.

Further in this section -

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.

Comment: Standard medical practice may be inadequate in these unique circumstances. Good management should determine and implement a series of decision "gateways" to ensure that all checks and balances have been strictly implemented and acted upon throughout the process.

And further:
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. …….. therefore their inclusion here should be central in accessing services and ensuring patient safety.

Comment: Such emergencies and any untoward consequences can minimised by the development and implementation of pre-planned procedures. A specific relevant recommendation to Hospital management should be included in this section.

And further:
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.

Comment: These two paragraphs predicate a situation where the two viable lives are in competition with competing claims, an "either the mother or the unborn" scenario. It should not be considered in that way. Procedures should be balanced. A balancing of the risk levels for both consequent on a particular

procedure being implemented. Applying a zero risk strategy with respect to the treatment of the mother and a 100% risk to the life of the unborn is intrinsically unfair.

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 and

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.

Comment: The lack of definition of the word "emergency" has already been noted by us, this failure when applied under Head 3 has potential for the abuse of the spirit and intent of this Bill. All of the proposed controls and safeguards of the Bill under these unspecified circumstances risk being by-passed. The terminology used also contains "acute emergency" and "medical emergency" without differentiation or explanation. It refers to "clear and appropriate parameters" but fails to outline or expand on the form or nature of such limits.
The acceptance of a "health facility that is not covered as an appropriate location" in an "emergency" as being legal for a termination of a pregnancy increases the risk for all of the proposed controls and safeguards of the Bill being by-passed to varying degrees ranging from genuine cases to deliberate avoidance.

Head 4 Risk of loss of life from self-destruction

Comment: Our comments as applied to previous Heads apply here also in the matter of terms and phrases lacking clarity. We also include the recommendation of a person nominated to represent the unborn child/ *In locus infantia*

In this particular Head, given that both the pregnant woman and the unborn child are healthy with the only issue being "Suicide", a "reasonable" opinion, no matter how well defined, is not enough to justify termination, neither can the phrase "a matter of probability" be overlooked. Clearly 100% certainty is impossible. Incurring the risks of wrong opinions and gambling on probabilities with inherent dangers of misdiagnosis are unnecessary when a clear alternative exists, namely a caring environment which will prevent the pregnant woman injuring herself or the unborn.

This care would include a comprehensive support and counselling service including interaction with other pregnant women. The maximum period required would possibly be 9 months but could be extended as required. As part of such service facilities the fostering and adoption of the baby may be an integrated part of the care if necessary and by agreement with the mother. Existing caring environments of this nature have a proven record of success.

The established experience of such caring environments, which also care for mothers who have had an abortion, is that the risk of suicide still remains. This fact challenges those certifying under Head 4 to consider that after an abortion the pregnant woman may still commit suicide.

Explanatory notes

…….a real and substantial risk that can only be averted by a termination of pregnancy.

This is patently untrue. Termination will kill the unborn that is certain but uncertainty will remain, as expert testimony can provide, that the pregnant woman may still commit suicide. The X case criteria were unique to that case. Basing legislation on one case is untenable, especially given established research and expert opinions.

Head 6 Formal Medical Review Procedures

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.
Comment: Our previous comments with regard to the various Heads apply here also, including the appointment of a nominated person *In locus Infantiae* that is in place of the unborn under each category.

(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
Comment: This list of prescribed bodies is too restrictive.

Head 11 Notifications and Explanatory Note

Head 11 (4) states that "The Freedom of Information Act 1997 shall not apply to any record under this head"
The Explanatory Note attached to this section states "It is not intended that the Freedom of Information Act 1997 will apply to these records".

The explanatory Note list states that what should be recorded in the notification of all terminations carried out under the Bill will include the following details
Location
Grounds for Termination
Names of the Medical Practitioners Involved
Gestation

Comment:
The Freedom of Information Act 1997 states under Part II Access to Records section

6- (1) Subject to the provisions of this Act, every person has a right to and shall, on request therefore, be offered access to any record held by a public body and the right so conferred is referred to in this Act as the right of access.

