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The role of Article 40.3.3 in medical and parental decision-making

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Introduction

This paper considers a number of complex issues arising from A40.3.3. These include the effect of A40.3.3 on a woman's right to refuse or elect for treatment, the position of people who lack capacity and of minors as regards access to abortion, and the rights of parents in the context of abortion.

It should be noted that there are very few decided cases on these issues, which makes it difficult to be definitive about the legal position. A feature of such cases as do exist is that they often involve circumstances of great urgency, where both legal argument and the ultimate decision had to be completed very quickly. In addition, the few decided cases were not been appealed past the High Court which may somewhat limit their precedential status.

1. Tension between the rights of a pregnant woman and the right to life of the unborn

Though A40.3.3 is most commonly discussed in the context of abortion, it is important to recognise that the wording of the Article is, in fact, very general. It states:

> *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.*

Rather than establishing a constitutional prohibition on abortion *per se*, A40.3.3 establishes constitutional recognition for the right to life of the unborn. Because the Article is phrased in this way, it has effects outside the context of abortion, although it is difficult to say what, precisely, those effects are.

For example, A40.3.3 has been acknowledged to have some effect in the context of immigration[1] and in the context of the withdrawal of life support from a brain dead pregnant woman.[2] However, the Supreme Court has concluded that A40.3.3 did not

[1] *Baby O. v. Minister for Justice, Equality and Law Reform* [2002] 2 I.R. 169, IRM v Minister for Justice [2016] IEHC 478

[2] *PP v HSE* [2014] IEHC 622

apply to surplus embryos created in the course of IVF,[3] where those embryos had not been transferred into the woman's uterus. This divergence in approach is illustrative of the indeterminate nature of A40.3.3, and the difficulty in saying definitively what the effect of the Article is.

A further question that arises is whether A40.3.3 recognises rights of the foetus other than the right to life. Decisions in the immigration context have considered this, and while judges have disagreed on the issue,[4] the most recent High Court decision, in *IRM v Minister for Justice*[5] took the view that in making deportation decisions the Minister for Justice was required to consider the rights of the unborn, including rights extending beyond the right to life.

It appears that the unborn may enjoy rights other than the right to life, but it is very difficult to say how those rights will be balanced against the rights of the mother. A40.3.3 only governs a situation where the balance to be drawn is between the mother's right to life and the foetus' right to life. It is this situation that was addressed in *Attorney General V X,*[6] and in this context that the Supreme Court decided that an abortion was permissible where there was a "real and substantial" threat to the life of the mother.

AG v X does not govern a situation where the balance to be drawn is between rights of the woman and rights of the foetus other than the right to life.

Consider, for example, a woman who decides to use heroin, or to consume alcohol in excess during the course of her pregnancy. In this instance there might be no risk to the life of the foetus, but there might be a risk that the foetus, when born, will have developmental problems which could affect its health in quite significant ways. In that case, the conflict is between the right of the woman to autonomy and privacy, and the right of the foetus to bodily integrity. It does not appear that A40.3.3 governs this situation. Nor does there seem to be a stateable case that A40.3.3 requires the State to take steps to prevent harm to the foetus by controlling the activity of the woman in a case like this.

Ultimately, it is difficult to say definitely what the full effects of A40.3.3 are. The obligation in Article 40.3.3 is to defend the right to life of the unborn as far as practicable. It might not be practicable for the State to monitor the activities of all pregnant women to ensure that they were not endangering the life of the foetus.

[3] *Roche v Roche* [2010] 2 IR 321

[4] See contrast between decision of Irvine J in *O.E. v. Minister for Justice, Equality and Law Reform* [2008] 3 I.R 760 and Cooke J in in *Ugbelase v. Minister for Justice, Equality and Law Reform* [2010] 4 I.R. 233 and Kangethe v. Minister for Justice, Equality and Law Reform [2010] IEHC 351.

[5] IRM v Minister for Justice [2016] IEHC 478

[6] *AG v X* [1992] 1 IR 1

As stated, the courts have given little consideration to what rights, if any, might be held by the unborn, other than the right to life. Furthermore, in cases where foetal rights other than life have been recognised, there has generally been no conflict between the rights of the foetus and the wishes or interests of the mother, e.g. in the immigration context. It is therefore not possible to assess how the courts would respond to situations where such conflict existed and where the actions of a pregnant woman threatened other rights of the foetus.

