Paper prepared for presentation to the Citizens Assembly at the request of Justice Mary Laffoy, dealing with the operation of the Protection of Life During Pregnancy Act (2013) in Cork University Maternity Hospital

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The Act has now governed obstetrics practice in Ireland for the two calendar years of 2014 and 2015 and most of 2016. Two reports (*section 15*) have been laid before the Oireachtas, both of which record an identical set of statistics for 2014 and 2015, namely: that 26 medical procedures were carried out under the Act, 14 arising from a risk of physical illness, 3 arising from a risk from suicide and 9 from emergencies arising from physical illness. The figures for 2016 are not yet to hand.

Based on my experience of obstetrics practice since the Act came into effect, I would say that arrangements governing termination of pregnancy under section 7 (physical illness) and section 8 (physical illness in emergency) appear to be working. Obstetricians understand their scope of action and are prepared to give effect to these sections where there is a real and immediate danger to the life of the mother. By and large while the Act has provided a legal framework/protocol, the clinical decision making has been following long established practices.

The operation of section 9 (risk of suicide) of the Act is more complex.

I will present three case histories, the first two fall within section 7 and the third case falls within section 9 of the Act.

CASE 1:

* Mary Murphy a 33 year old mother of two, has booked at her local maternity hospital on her third pregnancy. Her first two pregnancies were uncomplicated. At 18 weeks gestation (*normal pregnancy is 40 weeks long*) she presents herself at the emergency room of the maternity hospital. She is leaking clear fluid from her vagina. She is examined and assessed and it is diagnosed that she has "ruptured membranes". (*The fetus normally develops within a sac of fluid in the womb. This fluid is important for normal development. The fluid sac also provides an environment where the fetus is protected from infection*.) Mary is admitted to the hospital and is frequently monitored for any change in her temperature and her pulse. She has blood tests taken regularly to test for any markers of infection.

Two weeks later, at 20 +1 weeks gestation, she wakes in her hospital bed feeling very unwell. She is cold and shivery. Her temperature is very high. Her heart rate is very fast. She has also noticed that the clear fluid she has been leaking from her vagina has changed colour and is now green. She is complaining of pain in her abdomen. When she is examined it is noted that she looks very unwell, and is quite distressed and flushed. On examining her abdomen, it is painful to touch. A diagnosis of chorioamnionitis is made and that the patient is in septic shock (*chorioamnionitis is where infection develops inside the womb*). A decision is made that because of a substantial risk to both mother and fetus she needs to be delivered. She is started on antibiotics via a drip and she is also given medications to ensure that she labours. She delivers a stillborn baby three hours later.

Question 1:
What are the main causes for concern when Mary presented to the emergency room?

> **Answer:** Once the diagnosis of ruptured membranes is confirmed, there is a long term concern about the ultimate outcome of the pregnancy and the development of the fetus. There is a more immediate concern about the risk of infection entering the womb through the break in the pregnancy sac.

Question 2:
What is the treatment if infection takes hold in the womb and in particular if the patient becomes septic?

> **Answer:** The treatment is to give the mother antibiotics through a drip and to intervene to deliver the fetus as quickly as possible.

Question 3:
At 20 +1 weeks gestation, is there any hope that if the baby is born alive it could survive?

> **Answer:** No, at this stage of the pregnancy, there is no hope of survival after delivery.

Question 4:
What is the main cause of concern if chorioamnionitis occurs?

> **Answer:** The concern is that the mother, and indeed the fetus, will become so unwell that they will die from overwhelming sepsis.

Question 5:
What are the main procedures and processes that happen once the decision has been made that a delivery is needed because of significant risk to the mother?

> **Answer:** The decision would require two consultant obstetricians to confirm the diagnosis of chorioamnionitis with associated sepsis. The mother will be counselled about the seriousness of her condition and the need to act promptly. Ultimately, the case is notified as per the legislation.

CASE 2

* Mary Murphy, a first time mother at 42 years of age, has booked at her local maternity hospital. She has always been very fit and well and has no medical history. However, her family history is significant. Her mother's first pregnancy was complicated by very early on-set "severe toxaemia". Mary didn't have all the details but she knows that the baby in this case was stillborn.