Notwithstanding that the Freedom of Information Act 1997 has certain limitations it is essential for the proper monitoring of the effects of the Protection of Life During Pregnancy Bill 2013 that the citizens of this state, namely the Republic of Ireland, have access to the relevant records as listed above, i.e. Location, Grounds for Termination, Names of the Medical Practitioners Involved and Gestation. The intention to restrict access to such records carries with it the notion that the information gathered may never be made public or if made public will be done in a selective fashion intended to portray the effects of Protection of Life During Pregnancy Bill 2013 in its best lights. This in turn will garner the suspicion that the Government of the day has something to hide and fears the proper examination of the matters in question as well as the effects of the Bill. The democratic principles upon which this state was founded will not be best served by depriving its citizenry of information on the matter of how the lives of certain of its unborn children are terminated if this Bill becomes law.

It is therefore essential that the notion of not applying Freedom of Information Act 1997 to the Protection of Life During Pregnancy Bill 2013 should be suspended.

Head 12 Conscientious Objection

(3) No institution, organisation or third party shall refuse to provide a lawful termination of pregnancy to a woman on grounds of conscientious objection.
Comment: This is in breach of Constitutional Rights

(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.
Comment: We consider that this should be the responsibility of the approved location institution.

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.

Comment: We consider that in the event of this Bill being enacted it must be reviewed rigorously within the first 12 months of its operation. Therefore we recommend the addition of the following Head.

Head 21 Termination
This Act will terminate 12 months after commencement. A Review of its workings will take place as to its suitability, feasibility and acceptability during the last 3 months of it operation. A New Act shall be placed before the Oireachtas if required.

Conclusion

We believe that the Bill is based on a false medical premise, as determined by the Supreme Court Judgment in the 'X' case, to the effect that abortion is the only solution for a pregnant woman with suicidal ideation.

The short term solution we believe is for current best medical practice, based on the two patient model, should be clarified by way of a statutory instrument or statutory instruments.

The long term solution is the reversal of the Supreme Court Judgment in the 'X' case by means of a referendum.

Re: PROTECTION OF LIFE DURING PREGNANCY (HEADS OF) BILL 2013 – REQUEST FOR SUBMISSIONS

Introduction.

Having read the Protection of Life during Pregnancy (Heads of) Bill 2013, I am submitting as a member of the public. I read constitutional law in college at the in the year following the X case. I am not a member of any political party or organisation. My observations and recommendations are as follows:

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

Observation: Person making an abortion request may feign suicidal intent.

It is not possible to measure and predict suicidal intent accurately. Therefore a person making a request may convince a panel of suicidal intent without there actually being any suicidal intent. The person may be requesting abortion for anther reason.

Secondly this is a multi-cultural society. Some cultures and communities attach significantly greater value to a male rather than female foetus. Gender selection is now recognised as a significant issue in the UK where the numbers of males significantly exceeds the number of females in specific communities. Suicidal intent may be used as a guise in such cases not least where a person may be under undue influence to a have an abortion due to foetal gender. This head will remove existing protection for a mother who actually wants to carry a foetus to term. Also given language and cultural barriers assessments of suicidal intent are like to be less reliable. The role and responsibility of interpreters has not been addressed.

Observation: Viability and non-provision of time limits on abortion requests.

It is recognised that rights attract limits and curbs. The heads of bill does not adequately address potential viability (currently 22-24 weeks and with better medical practice and technology likely to reduce to 20 weeks). Termination of pregnancy upon achievement of viability would put Ireland in a dubiously unique position that needs to be considered carefully. Additionally would liability accrue to the state where disablement by virtue prematurity was caused by state intervention? This would be a new departure for Irish medical practice. Finally this liberalised regime may prove attractive to citizens across the EU wishing to take advantage of the new regime allowing late term abortions thereby giving rise to inward 'abortion tourism'.

Observation: Viability and non-provision of legal representation

The bill is mistakenly silent on legal representation for the foetus. At minimum post viability the foetus should have legal representation. The right to legal representation is well established at this point in this jurisdiction.

Observation: Lack of provision of advice and councelling for abortion alternatives.

The bill is silent on the provision of advice and councelling for abortion alternatives eg adoption etc. As someone willing to adopt an 'unwanted' Irish citizen I found that there were no Irish babies available for adoption. The bill is mistakenly silent on the role of the Adoption Services particularly around viability.