2. Whether a pregnant woman's right to refuse treatment is affected by A40.3.3

i) The Right to Refuse Treatment

The right to refuse medical treatment is a very important right, as a matter of medical ethics, and as a matter of law. The Guide to Professional Conduct and Ethics for Registered Medical Practitioners of the Medical Council of Ireland recognises this, providing as follows at Section 15(1):

> *Every adult with capacity is entitled to refuse medical treatment or withdraw consent.*
> *You must respect a patient's decision to refuse treatment or withdraw consent, even if you disagree with that decision. In these circumstances, you should explain clearly to the patient the possible consequences of refusing treatment and, where possible, offer the patient a second medical opinion.*

Similarly, the National Consent Policy provides as follows at para. 7.7:

> *If an adult with capacity to make an informed decision makes a voluntary and appropriately informed decision to refuse treatment or service, this decision must be respected, even where the service user's decision may result in his or her death.*[7]

In Ireland, the right to refuse treatment is protected at common law and also protected by the Constitution. In the case of *In re a Ward of Court (Withholding of Medical Treatment)*[8] the Supreme Court recognised the constitutional position of the right to refuse treatment. Denham J commented:

> *Medical treatment may not be given to an adult person of full capacity without his or her consent. There are a few rare exceptions to this e.g., in regard to contagious diseases or in a medical emergency where the patient is unable to communicate. This right arises out of civil, criminal and constitutional law. If medical treatment is given without consent it may be trespass against the person*

[7] HSE National Consent Policy (2014)
[8] *In re a Ward of Court (Withholding of Medical Treatment* [1996] 2 IR 79

in civil law, a battery in criminal law, and a breach of the individual's constitutional rights. The consent which is given by an adult of full capacity is a matter of choice. It is not necessarily a decision based on medical considerations. Thus, medical treatment may be refused for other than medical reasons, or reasons most citizens would regard as irrational, but the person of full age and capacity may make the decision for their own reasons.[9]

The right to refuse treatment includes the right to refuse life-saving treatment, as has been recognized in the context of a prisoner on hunger strike.[10] As such, the right is a very strongly protected one, which can only be interfered with in very limited circumstances. In *Re a Ward of Court* Denham J mentioned as examples of instances in which the right could be infringed, the case of contagious diseases or medical emergencies in which the patient is unable to communicate.

It should also be noted that the right to refuse treatment extends to the right to take decisions which are against a person's medical best interests, including decisions which are objectively irrational[11], or as Denham J put it, even to decisions which "most citizens would regard as irrational."[12]

ii) The Right to Refuse Treatment in Pregnancy

The right to refuse treatment is thus a right which is very strongly protected in law. The question that arises therefore is whether A40.3.3 means that the woman's right to refuse treatment is limited during pregnancy where the treatment may be necessary to protect the unborn. This question may be broken down into circumstances where the treatment is necessary to protect the life of the unborn, and circumstances where the treatment is necessary to protect the health of the unborn.

It is not at all clear that A40.3.3 would provide a basis for restricting the woman's right to refuse treatment by reference to the need to protect the health of the unborn. The Article refers only to the State's duty to protect the life of the unborn, not to protect its health. Furthermore, given the very high constitutional status of the right to refuse treatment, it would be hard to see how this could be trumped by an expansive, and arguably strained, interpretation of A40.3.3.

By contrast, there might be an arguable case that if the treatment is necessary to safeguard the life of the foetus, then A40.3.3 might require that treatment be provided in the absence of the woman's consent, effectively nullifying her right to refuse treatment. The paradigm example of this is where a caesarean section is necessary to safeguard the life of the foetus, and the woman refuses her consent.

[9] *In re a Ward of Court (Withholding of Medical Treatment* [1996] 2 IR 79 at 156.
[10] [2015] IEHC 259
[11] *Fitzpatrick v. FK* (No.2) [2008] IEHC 104, [2009] 2 I.R. 7
[12] *In re a Ward of Court (Withholding of Medical Treatment* [1996] 2 IR 79 at 156.

However, in the only decided case on this issue, the High Court declined to make an order compelling the woman to have a caesarean section against her will.