At 19 +5 weeks gestation, Mary attends her GP feeling unwell with a bad headache. The GP checks Mary's blood pressure and it is noted to be very high. She also checks Mary's urine and notes lots of protein in the urine. The GP had seen her three weeks ago for a routine visit and her blood pressure and urine had been normal. The GP sends her in immediately to the emergency room of the maternity hospital. At the maternity hospital, Mary's blood pressure is again noted as being very high and at a dangerous level. She still has a headache and feels "jittery". She has blood tests taken and she has evidence of damage to her liver, kidneys and blood clotting system. She is admitted to the High Dependency Unit and given medications to both lower her blood pressure and to prevent her developing any seizures. She is very closely monitored and assessed immediately by her obstetric team including a specialist in high risk pregnancy. She is also seen by a number of physicians to rule out any atypical medical disorder. In the end, the medical team come to the conclusion that she is suffering from severe early onset preeclampsia (*often referred to in common parlance as toxaemia of pregnancy*. *It commonly presents with high blood pressure and protein in the urine but it can affect every organ in the body*). By the third day in HDU, despite persistent efforts to lower her blood pressure, it becomes uncontrollable. A decision is made by the team that she needs to be delivered. Medications are given to induce delivery. Her blood pressure and abnormal blood tests are all improving by four days after delivery. She delivered a baby that showed signs of life for a few minutes before passing away in Mary's arms.

Question 1:
Is this type of preeclampsia occurring at 19 +5 weeks unusual?

> **Answer:** Yes, it is very unusual. Preeclampsia is usually thought of as a disorder of the second half of pregnancy but rarely it can present very early.

Question 2:
What would be the main cause of concern for Mary's wellbeing?

> **Answer:** The very high blood pressure would mean that Mary would be at risk of a haemorrhagic stroke (a blood vessel in the brain may rupture because of the high blood pressure). There is also the risk that Mary will have seizures (seizures in this scenario would be referred to as eclampsia). Both these complications are serious and both have a significant risk of maternal death associated with them.

Question 3:
Are there not medications one could use to treat this condition, rather than inducing labour?

> **Answer:** There are medications which may be beneficial, especially medications to lower blood pressure and prevent seizures. However, when the condition is severe, it tends to be progressive and ultimately, as in this case, even combinations of blood pressure medications may not be enough to control the blood pressure. The only definitive cure for this disorder is delivery.

Question 4:
What are the main procedures and processes that happen once the decision has been made that a delivery is needed because of significant risk to the mother?

> **Answer:** As on Case 1, two obstetricians need to confirm their assessment.

CASE 3

*Mary Murphy is a 28 year old woman who is pregnant for the first time. This is an unplanned pregnancy. Mary has a long history of depression since her late teens. Mary has had several admissions to her local psychiatric hospital with depression. She attends her

GP, thinking she is about eight weeks pregnant and her GP performs a pregnancy test which is positive.

Her GP is concerned when talking to Mary that she seems very "low". She has no ongoing relationship with the father of this pregnancy. She voices "suicidal thoughts" to the GP. Her GP is concerned enough to contact her psychiatrist (who has been looking after her for the past twelve years). Mary is seen by her psychiatrist two days later. Mary tells the psychiatrist that the pregnancy is "the worst thing that could have happened". She again voices suicidal thoughts and she tells her psychiatrist that she cannot see how she could possibly be able to cope with the rest of the pregnancy. Her psychiatrist contacts the local maternity hospital and speaks to the consultant obstetrician on call and she attends the maternity unit for an ultrasound scan. This confirms that Mary is 8+ weeks pregnant with a viable fetus. Shortly after this scan, she is seen by a psychiatrist who is attached to the maternity hospital. He has a long consultation with her and he again concludes that Mary is very depressed with suicidal ideation and that the pregnancy is a significant focus of her concerns. He believes that this places Mary's life at significant risk and contacts Mary's consultant psychiatrist to discuss his concerns. He then contacts the consultant obstetrician on call, who in turn asks another obstetric colleague to see Mary. The second obstetrician comes and meets Mary and after assessing her and discussing the case with the maternity hospital psychiatrist, a decision is made that Mary's life is at substantial risk and a medical termination of pregnancy is performed. After this procedure, the mother is admitted to her local psychiatric hospital.

Question 1:
Is it common for pregnant women to have a history of depression?

> **Answer:** It is very common. It is one of the most common pre-existing medical conditions. It would be much less common for the patient to be actively suicidal.

Question 2:
Why did the obstetrician on call in the maternity hospital refer the case on to a second obstetrician?

> **Answer:** The first obstetrician indicated that she was not comfortable with the clinical decision and in this instance had a conscientious objection to performing a termination.

Question 3:
What process and procedure takes place?

Answer: In this case, the procedure involves two psychiatrists confirming that they are in agreement that there is risk of loss of life from suicide. In addition, an obstetrician also certifies that there is a real and substantial risk of loss of life to the mother from suicide.