Observation: Doctors must practice evidence-based medicine

Psychiatrists themselves are the first to admit they cannot accurately predict suicide. Consequently there would be a very large number of terminations in order to potentially get it right. Review of the evidence shows the risk of suicide is significantly less in pregnant females (1/3 to 1/2) compared to non-pregnant females of similar age. However, the risk of suicides increases significantly after an abortion. Pregnancy appears to confer a protective role against suicide. This has been shown in studies published by the British Medical Journal (1996) and the American Journal of Psychiatry (1997). Indeed the Finnish studies looked at all their registers between 1987 and 1994 and found no cases of suicide in pregnancy but a 3 fold increase in suicide in the first year after abortion.

Recommendation:

The thinking surrounding this head is at this point incomplete, susceptible to challenge and should be withdrawn from the bill to allow the earlier heads succeed in enactment. A separate bill may be introduced later when the thinking has appropriately matured to address risk of loss of life from self destruction.

Head 11 Notifications

Recommendation:

The Irish Medical Council who are the regulatory body for Doctors and are independent of the HSE should play a role in the regulation, monitoring and review of termination practices.

The bill indicates notification of all terminations will include the following details

- Location
- Grounds for termination
- Names of medical Practitioners involved
- Gestation

Foetal gender and nationality should also be included.

Annual reports should however be published indicating metrics, grounds for termination, gestation, nationality. This is an area of significant public interest and should be appropriately reported.

END OFSUBMISSION

Signed William Spencer 7/5/2013

Deputy Jerry Buttimer, TD,
Chairperson of the Oireachtas Committee on Health and Children,
Leinster House,
Kildare Street,
Dublin 2

08th May 2013

Re/ Submission to Health Committee on the Bill for Protection of Life during Pregnancy 2013

Dear Deputy Buttimer,

I am writing to you both as a woman who has had an abortion as a woman who is in continuous contact with women and men who face many difficulties after their abortion.

Women Hurt would like to be represented at the upcoming hearings. We were not included in the previous one in January and we feel that our input is of great importance. We also would like to have our written submission included. Before your committee decides on the heads of the bill I would like you to listen to those who have experienced abortion. We are the women who in the past chose abortion when in less than ideal circumstances in our lives. We have gone onto be terribly affected by that decision.

We are more than willing to be questioned on our experiences and would like to respond fully to the committee.

Please find details of our group and our concerns with 'The Protection of Life during Pregnancy Bill 2013'.

Contact details for Women Hurt are as follows:

E-mail: info@womenhurt.ie

Address: Women Hurt, Mespil Hse, Sussex rd, Dublin 2.

Phone: 087 8592877

WOMEN HURT - ABOUT US:

As you may know, Women Hurt is made up of women who have experienced abortion. Our abortions have had a negative impact on our lives. We want to share our stories and enable others to do likewise. We wish to reach out to other women hurt by abortion and encourage them to seek help and healing.

We know from our own experiences and the constant correspondence we have with women who have had abortion that there is a huge story not being told. There is an unknown number of women out there whose voices are not being heard and negative experiences of abortion are not being told.

CONCERNS OVER THE BILL:

Women Hurt do not endorse this bill in any way. We make clear reference to Heading 4 as it deals specifically to abortion in the case of risk of suicide.

As an organisation we base the reality of abortion on what we know personally and on the many women who confide in us on their own post-abortion experience. There is no evidence that supports the suggestion that abortion is of any benefit to a woman's mental health. There is growing evidence that indicate that some women suffer from abortion.

The Finnish study by Gissler (*Gissler, M, et al., 'Injury deaths, suicides and homicides associated with pregnancy, Finland 1987–2000', European Journal of Public Health, Volume 15, Issue 5, 2005)* and others show that women are six times more likely to commit suicide after an abortion. The Fergusson study of 2008 (*David M. Fergusson, L. John Horwood and Joseph M. Boden, 'Abortion and mental health disorders: evidence from a 30-year longitudinal study,' British Journal of Psychiatry (2008))* stated that there is no evidence in the literature on abortion and mental health that suggests that abortion reduces the mental health risks of unwanted or mistimed pregnancy.

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

Women Hurt have experienced abortions and have suffered as a result. We are in agreement with each other that at the time of our unplanned pregnancies we were in crisis but not suicidal.

For the majority of us we would have said anything to get our abortion even if it meant saying we were suicidal. Some of the women in the group had suicidal thoughts and even attempted suicide after the abortion. Something they say had never entered their minds before the abortion.