In this regard, the National Consent Policy acknowledges the difficulties that arise in this context, providing as follows:

> *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 significant legal uncertainty regarding the extent of a pregnant woman's right to refuse treatment in circumstances in which the refusal would put the life of a viable foetus at serious risk. In such circumstances, legal advice should be sought as to whether an application to the High Court is necessary.*
> *Relevant factors to be considered in this context may include whether the risk to life of the unborn is established with a reasonable degree of medical certainty, and whether the imposition of treatment would place a disproportionate burden or risk of harm on the pregnant woman.*[13]

HSE v B

In the case of *HSE v B*[14] the High Court considered an application by the HSE for an order forcing a pregnant woman to have a caesarean section against her will in order to vindicate the right to life of her unborn child. The HSE, the woman (referred to as Ms B) and the unborn child were all separately represented in the proceedings. Ms B had already had three children all by caesarean section. The medical evidence provided by the HSE was that if she tried to deliver the baby naturally there was a risk of her uterus rupturing which could lead to the death of her baby and the death of Ms. B herself. The risk of uterine rupture was estimated as 1 in 10. The medical advice Ms B received was that she should have an elective caesarean section, rather than attempting a natural delivery which risked uterine rupture.

The Court stated that it could not see why Ms B would want to take such an unnecessary risk, but accepted that the Court's role was not to say whether it agreed with Ms B, but rather whether she could be forced, against her will, to submit to a surgical procedure in her interests and in the interests of her unborn child.[15]

In deciding whether Ms B was entitled to decide to refuse the caesarean section pursuant to A40.3.3, the Court adopted the test for State intervention which applies in situations where the State applies to override a decision made by a parent in relation to his or her children. (This parental autonomy case law is discussed below

[13] National Consent Policy, 7.7.1.
[14] [2016] IEHC 605
[15] The Court found that Ms B had capacity, and therefore would have been fully entitled to refuse treatment, if there were no question of the rights of the foetus. (para. 12)

at Section 5) This was perhaps a somewhat unusual approach to the question. Instead of looking to the case law on A40.3.3 the Court relied on what had previously been regarded as a completely separate body of constitutional case law. Further, it should be noted that this body of case law concerned a constitutional provision that had been repealed by the Children's Rights Referendum (albeit replaced with a similar, but differently worded, provision[16]).

In essence, therefore what the Court in *HSE v B* did was ask whether the woman had the right to subject the foetus to the risk posed by a natural delivery.

The Court found that the test for State intervention in a parent's decision was whether the circumstances of the case where "exceptional." The Court found that it would be a "step too far"[17] to force the woman to undergo a caesarean section against her will. The woman subsequently agreed to have a caesarean section.

The decision in *HSE v B* suggests that A40.3.3 will not be interpreted to mean that a woman can be forced to undergo a caesarean section against her will. However, the reasoning in the decision is very brief. Importantly, the medical evidence indicated that it was not a certainty that the foetus' life would be endangered by a natural delivery, although it was described as carrying significant risk. It remains possible that a subsequent Court could take the view that A40.3.3 required compulsory caesarean section, especially if a higher degree of risk to the unborn was established.

More broadly, the decision in *HSE v B* suggests that A40.3.3 has a limited impact on a woman's right to refuse treatment, but given that this is the only decided case on the issue, it is not possible to say definitively what its effect is.

iii) Maternal Brain Death

A context in which A40.3.3 has been found to have an important impact is where a pregnant woman is diagnosed as brain dead but the foetus remains alive. The general medical definition of death is the death of the brain stem.[18] As the name suggests, this means the death of all of the brain, including the lower part, or 'stem.' Today, when we say someone is dead, we mean that they are brain dead. A person may be brain dead, but maintained on a ventilator, colloquially known as a "life-support machine."

[16] Article 42A replaced Article 42(5).
[17] [2016] IEHC 605, para. 21.
[18] See e.g. Eelco FM Wijdicks, 'The Diagnosis of Brain Death' New England Journal of Medicine 344(2001) 1215-1221, WF Haupt, J Rudolph, 'European Brain Death Codes: a Comparison of National Guidelines' Journal of Neurology 246(1999) 432-37, Eelco FM Wijdicks, Brain Death, (New York, OUP, 2011).