Based on regular contact with women who are suffering after their abortion and on the most current research in this area we have serious concerns that legislators are overlooking or are confused over what is actually best practise for a woman in a crisis pregnancy or who is feeling suicidal.

We don't think legislators should proceed without examining the untold and indeed some would say suppressed stories of women who regret their abortions. Oftentimes decisions are made without due care and it is only years later that the downsides are realised.

RECOMMENDATIONS:

We feel that the story of women who regret their abortions is growing and growing and sections of the media that don't wish to hear our voices will simply have to acknowledge the true scale of the effects of abortion on women. We urge you as our elected representatives to not allow false information and assumptions which are being made about the supposed need for abortion, especially those assumptions relating to suicide and the 'need' for abortion. Just because some voices are shouting louder than others does not mean a compelling case has been made for legislation. Legislators have a responsibility to probe these issues more deeply and to find the true picture of what is best for women and their babies.

We would to have open dialogue with the health committee, firstly through the upcoming Hearings but also on an ongoing basis.

We would also recommend that the Health Committee study the most relevant and up to date research relating to abortion and suicide and abortion and mental health consequences.

We very much wish to meet with your committee to expand on our concerns and to share with you some insight regarding the emotional scars many of carry with us as a result of a decision we took that we were told would have no lasting consequences.

We look forward to hearing from you,

Yours sincerely

Bernadette Goulding.

SUBMISSION TO THE

JOINT OIREACHTAS COMMITTEE ON HEALTH AND CHILDREN
REGARDING THE

PROTECTION OF LIFE IN PREGNANCY BILL 2013

8 MAY 2013

The Government is not 'required' to legalise abortion because of the European Court ruling in the ABC case. The Court simply said that Ireland needed to provide clarity in its abortion laws. This proposal goes much further.

Guidelines clarifying existing medical practice could give clarity to doctors if that is required, though many obstetricians say that the current provisions allow them to protect both mother and baby.

Abortion was legalised in Britain on similar grounds to this Bill and has led to abortion on demand.

The experience of California in this regard has been brought to the attention of the Committee.

The X-case ruling was a flawed judgment which heard no medical evidence and the people should be given the right to overturn the ruling by amending the Constitution.

An Taoiseach, Enda Kenny, has made much of the Constitution being his 'book'. The Committee should remember that the Constitution belongs to the people, not the government.

This proposal seeks to legalise abortion without term limits according to Minister of State, Alex White. This means that the horror of late-term abortion will be permissible in Ireland on mental health grounds.

The Committee will be aware that the medical evidence given at hearings in January confirmed the following:

- In particular, experts agreed that abortion is not a treatment for suicide.

- They also confirmed that they had never come across a case where abortion was the only treatment for a woman who was suicidal.
- Doctors agreed that not one woman has died in this country because of our ban on abortion or the provisions of the 1861 Act.

- They also confirmed that doctors do not need to directly end the life of the unborn child in order to save a mother's life. Evidence from the British Department of Health also shows that Irish women are not travelling to Britain to undergo abortions to save their lives.

  The Committee will also be aware that 113 psychiatrists have since told the government that the new legislation would require doctors to "participate in a process that is not evidence-based" and said that should not be asked of the profession.

  The proposal in its current form is cruel, heartless and should be abandoned. Mothers are not kept safe by allowing for the lives of babies to be ended. The Committee should endeavor to ensure that Ireland keeps them both safe.

SENT TO:

paul. kelly@oireachtas.ie

Paul Kelly

Principal Clerk

Joint Committee on Health & Children

Houses of the Oireachtas

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[i] Anthony Fisher, "Bioethics After Finnis", *Reason, Morality and Law – The Philosophy of John Finnis* (Oxford: Oxford University Press, 2013) 272.

[ii] See Robert M. Byrn, An American Tragedy: The Supreme Court on Abortion, 41 *Fordham L. Rev*. 807 (1973).

[iii] See Anthony Fisher, OP, "Catholic Teaching on Abortion", *The Allen Review*,7 (Trinity 1992), 12-17.

[iv] See Justice Hamilton, *SPUC v Open Door Counselling* (1988) IR 593, at 598.

[v] John M. Dolan, "Homicidal Medicine", *Suicide – A Christian Response* (eds. Timothy J. Demy & Gary P. Stewart) (Michigan: Kregel Publications, 1998) 248.