In the case of *PP v HSE*[19] the High Court considered the case of a woman who had suffered a brain injury during pregnancy. She died while on a ventilator, and was diagnosed as brain dead. The foetus was at approximately 15 weeks' gestation and still had a heartbeat. The absolute limit of foetal viability is now around 22 weeks, but a foetus born at that stage is likely to be born with a significant long-term disability [20]

The woman's family applied to the High Court to have the ventilator switched off, with the result that the foetus would die. Ultimately the High Court granted this order, but the decision was very much premised on the medical evidence which demonstrated that the foetus had no prospect of surviving until the point of viability. Because of that, the Court treated this like a withdrawal of treatment case, describing the treatment as futile. This was central to the Court's ruling. A possible implication of the Court's analysis is that if there were a prospect of the foetus surviving to viability then the treatment would have to be continued. However, given the very particular circumstances of this case, it is difficult to make predictions about how the courts would approach future cases.

In coming to its conclusion the Court had to consider whether *NP,* as a dead person, enjoyed any constitutional rights. It concluded that she did retain a right to "dignity with proper respect for her autonomy, with due regard to the grief and sorrow of her loved ones and their wishes."[21] Those rights were, however, subordinated to the rights of the foetus. The Court commented:

> *When the mother who dies is bearing an unborn child at the time of her death, the rights of that child, who is living, and whose interests are not necessarily inimical to those just expressed, must prevail over the feelings of grief and respect for a mother who is no longer living.*[22]

The clause "whose interests are not necessarily inimical to those just expressed" may leave the door open to a later court deciding that – in a particular case – the interests of the unborn might be inimical to the dignity interests of the mother. It should be noted, however, that these comments were not central to the court's holding and may not, therefore, have significant weight in future cases.

The result of *PP v HSE* seems to be that if the foetus in a case like this is viable, then A40.3.3 may require that treatment be maintained. This could be especially problematic in cases where this is strongly opposed by the family, or where a woman

[19] [2014] IEHC 622

[20] *Prenatal Management of Pregnant Women at the Threshold of Infant Viability (The Obstetric Presepective)* RCOG Scientific Impact Paper No . 41, February 2014.
See studies conducted by EPICure, available at www.epicure.ac.uk. See also for example F. García-Munoz Rodrigo et al, "End of Life Care and Survival without Major Brain Damage in Newborns at the Limit of Viability" (2017) 111 Neonatology 234-239.

[21] [2014] IEHC 622 at 55.

[22] [2014] IEHC 622 at para. 56.

had in place an advance directive saying that she wished treatment to be discontinued in circumstances like this.

It should be noted that there is a very important distinction between cases where the woman is brain-dead, and cases where the woman is alive but lacks the capacity to make decisions, e.g. in a coma or a persistent vegetative state. In the latter case, the dignity and other rights of the woman might hold greater weight against the right to life of the unborn.

The Assisted Decision-Making (Capacity) Act 2015 created a statutory framework for advance decision making in Irish law. This Act specifically contemplates the difficulties that arise where a pregnant woman loses capacity but the foetus is alive. Under that Act, if the woman has an advance directive in place which refuses treatment but does not specifically refer to the case of pregnancy, then there is a presumption that treatment will be continued. If the advance directive does refer to pregnancy and refuses treatment in that context, then the Act requires that the matter be determined by the High Court.[23]

3. Whether a pregnant woman's right to elect to undergo treatment is affected by A40.3.3

Circumstances may arise where treatment that is medically indicated for a pregnant woman may have a detrimental impact for the foetus. This could occur if the pregnant woman was suffering from cancer and chemotherapy was medically indicated. This might constitute a life-saving treatment for the woman, but could present a risk to the life of the foetus.

It might also be the case that medically indicated drugs or treatments might present a risk to the health rather than to the life of the foetus.

i) A40.3.3 and the Right to Elect for Treatment

In assessing the impact of A40.3.3 on the right to elect for treatment, we return to the distinction noted in the previous two sections: the distinction between a risk to the life of the foetus and a risk to the health of the foetus. As stated above, the courts have not given much consideration to whether the foetus holds constitutional rights other than the right to life. It is therefore not possible to assess how the courts would resolve any conflict between such rights and the mother's right to elect for medical treatment.

On the wording of A40.3.3 it is arguable that the Article requires that the State protect the right to life of the foetus if the woman's election of treatment results in a

[23] Section 85(6). Note that at the time of writing this section has not yet been commenced.

risk to the life of the foetus e.g. in the case of a woman who has cancer and elects to have chemotherapy that could result in the death of the foetus. However, the Article only requires that the right to life of the foetus be protected with "due regard to the equal right to life of the mother" and also only that it be respected "insofar as practicable."

There do not appear to be any decided cases in which the Courts have applied A40.3.3 to constrain the right of a woman to elect for treatment in a case of this kind. Therefore, the point might be viewed as an open one. However, in principle such a scenario may be capable of triggering the test laid down by the Supreme Court in the *X* case. In that case, the Supreme Court held 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. The same reasoning would seem to allow for medical treatment, one effect of which is to terminate a pregnancy, where there is a real and substantial risk to the life of the mother if she does not undergo the treatment.

ii) Protection of Life in Pregnancy Act 2013

The purpose of the Protection of Life in Pregnancy Act 2013 (the "**2013 Act**") was to codify the test for balancing the right to life of the mother and the right to life of the unborn, as set down in *X v Attorney General* and to establish procedures via which an abortion/induced delivery could be obtained in those circumstances.

The 2013 Act is drafted in broad terms, extending beyond circumstances in which a woman simply makes a request for an abortion on the basis of a real and substantial risk to her life. The 2013 Act does not refer to abortion or termination, but instead to "medical procedure" which is defined as including "the prescribing, by a medical practitioner, of any drug or medical treatment."[24] The Act goes on to set out conditions for the circumstances in which it is lawful to carry out a medical procedure:

> *[I]n respect of a pregnant woman in accordance with this section in the course of which, or as a result of which, an unborn human life is ended…"*[25]

This wording therefore appears to apply to medical procedures which have the result of ending the life of the foetus, or to medical procedures, in the course of which the

[24] Section 2, 2013 Act.
[25] Section 7, 2013 Act.

foetus' life is ended. It seems clear that the destruction of the foetus need not be the *purpose* of the procedure. As such, it seems that the Act applies to medical procedures other than abortions/terminations, and could therefore operate to govern other medical treatments that pose a risk to the life of the foetus, such as the chemotherapy example.

The effect of the 2013 Act thus appears to be to apply the X-Case criteria to such "medical procedures." The 2013 Act provides that such medical procedures are lawful where there is a real and substantial risk to the life of the mother, and that risk is certified by two medical practitioners. It must be the opinion of the medical practitioners that the risk can only be averted by carrying out the medical procedure.[26]

The 2013 Act requires that the reasonable opinion of the medical practitioners must be one formed "in good faith which has regard to the need to preserve unborn human life as far as practicable"[27] The purpose of this proviso may be to impose on doctors an obligation to ensure that in cases where the foetus is viable, an early delivery is performed rather than an abortion, but the Act does not impose a specific obligation to this effect.

The Guidelines to accompany the 2013 Act specifically address the issue of gestational age. [28] They state that there is no time limit imposed by the 2013 Act in carrying out the medical procedure, but that it legally requires doctors to preserve unborn life as far as practicable without compromising the woman's right to life. The Guidelines state:

> *Therefore, there is no specific stage of pregnancy below which the certifying doctor will not have to consider the possibility of preserving the life and the dignity of the unborn where practicable without compromising the life of the mother.*[29]

The Guidelines state that clinicians must use their clinical judgment to decide whether circumstances are appropriate for a medical or surgical termination, or for an early delivery by caesarean section.

This overriding duty to consider the life of the unborn raises a question as to whether a doctor might be required to consider the possibility of delaying treatment until the end of the pregnancy. This could potentially be required, even if there was a consequential detriment for the health of the woman.

[26] Where the risk to life is from suicide, three medical practitioners are required.
[27] Section 7(a)(ii), 2013 Act.
[28] Department of Health, *Implementation of the Protection of Life During Pregnancy Act 2013: Guidance Document for Health Professionals* (September, 2014)
[29] Section 6.4, at p 31.

4. Capacity

i) The Law on Capacity to Consent to Medical Treatment

Historically, the law took a status-based approach to capacity. This meant that a person's legal capacity was defined by reference to the category of person to which they belonged. So, if a person had a mental disability, suffered from a psychiatric illness, or had dementia, this would mean that they were considered to be legally incompetent to make decisions about their medical treatment. Today, the law generally favours a functional approach to capacity.[30] Under the functional approach, the assessment of capacity is made by reference to the person's ability to make a specific medical decision, at a specific time. So, for example, even though a person might have dementia they may be able to fully understand a particular medical decision and make a reasoned decision for themselves.

The functional test of capacity was recognised by the High Court in the case of *Fitzpatrick v FK.*[31] It has now been placed on a statutory footing by the Assisted Decision-Making (Capacity) Act 2015, albeit the relevant parts of this Act have not yet been commenced. This Act provides:

> *[A] person's capacity shall be assessed on the basis of his or her ability to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made by him or her in the context of the available choices at that time.*[32]

Where a person lacks capacity, decisions as to medical treatment have traditionally been made by the responsible medical practitioner, acting in the patient's best interests. The Guidelines of the Medical Council of Ireland provide:

> *If there is no-one with legal authority to make decisions on the patient's behalf, you will have to decide what is in the patient's best interests. In doing so, you should consider:*
> *• which treatment option would give the best clinical benefit to the patient;*
> *• the patient's past and present wishes, if they are known;*
> *• whether the patient is likely to regain capacity to make the decision;*
> *• the views of other people close to the patient who may be familiar with the patient's preferences, beliefs and values; and*
> *• the views of other health professionals involved in the patient's care.*

[30] Capacity of minors is still judged via a status-based approach, as set out below.
[31] *Fitzpatrick v. FK* (No.2) [2008] IEHC 104, [2009] 2 I.R. 7
[32] Section 3, Assisted Decision-Making (Capacity) Act 2015

Under the Assisted Decision-Making (Capacity) Act 2015 decisions are made for a person who lacks capacity on the basis of the person's will and preferences, beliefs and values, insofar as they can be ascertained. The Act also sets down further guidance on medical interventions made in the absence of capacity.[33]

Where a pregnant woman loses capacity, treatment decisions are made by the medical practitioner, acting on the basis of the woman's will and preference, beliefs and values. A medical practitioner would be required to consider the best interests of the foetus, as well as the woman, in providing medical treatment to a woman in the absence of capacity.

ii) Capacity of Minors

Although the law is not entirely clear on this point, it would appear that children of 16 years and above have the right to consent to medical treatment. There is some question, however, that the right to consent to medical treatment may not become fully effective until the age of 18.

Section 23 of the Non-Fatal Offences Against the Person Act 1997, states:

> *(1) The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his or her person, shall be as effective as it would be if he or she were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his or her parent or guardian.*
> *(2) In this section 'surgical, medical or dental treatment' includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.*

Pursuant to this section, a minor of 16 years or above may be legally entitled to consent a medical procedure which would lead to the death of the foetus subject of course to the provisions of the 2013 Act. It should be noted that the right conferred by this section is a right to *consent* to treatment, not a right to *refuse* treatment. The right of a minor (pregnant or otherwise) to refuse treatment is uncertain as it has not been the subject of judicial determination in an Irish court to date.

Children under the age of 16 are in a different position. They do not enjoy a statutory right to consent to treatment, and consent must be provided by their legal guardian. In the UK, case law has established that where a child under 16 is sufficiently

[33] Section 8, Assisted Decision-Making (Capacity) Act 2015

mature, they may enjoy a right to consent to treatment.[34] This line of case law has not, as yet, been followed in the Irish Courts, but may have persuasive value. An important distinction between the UK and Ireland is that the Irish Constitution strongly protects the rights of parents to make decisions regarding their children, discussed below in Section 5. This may militate against children under 16 being found to have an independent legal right to consent to treatment. However, this matter must be regarded as undecided at the present time.

If a child is in long term State care[35] all the rights of the parent to consent or refuse to medical treatment are enjoyed by the State, which is in *loco parentis.* In the case of *A and B v Eastern Health Board*[36] the High Court considered the position of a child in State care who was pregnant as a result of rape. The Court held that the travel amendment to A40.3.3 did not confer a positive right to travel to obtain an abortion, it merely prevented the Courts granting injunctions which prevented women travelling for that purpose. As such, the Courts had no jurisdiction to authorise travel to another jurisdiction for the purposes of obtaining an abortion which was not permitted under the test in *X v AG.* On the facts, the girl in question did present a suicide risk, and was therefore entitled to an abortion under the Constitution.

iii) Capacity to consent to treatment where a person is resident in an Approved Centre

Where a person is being treated in an Approved Centre under the Mental Health Act 2001 but retains legal capacity she retains the right to consent to or refuse medical treatment, subject to certain specific provisions regarding psychiatric treatment.[37] If the person lacks capacity vis a vis a particular decision they will be treated according to the principles under the Assisted Decision-Making (Capacity) Act 2015, which if they are pregnant will include a consideration of the best interests of the foetus.

5. Parental Authority

i) Constitutional Protection for Parental Decision-Making

The Irish Constitution strongly protects the right of parents to make decisions about their children. This is possibly relevant to abortion decisions in two contexts. The first concerns decisions by parents of a minor who is pregnant. The second concerns whether there is any scope for fathers' rights in the context of abortion.

In the past, the Courts have set a very high threshold for intervention on the part of the State in parental decision-making. In case of *North Western Health Board v*

[34] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] A.C. 112
[35] i.e. pursuant to a full care order under Section 18 of the Child Care Act 1991 as amended
[36] [1998] 1 IR 464.
[37] See Sections 58-60 Mental Health Act 2001 as amended.

HW[38] a health board sought to override the refusal of parents to their child having a phenylketonuria (PKU) test. Commonly known as the 'heel prick test,' it literally involves a pin prick to the baby's heel, and tests for diseases that if left untreated can lead to the child's suffering severe mental and physical damage. In that case the Supreme Court refused to grant an order allowing the test take place without the parents' consent. It concluded that in the case of non-abusive and non-neglectful parents, the State was only entitled to intervene in parental decision-making where there was an immediate threat to the capacity of the child to continue to function as a human person, whether physically, morally or socially. This sets a high threshold for intervention.

The legal position as regards parental decision-making is now governed by to Article 42A of the Constitution. This states:

> *In exceptional cases, where the parents, regardless of their marital status, fail in their duty towards their children to such extent that the safety or welfare of any of their children is likely to be prejudicially affected, the State as guardian of the common good shall, by proportionate means as provided by law, endeavour to supply the place of the parents, but always with due regard for the natural and imprescriptible rights of the child.*

This has not yet been definitively interpreted by the Courts, so it is difficult to say precisely what its impact is.

Where the decision is one made by the parents of a pregnant minor, Article 42A clearly applies. They will be entitled to make decisions, unless the threshold for State intervention set down in that article is met.

To some extent, these aspects of the Constitution are in conflict. The right to parental authority gives a parent the right to subject their children to certain risks, as long as they do not reach a particular threshold. A40.3.3 effectively requires the State to protect the life of the foetus, including where the threat to the life of the foetus arises from the decision of the woman herself.

ii) Rights of Fathers in the Context of Abortion?

Because of the very limited circumstances in which an abortion is permissible in Ireland, the courts have not had to consider whether any person other than the pregnant woman has a legal role to play in choosing an abortion.

[38] North Western Health Board v HW [2001] IESC 90, [2001] 3 IR 622.

A40.3.3 makes no mention whatsoever of the father of the unborn. There does not appear to be any case law which suggests that the father has any specific rights in relation to abortion. Furthermore, A40.3.3 expressly preserves the right of a woman to travel abroad, and says that that right is not limited in any way by the Article. It might be argued that this suggests that a father would have no entitlement to prevent a woman travelling to obtain an abortion.

Perhaps the more relevant question relates to what persons would have the entitlement (or 'standing') to bring proceedings to protect the life of the foetus, if it were under threat. The Irish Courts have taken a relaxed view of standing to take proceedings to protect the right to life of the foetus[39] on the basis that the foetus is obviously not in a position to take action to protect its own rights. As such, a father would almost certainly be entitled to take proceedings seeking to protect the foetus from an unlawful threat, such as an illegal abortion.

[39] *Society for the Protection of Unborn Children v Coogan* [1989] IR 734